



SOLVE Guidelines for the Public Service 2012,

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## FOREWORD

This **SOLVE** Guideline is presented to National and Provincial departments to implement the Guideline on management of psychosocial stressors in the Public Service. The guideline addresses nine psychosocial factors, namely: **Stress, Tobacco, Alcohol, HIV&AIDS, Violence, Nutrition, Physical Activity, Healthy Sleep, and Economic Stress**. This guideline is meant to operationalize the existing Wellness Management Policy for the Public Service, which addresses issues of psychosocial wellness, physical wellness, organizational wellness and work-life balance.

Stress, the problems of addiction (alcohol and drugs, tobacco); violence (both physical and psychological); the problems associated with HIV&AIDS; lack of adequate sleep, nutrition and regular exercise and financial problems lead to health-related problems for employees and lower productivity for the organization. Taken together they represent a major cause of accidents, fatal injuries, disease, absenteeism and presenteeism at work. These problems may emerge due to the interaction between home and work, they may start at work and be carried home (or into the community) or vice versa.

South Africa is going through four (4) pandemics namely: **HIV&AIDS and TB, Maternal and Child Mortality, Non-Communicable Diseases (NCDs), and Violence and Injury**. With regards to Non-Communicable Diseases, they are not only biomedical; they are largely diseases of life-style which are divided into four categories namely: **High Blood Pressure, Diabetes, Chronic Respiratory Diseases, and the Cancers**. Added to these conditions is the ever increasing incidence of **Mental Health** which is mainly driven by four identifiable factors namely: **Smoking, Harmful use of Alcohol, Unhealthy eating behaviour (Diet), and Lack of Physical Exercise**. According to Government Employee Medical Scheme (GEMS) Key Healthcare Trends Report, lifestyle-related conditions such as diabetes, hypercholesterolemia and hypertension; and mental health conditions were among the predominant cost drivers for 2009-2010.

Through this guidelines, government as an employer seeks to promote the health and wellbeing of employees in the Public Service. This will in turn, enhance productivity within the Public Service, leading to improved service delivery for the citizens of the Republic of South Africa.

## **PURPOSE OF THE DOCUMENT**

### **Title of the Document:**

SOLVE Guidelines for the Public Service 2012,

### **Goal of this document:**

To provide technical assistance to national and provincial departments on how to manage psychosocial stressors in Public Service workplaces. To improve productivity within the context of Employee Health and Wellness Strategic Framework and policies in the Public Service.

### **Overview**

SOLVE is based on the recognition of the interdependent relationships between psychosocial factors and other health-related behaviours and their underlying causes in the workplace (work organization, working conditions, labour relations). It deals with the prevention of work-related stressors, alcohol and drug abuse, violence, the prevention of HIV/AIDS, promotion of tobacco-free workplaces, promotion of good nutrition, physical activity, healthy sleep and prevention of economic stress.

### **Targeted Audience**

The target is all National and Provincial Government Departments; their DGs, the human resources managers, managers of Employee Health and Wellness programmes, and any organisation providing technical guidance to national and provincial government departments on wellness issues.

### **Structure of this document:**

This document comprises various distinct sections. Each section illuminates a key element of SOLVE:

- Introduction
- Problem Statement
- Objectives of the Guidelines
- Situational Analysis
- Guiding Principles
- Legal and Policy Framework,
- The nine psychosocial stressors. Each section is discussed in the following format:
  - Aims
  - Scientific Evidence
  - Rationale
  - Contextual Issues
  - Interventions
  - Organizational Support Initiatives
  - Governance Initiative
- Implementation of the guidelines.

**Consultative process:**

There has been an extensive consultative process leading up to the compilation of this document. All National and Provincial Departments were consulted and their inputs incorporated into this document. This is not a static document it will be reviewed in line with future developments.

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## LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CAPIME	Capacity Building, Assessment, Planning, Implementation, Monitoring and Evaluation
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
COIDA	Compensation for Occupational Injuries and Diseases Act
DG	Director General
DoH	Department of Health
DoL	Department of Labour
DPSA	Department of Public Service and Administration
EAP	Employee Assistant Programme
EH&W	Employee Health and Wellness
EH&WSF	Employee Health & Wellness Strategic Framework
GEMS	Government Employee Medical Scheme
HR	Human Resource
HIV	Human Immunodeficiency Virus
HOD	Head of Department
HPM	Health and Productivity Management
HR	Human Resources
HRD	Human Resource Development
ILO	International Labour Organization
MDG's	Millennium Development Goals
MRC	Medical Research Council
M&E	Monitoring and Evaluation
NCDs	Non-Communicable Diseases
OD	Organizational Development
OHS	Occupational Health and Safety
PALAMA	Public Administration Leadership and Management Academy
PILIR	Policy and Procedure on Incapacity Leave & Ill-Health Retirement
PSC	Public Service Commission
QWL	Quality of Work Life
ROI	Return on Investment
SHERQ	Safety, Health, Environment, Risk and Quality
SOLVE	<b>Stress, Tobacco, Alcohol, HIV&amp;AIDS, and Violence</b>
UN	United Nations
WLB	Work Life Balance
WHO	World Health Organization

## 1. INTRODUCTION

The **Employee Health and Wellness Strategic Framework for the Public Service** was developed and launched in 2008 following the research and benchmarking of international and local best practices and by obtaining inputs from stakeholders. The integrated approach to employee health and wellness recognises the importance of individual health, wellness and safety and its linkages to organisational wellness and productivity in the Public Service.

Based on the Strategic Framework, four EHW policies were developed and approved in 2009 for implementation in National and Provincial government departments with effect from 01 April 2010; the policies undertake to operationalize the four pillars of the EHW Strategic Framework, namely:

- HIV&AIDS, STI and TB Management
- Health and Productivity Management
- Safety, Health, Environment, Risk and Quality Management (SHERQ)
- Wellness Management

The **Wellness Management policy** has four objectives, namely: Psychosocial Wellness, Physical Wellness, Organizational Wellness and Work-Life Balance. The SOLVE programme addresses the above objectives of the Wellness Management Policy. To operationalize the Wellness Management Policy and the Generic Implementation Guide for the policy, the DPSA studied, researched, consulted and adapted elements of the International Labour Organization (ILO) **SOLVE** Model. The SOLVE model was found to be a good model that can be used to address psychosocial problems in the Public service workplace. The original SOLVE Programme addressed only five psychosocial factors, namely: **Stress, Tobacco, Alcohol, HIV&AIDS, and Violence**. The model has since been improved to focus on four other factors, namely: **Nutrition, Physical Activity, Healthy Sleep, and Economic Stress**.

The SOLVE Program was launched by the ILO's SafeWork Programme in 2001 to address psychosocial problems at work. It has expanded to over 40 countries, and course materials are currently available in eight languages. SOLVE is an interactive educational programme designed to assist in the development of policy and action to address health promotion issues at the workplace. The SOLVE methodology includes a policy and action-oriented educational package that addresses the issues of stress, drugs and alcohol, violence, HIV&AIDS, and tobacco in an integrated way. It is based on the recognition of the interdependent relationships between psychosocial factors and other health-related behaviours and their underlying causes in the workplace (work organization, working conditions, labour relations). It deals with the prevention of work-related stressors (both work-place stress and economic stressors), alcohol and drug abuse, violence (both physical and psychological), the prevention of HIV& AIDS, STI and TB, as well as the promotion of tobacco-free workplaces.

Stress, the problems of addiction (alcohol and drugs, tobacco); violence (both physical and psychological); the problems associated with HIV&AIDS; lack of adequate sleep, nutrition and regular exercise and financial problems lead to health-related problems for employees and lower productivity

for the organization. Taken together they represent a major cause of accidents, fatal injuries, disease, absenteeism and presenteeism at work. These problems may emerge due to the interaction between home and work, they may start at work and be carried home (or into the community) or vice versa. SOLVE focuses on prevention. The combined effects of these psychosocial issues have considerable negative ramifications for workers, employers, the worker's family and society.

There are numerous interrelationships between the above-mentioned psychosocial problems. Any one of these problems may be a causal factor for the others. Each one may be an end result or find its roots among the others. Thus psychosocial problems can initiate or exacerbate an increasingly damaging cycle that will lead to negative consequences for the individual, for the organization and for society as a whole. The traditional approach in dealing with psychosocial problems has been reactive and isolated, focusing on just one of the problems and treating its symptoms. But the problems are increasing and because they are interlinked treating just one can be ineffectual. Therefore a major paradigm shift towards an integrated, proactive and prevention-oriented approach is needed and a multi-level approach is essential.

To address these problems at the workplace, a comprehensive policy should be put in place. The workplace policy should focus on occupational safety and health needs including psychosocial problems. Traditional approaches have neither addressed the policy requirements nor action required to reduce the negative impact of psychosocial problems. Through improved psychosocial working conditions, workers will be healthier with a higher morale and employers will see productivity increase. The government as an employer can also benefit from such initiatives, but in addition can use the SOLVE methodology to meet its own mandate to improve working conditions.

## **2. PROBLEM STATEMENT**

Working in a stressful environment can lead employees to smoke or drink more, and in some cases to start using drugs in order to cope with the problems; stress can also lead to violence in the workplace. The use of alcohol and drugs has an impact on sleep, performance and judgement, and can increase the risk of unprotected sex. The 'tension' some jobs impose also affects employees' eating and sleeping habits. The sedentary nature of other jobs, together with the lack of exercise, can cause problems such as obesity and high cholesterol levels. All these psychosocial factors should be managed in an integrated manner because there is an inter-relationship between them.

Taken together, all these factors lead to health-related problems for the employee and lower productivity for the organization. They also represent a major cause of accidents, fatal injuries and diseases at work. Psychosocial problems also take a heavy toll in terms of reduced productivity and efficiency by means of absenteeism, higher medical costs and staff turnover, as well as the associated cost of recruiting and training new workers. Both employers and employees have the responsibility to address psychosocial hazards at the workplace and find innovative ways to deal with the consequences of the risks associated

with psychosocial factors in the workplace. Initiatives to improve working conditions by promoting occupational health contribute at the same time to employees' well-being and productivity.

For employees, psychosocial problems may result in illness, injury, stigmatization, isolation, and even death. And they can have a considerable impact on the employer - such as lost work days, increased accidents, reduced productivity, higher medical costs, and lowered morale. "These problems have a compounding effect and cannot be addressed on a one-off basis. They are interrelated, and therefore the programmes that address them need to be interrelated.

Public servants experience a variety of psychosocial problems, which impact on both their private and work life. There is inadequate comprehensive programme to address psychosocial problems in the workplace and inadequate number of trained / professional individuals to perform relevant and appropriate interventions.

Research reports indicate that many Public Servants experience psychosocial problems which have an impact on productivity.

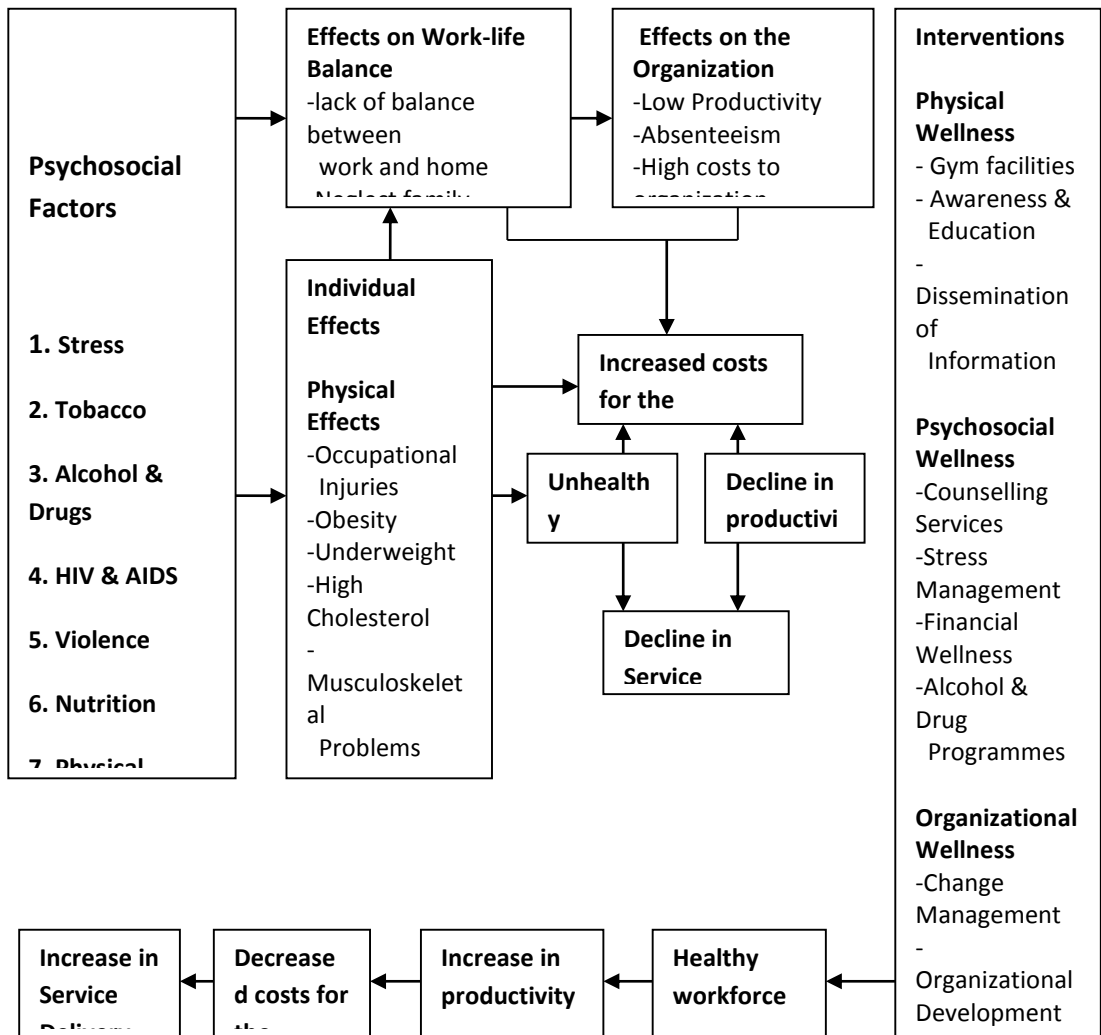
Such reports include:

- Impact of Public Service Strike report (June 2007);
- GEMS Key Health Trends (2009)
- EHW Indaba Report VIII (2008)
- WHO: World Health Report 2008
- PSC Reports EAP and HIV 2006/7
- Health Risk Management Report
- ICAS Reports on EHW service to government;

The main psychosocial problems that are identified in the Public Service through these reports are the following:

- Stress
- Violence
- Alcohol and Drugs
- HIV and AIDS
- Tobacco
- Mental illnesses
- Relationship problems (both at work and at home)
- Financial problems
- Sleep deprivation,
- Inadequate nutrition,
- Lack of regular exercise,

The diagram below demonstrates the effects of psychosocial factors at an individual level, effects on work-life balance and at an organizational level. It also depicts the different interventions classified as per the objectives of the Wellness Management Policy.



**Business Case for SOLVE**

### 3. OBJECTIVES OF THE GUIDELINES

The overall objective of these guidelines is to develop knowledge and skills for Wellness Managers and Practitioners to enable them to integrate psychosocial and health promotion issues into a comprehensive workplace programme. Through these guidelines, Wellness Practitioners will be better able to:

- Understand the nature, the generation process and impact of the following problems: stress, workplace violence, HIV&AIDS, alcohol and drug abuse, smoking, lack of exercise, bad nutrition, unhealthy sleep and economic stress.
- Identify the potential inter-relationships among these health related problems.
- Identify the measures to avoid the causes for these problems, to prevent the generation of unhealthy consequences and to mitigate their impact in both the worker and the organization.
- Develop integrated workplace programmes to address health promotion and prevention of work-related stressors.
- Provide access to therapeutic, clinical interventions and referral for affected employees.

### 4. SITUATIONAL ANALYSIS

#### **4.1 World Health Organization (WHO)**

According to the **World Health Organization (WHO)** Social Determinants of Health, it is increasingly recognized that overwork and the resulting imbalance between work and private life (**Work-life Balance**) has negative effects on health and wellbeing (Felstead et al., 2002). Rebalancing work and private life requires government policy and legislative support that provides parents the right to time look after children, through provisions such as flexible working hours, paid holidays, parental leave etc. Furthermore, the WHO also recognises that the conditions of work affects health and health equity, poor work quality may affect mental health almost as much as loss of work. Stress at work is associated with a 50% excess risk of coronary heart disease (Marmot, 2004; Kivimaki et al., 2006). There is consistent evidence that high job demands, low control, and effort-reward imbalance are risk factors for mental and physical health problems (Stansfeld & Candy, 2006).

#### **4.2 Government Employee Medical Scheme (GEMS) Key Healthcare Trends Report (2009-2010)**

According to GEMS Key Healthcare Trends Report (2009-2010), lifestyle-related conditions, community acquired infections, mental health conditions, pregnancy related conditions and Spinal and joint diseases were among the predominant cost drivers.

- Lifestyle related and certain other treated chronic diseases
  - Diabetes, hypertension, high lipids predisposing to ischaemic heart disease, stroke and vascular diseases.
  - Chronic diseases e.g. asthma, emphysema, epilepsy etc
- Community acquired infections
  - Pneumonia and gastroenteritis
  - Tuberculosis
  - Bronchitis and meningitis
- Mental health conditions
  - predominantly depression
  - Other psychoses
  - Anorexia nervosa and alcohol and substance abuse
- Pregnancy related conditions
- Spinal and joint disease
  - Spinal and joint surgery
  - Chronic back and neck pain
  - Chronic arthritis

### Lifestyle-Related conditions

In this report, “true” lifestyle-related conditions such as diabetes, hypercholesterolemia and hypertension were combined with chronic conditions which could impact on productivity at the workplace such as asthma, seizure disorders, various conditions resulting in abdominal pain and cerebrovascular disease (stroke as a possible complication of uncontrolled hypertension as well as migraine), because adequate control of these conditions are dependent on early diagnosis and adherence to appropriate treatment.

A sedentary lifestyle, obesity, dietary deficiencies and smoking are modifiable risk factors for premature and severe disease and premature death. There is also evidence from a multitude of small and large scientific studies indicating statistically and clinically significant positive outcomes associated with lifestyle change. For relevant subpopulations, maintained improvement in lifestyle, with smoking cessation, moderate exercise and weight loss is associated with up to 25% reduction in diabetic, cardiovascular and cancer morbidity and mortality rates.

Doctors are therefore admonishing their patients to exercise moderately and regularly, maintain ideal body mass, eat at least five helpings of fruit and vegetables per day, stop smoking and adhere to treatments for chronic disease. This important advice should be followed by everyone; young, old, healthy and sick, because it could:

- Primarily prevent diseases associated with a poor lifestyle (notably hypertension, heart disease, diabetes, mechanical back problems and various types of cancer).
- Prevent complications of such diseases (secondary prevention which includes not only lifestyle changes, but also adherence to established treatment).
- Prevent negative outcomes of complicated diseases, in other words play a major part in rehabilitation (tertiary prevention).

### Mental Health conditions

Although the bulk of GEMS members have access to chronic benefit cover for mental health diseases, mental health admissions continue to feature in the top 10 hospital admissions by frequency and cost. Causation is nearly always multifactorial and aetiological factors include:

- Genetic predisposition: It is assumed that several genes have an influence on the development of the majority of conditions.
- Family background factors: Unhappy childhood, parental disharmony, abuse, emotional over-involvement and hostile attitudes are adverse influences in the course of psychiatric illness.
- Physical illness: Chronic ill health predisposes to psychiatric disorder.
- Stressful life events: A wide range of such events can precipitate episodes of illness in vulnerable people.
- Social factors: Social deprivation is associated with alcoholism and drug dependence.

The prevalence of psychiatric illness varies in different populations, but in general 15 to 20% of communities suffer from some kind of mental health-related condition. The symptoms of psychiatric disorders involve abnormalities of behaviour, mood, perception, thinking and intellectual function. Some of these abnormalities impair judgment or contact with reality so that patients become a danger to themselves or other people with loss of productivity. Diagnosis and appropriate treatment of these conditions are therefore of importance to employers. The facilitation of awareness, removal of the stigma, early diagnosis and appropriate care is an important goal for management (including health and wellness) programs, both for medical schemes and employers.

### **4.3 Health Budget Vote Policy Speech by Dr A Motsoaledi**

During the Health Budget Vote Policy speech on 31 May 2011, the Minister for Health, Dr A Motsoaledi stated that extensive studies commissioned by the prestigious British Medical Journal the Lancet but conducted by scientists and researchers in South Africa has clearly revealed that South Africa is going through four (4) pandemics namely: ***HIV&AIDS and TB, Maternal and Child Mortality, Non-Communicable Diseases (NCDs), and Violence and Injury***. With regards to Non-Communicable Diseases, the Minister mentioned that these are not only biomedical, they are largely diseases of life-style which are divided into four categories namely: High Blood Pressure, Diabetes, Chronic Respiratory Diseases, and the Cancers. Added to these conditions is the ever increasing incidence of Mental Health

which is mainly driven by four identifiable factors namely: Smoking, Harmful use of Alcohol, Unhealthy eating behaviour (Diet), and Lack of Physical Exercise.

Non-Communicable Diseases is a fast growing global phenomenon and is becoming more devastating in Sub-Saharan Africa because it is adding on problems of communicable diseases or infectious diseases that have been plaguing Africa for centuries. The World Health organization (WHO) and the United Nations (UN) called all the Ministers of Health to Moscow on 28-29 April 2011 for the first Global Ministerial Conference on Healthy Lifestyles and Non-Communicable Diseases. The outcome of the conference were documented formally and referred to as the "**Moscow Declaration**".

In summary, the Moscow Declaration deals with the following issues:

- Notes that **policies that address behavioral, social, economic and environmental factors associated with NCDs should be rapidly and fully implemented** to ensure the most effective responses to these diseases, while increasing the quality of life and health equity.
- It further emphasizes that **prevention and control of NCDs requires leadership at all levels, to create the necessary conditions for leading healthy lives**. This includes promoting and supporting healthy lifestyles and choices, relevant legislation and policies.
- It recognizes that **a paradigm shift is imperative in dealing with NCD challenges as NCDs are caused not only by biomedical factors** but also caused or strongly influenced by **behavioral, environmental, social and economic factors**.
- The Moscow Declaration says that the Rationale for Action is that **worldwide, NCDs are important causes of premature deaths, striking hard the most vulnerable and poorest populations**. Subsequently they impact on lives of billions of people and can have devastating financial impact that impoverishes individuals and families, especially in low and middle income countries.
- It goes on to state categorically that examples of cost-effective interventions to reduce the risk of NCDs which are affordable in low-income countries and could prevent millions of premature deaths every year, **include measures to control tobacco, reduce salt intake and reduce harmful use of alcohol**. It says particular attention should be paid to promote healthy diets i.e. low consumption of saturated fats and trans-fats, salt and sugar and high concentrations of fruits and vegetables and physical activity in all aspects of daily living.
- Effective NCD prevention and control **require leadership and concerted "whole of government" at all levels (National, Sub-National and local) and across a number of sectors such as health, education, energy, agriculture, sports, transport and urban planning, environment, labour, trade and industry, finance and economic development**.
- Lastly it states **that effective NCD prevention and control require the active and informed participation and leadership of individuals, families and communities**, civil society organisations, private sector where appropriate, employers, health care providers and international community.

According to the Medical Research Council (MRC) Comparative Risk Assessment (2008), in Gauteng province alone the total number of patients on chronic dialysis both haemodialysis and peritoneal dialysis is 561. Those on the waiting list for an opportunity to avail itself the total number is 238. 40-60% of people with end stage renal failure is due to high blood pressure at an average age of 39 years. The main risk factor for high blood pressure is **smoking, lack of exercise and high salt intake**. So instead of demanding more dialysis machines and subsequently demanding new kidneys, there is a need to reduce the prevalence of hypertension by eliminating the risk factors. The need for targeting tobacco and alcohol has already been outlined.

South African diet has been shown to be very high in salt. The desired amount of salt for your body is known to be 4-6 grams per day. But in our country it is up to 9,8 grams per day i.e. more than 2 times the physiologically required amount. More salt is already found in food rather than individuals adding it on the table. Britain has taken a lead in this case, since 2006, they have agreed to reduce salt intake by 40% within 5 years. In South Africa, studies show that reducing salt intake just on bread only will save close to 6,500 lives per annum. In Britain studies show that just in the second year of reduction in salt intake by 10%, 6000 deaths were averted and a saving of 1,5 billion British Pounds was achieved.

Furthermore, the Minister highlighted another issue which is extremely important which the MRC ranks as number 5 risk factor after unsafe sex; injuries and violence; alcohol and tobacco is **high body mass index or excess body weight**. This coupled with lack of exercise which is ranked as risk number 12 becomes very problematic. It is an international problem not confined to any specific group of people. In South Africa, it is a fast growing phenomenon among school children, increasing from 17,2% overweight in 2002 to 19,7% in 2008. The figures of those who moved from overweight to obese are 4% in 2002 to 5,3% in 2008.

This means that by 2008-a total of 23% of school children can be classified as either obese or overweight. This is fast approaching a quarter of the school going population. The consequences to both individual and society are devastating. In the general population the national income dynamic study shows that 60% of women and 31% of men are either obese or overweight. If you consider women over 37 years the figure rises to a tremendous 70% classified as either overweight or obese. This is why the Moscow declaration is so important.

With regards to violence and injury, a lot is known about it because it is spoken about daily in the media. A study by UNISA in collaboration with the MRC shows that for every person killed by injury, 30 times as many are hospitalized and 300 times as many are treated for less serious injuries and discharged. It further states that depending on the cause, severity and circumstances of the injury, many of these results in varying degrees of physical, psychological, educational social and economic disadvantages for the affected individuals and families.

#### **4.4 The Public Service Commission Report**

The Public Service Commission (PSC) released a report in February 2008 on the over-indebtedness of employees in the Public Service. The report stated that twenty percent (20%) of the work force is in a debt spiral, this could adversely affect productivity leading to poor service delivery. This figure relates to money paid through the government's personnel and salary administration system (Persal) to micro-lenders and because of garnishee orders transactions that took place in the 2006/07 financial year.

The report revealed that the over-indebtedness of public servants has the following implications for the public service: administrative burden on the State; ill-health due to financial distress; low productivity; irregular remunerative work outside the public service; and ethical considerations. Among others, the PSC recommended that a fully-fledged Employee Assistance Programme (EAP) be embarked upon, looking into personal financial wellness with a key focus on legislative framework on micro-lending, procedure for the issuing of garnishee orders, credit rights as well as budgeting, borrowing, saving and how to manage these effectively.

#### **4.5 Budget Vote Speech by Deputy Minister for Public Service and Administration,**

##### **Ms Ayanda Dlodlo**

In her speech delivered on the occasion of the delivery of the budget vote to the National Council of Provinces on 8 June 2011, the Deputy Minister for Public Service and Administration, Ayanda Dlodlo, stated that the scourge of HIV and AIDS contributes to the loss of skilled staff and loss of man-hours due to ill health. The Minister of Health has also lamented the nation's unhealthy lifestyle and this is a problem for Public Service employees as well. In order to curtail the cost of ill health to the employer, the Government Employee Medical Scheme (GEMS) will accelerate its employee wellness programme to deal with this.

## **5. GUIDING PRINCIPLES**

5.1 **Confidentiality** will be maintained at all times except in cases of risk to self and others as per legislation.

5.2 **Voluntary Participation:** Employees participation in the programme is voluntary.

5.3 Only **registered professionals** will provide therapeutic interventions.

5.4 As far as possible the generic principles of respect for autonomy, non-maleficence, beneficence, and distributive justice will guide the actions of all professionals working in the field of Wellness Management.

5.5 Focus on **all levels** of employment.

5.6 Cohesiveness with **HRM** processes.

5.7 **Policy coherence:** interventions should not contradict other related policies in the Public Service, e.g Leave Policy, Transport Policy etc.

5.8 **Coherence of service models:** the service delivery models should offer the same package to Public Servants in spite of it being in-house or outsourced.

5.9 Flexibility and adaptability.

5.10 Respond to the needs of designated employees (e.g people with disabilities and women).

## **6. LEGAL AND POLICY FRAMEWORK**

These guidelines should be read in conjunction with the following instruments:

- 6.1 WHO Global Strategy on Occupational Health for All
- 6.2 ILO Decent Work Agenda 2007-2015
- 6.3 ILO Promotional Framework for Occupational Safety Convention 2006
- 6.4 United Nations Millennium Declaration and its Development Goals (MDGs)
- 6.5 WHO Commission on social determinants of health
- 6.6 Occupational Health and Safety Act, 1993 (Act No. 85 of 1993)
- 6.7 Labour Relations Act, 1995 (Act No. 66 of 1995)
- 6.8 Basic Conditions of Employment Act, 1997 (Act No. 75 of 1997)
- 6.9 Employment Equity Act, 1998 (Act No.55 of 1998)
- 6.10 Disaster Management Act, 2002 (Act No. 57 of 2002) and National Disaster
- 6.11 Tobacco Products Control Amendment Act, 1999 (Act No. 12 of 1999)
- 6.12 The Promotion of Equality and the Prevention of Unfair Discrimination Act, 2000 (Act No. 4 of 2000).Mental Health Care Act, 2002 (Act No.17 of 2002)
- 6.13 National Sports and Recreation Act, 1998 (Act No. 110 of 1998)
- 6.14 National Strategic Plan on HIV&AIDS 2007-2011
- 6.15 National Strategic Framework on Stigma and Discrimination
- 6.16 National Occupational Health and Safety Policy of 2005
- 6.17 EAPA-SA Standards 2002
- 6.18 Mental Health Care Regulations 14 February 2003
- 6.19 The Public Service Regulations, 2001 as amended.
- 6.20 Policy and Procedure on Incapacity Leave& Ill-Health Retirement
- 6.21 Employee Health and Wellness Strategic Framework
- 6.22 Wellness Management Policy for the Public Service
- 6.23 HIV&AIDS and TB Management policy for the Public Service
- 6.24 Health and productivity Management policy for the Public Service
- 6.25 SHERQ Management Policy for the Public Service
- 6.26 Public Health (Tobacco) Regulation (PHTR) 2009 on advertising on the premises, health warnings and other notices. (The Guidelines are aligned to regulations relating to smoking in public places and certain outdoor public places, gazetted on 30 March 2012).
- 6.27 WHO Convention on Tobacco Control (CTC)

## **7. INTERGRATION OF THE PSYCHOSOCIAL STRESSORS WITHIN THE GUIDELINE**

This SOLVE guideline demonstrates the integration and the interrelated relationship between the nine psychosocial factor namely; Stress, Tobacco, Alcohol and Drugs, HIV & AIDS, Violence, Nutrition, Healthy Sleep and Economic Stress. When dealing with these factors, it is important to recognize that any one of these problems may be a causal factor for the others and each one may be an end result or find its roots among the others.

This guideline is divided into nine distinct sections for each psychosocial factor. Each section outlines the scientific evidence, rational, contextual issues, and interventions for that specific psychosocial factor. The sub-section on scientific evidence focuses various studies or researches that were conducted to prove the effects of the psychosocial factor on individuals and organizations. The rational explains reasons for evidence based programme to be put in place to address the effects. The sub-section on contextual issues looks at existing factors that are likely to affect programme implementation e.g. prevalence, incidence and demographics. Interventions for dealing with each psychosocial factor as outlined in each section follow the **APIME** Model (Assessment, Planning, Implementation, Monitoring and Evaluation). For each psychosocial factor, there is a table outlining activities and processes to be undertaken using the APIME Model.

Over and above this integrated guideline, the different sections are divided into nine booklets for manager for easy access and use. Furthermore, there are nine distinct booklets for each psychosocial specifically for the general employees. These booklets provide tips for employees on how to deal with psychosocial stressors.

## STRESS

### 1. Aims

Over and above the overall objective of developing knowledge and skills for Wellness Managers and Practitioners to enable them to integrate psychosocial and health promotion issues into a comprehensive workplace programme, the specific aims for this section on stress management are to:

- Provide guidance to Wellness Managers and Practitioners on how to manage stress an organizational level.
- Provide guidance to Wellness Managers and Practitioners on how to manage stress an individual level.
- Provide guidance to Wellness Managers and Practitioners on how to develop effective stress prevention programmes.
- Operationalize the Wellness Management Policy for the Public Service.

## **2. Scientific Evidence**

Stress is explained as an interactive psychological process or a psychological state between the individual and the situation<sup>i</sup> . Stress is seen as the perceived imbalance between internal and external demands facing the individual and the perceived ability to cope with the situation.

The symptoms of stress are divided into short-term and long-term:

### **Short-term Symptoms**

- Taking a sleeping pill
- Lighting up a cigarette
- Skipping breakfast
- Having an extra drink

### **Long-term Symptoms**

- Physical ill health
- Mental ill health

Stressful characteristics of work are divided into two groups, Content of work and Context to work:

### **Content of work**

- Work-environment
- Work equipment
- Task design
- Workload/work-pace
- Work schedule

### **Context to work**

- Organizational culture and function
- Role in organizations
- Career development
- Decision latitude and control
- Home work interface

- Interpersonal relationships at work (includes violence, harassment, and bullying)

The impact of stress on brain function is increasingly recognized. Various substances are released in response to stress and can influence distinct circuits of the Nervous System.

### **What happens in the brain when a person perceives a threat?**

- The sympathetic nervous system (SNS) turns on the fight or flight response.
- In contrast, the parasympathetic nervous system (PNS) promotes the relaxation response.
- The SNS and PNS carefully maintain metabolic equilibrium by making adjustments whenever something disturbs this balance.
- The hormones (chemical messengers produced by endocrine glands) travel through the bloodstream to accelerate or suppress metabolic functions.
- The trouble is that some stress hormones don't know when to stop. They remain active in the brain for too long – injuring and even killing cells in the hippocampus, the area in the brain needed for memory and learning.
- Because of this hierarchical dominance of the SNS over the PNS, it often requires conscious effort to initiate your relaxation response and reestablish metabolic equilibrium.
- The sympathetic nervous system does an excellent job of rapidly preparing a person to deal with what is perceived as a threat to safety.
- The adrenal glands release adrenaline (also known as epinephrine) and other hormones that increase breathing, heart rate, and blood pressure.
- Other hormones shut down functions unnecessary during the emergency.
- Growth, reproduction, the immune system all go on hold and blood flow to the skin is reduced. That's why chronic stress leads to sexual dysfunction and increases chances of getting sick.
- When a danger finally passes or the perceived threat is over, the brain initiates a reverse course of action that releases different biochemicals throughout the body.
- To bring back the balance, the brain seeks "homeostasis," the elusive state of metabolic equilibrium between the stimulating and the tranquilizing chemical forces in the body.
- If one of the stimulating or tranquilizing chemical forces dominates the other without relief, then a person will experience an on-going state of internal imbalance. This condition is known as stress and it can have serious consequences for the brain cells.
- An appropriate stress response is a healthy and necessary part of life. It releases norepinephrine, which is needed to create new memories.
- It also improves mood and encourages creative thinking that stimulates the brain to grow new connections within itself, therefore stress management is the key, not stress elimination.
- The challenge is to not let the sympathetic nervous system stay chronically aroused. This may require knowledge of techniques that work to activate relaxation response.

## Theoretical Framework

The most utilised model to optimise the potential and work-related wellbeing of employees at a primary level is the Job Demands-Resources (JD-R) model. The Job Demands-Resources model<sup>ii</sup> can be used to predict human factor outcomes, and consequently organisational performance, such as growth, competitiveness, turnover, productivity, absenteeism, corporate citizenship behaviour, and stress-related ill health level affecting the quality of employee outputs and the ability of employees to function optimally; value creating human factor outcomes are:

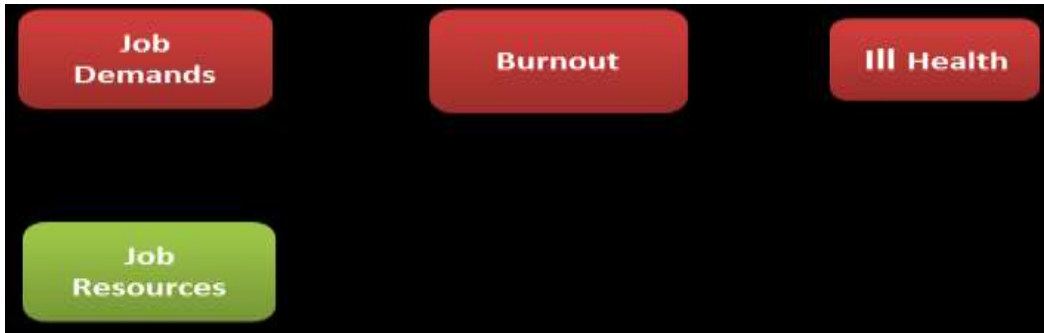
- Manageable stress levels,
- High work engagement,
- Low turnover intention,
- Good corporate citizenship behaviour, and
- Good health and lifestyle habits.

At the heart of the JD-R model rests the assumption that whereas every occupation may have its own causes affecting employee functioning and work-related wellbeing, these factors can be classified in two general categories, namely **job demands** and **job resources**, and thus constituting an overarching model that may be applied to various occupational settings, irrespective of the particular demands and resources involved.

The JD-R model states that employees excel in their work because they maintain the balance between the energy they give and the energy they receive (maintain a balance between job demands and job resources – workplace optimisation):



There is evidence for the existence of two simultaneous processes in the workplace. High job demands and low job resources (unbalanced work climate) exhaust employees' mental, emotional, and physical resources and therefore lead to the depletion of energy (burnout) and to stress-related ill health problems. This is the **health impairment process**:



In contrast, high job resources or a balance between job demands and job resources (a balanced work climate) foster employee engagement and extra-role performance. **This is the motivational process:**



The JD-R model predicts employee outcomes by measuring the work climate and employee work-related wellbeing and is therefore a useful model to manage the work-related wellbeing and the organisational causes impeding the work-related wellbeing of employees. Managers can utilise the principles of the JD-R model to ensure that they create an employee-friendly environment whilst being in a position to understand workplace contributors impeding employee functioning.

In summary:



### 3. Rationale

This guideline is based on the **SOLVE** Program that was launched by the International Labour Organization (ILO) Safe Work Programme in 2001 to address psychosocial problems at work. It is also based on the **World Health Organization (WHO)** Social Determinants of Health, which recognizes that overwork and the resulting imbalance between work and private life (**Work-life Balance**) has negative effects on the health and wellbeing of employees.

It seeks to respond to the Government Employee Medical Scheme (GEMS) Key Healthcare Trends Report (2009-2010) which identified **Mental Health conditions** as predominant cost drivers in the Public Service.

Furthermore, Health Risks Managers reports for the Public Service indicates that one of the leading conditions for incapacity leave applications is **Psychiatric illnesses (Depression and Anxiety)**.

For integrated stress and workplace risk management to be effective, adoption of the following principles are important:

***Stress and Work-related wellbeing risk management creates and protects value.***

Stress and Work-related wellbeing risk management contributes to the demonstrable achievement of objectives and improvement of performance in, e.g., workplace optimisation, work-related wellbeing of staff, occupational health and safety, efficiency in operations, governance and reputation.

***Stress and Work-related wellbeing risk management is an integral part of all processes in the organisation.***

Stress and Work-related wellbeing risk management is not a stand-alone activity that is separate from the main activities and processes of the organisation. Stress and Work-related wellbeing risk management is part of the responsibilities of all managers and an integrated part of the organisation's

processes, including strategic and business planning, operational performance and all project and change management processes.

***Stress and Work-related wellbeing risk management is part of decision-making.***

Stress and Work-related wellbeing risk management helps decision-makers make informed choices, prioritise actions and distinguish among alternative courses of action.

***Stress and Work-related wellbeing risk management is systematic, structured and timely.***

A systematic, timely and structured approach to stress and work-related wellbeing risk management contributes to efficiency and to consistent, comparable and reliable results.

***Stress and Work-related wellbeing risk management is based on the best available information.***

The inputs to the process of managing stress and work-related wellbeing risks are based on the experiences of all staff members via a rigorous and scientific approach (bottom-up approach) which allows staff to provide inputs regarding workplace experiences.

***Stress and Work-related wellbeing risk management is tailored.***

Stress and Work-related wellbeing risk management is aligned with the Organisation's external and internal context and risk profile.

***Stress and Work-related wellbeing risk management is transparent and inclusive.***

Appropriate and timely involvement of stakeholders, in particular, decision-makers at all levels of the organisation, ensures that stress and work-related wellbeing risk management remains relevant and up-to-date. Involvement also allows stakeholders to be properly represented and to have their views taken into account in determining risk criteria.

***Stress and Work-related wellbeing risk management is dynamic, iterative and responsive to change.***

Stress and Work-related wellbeing risk management continually senses and responds to change. As external and internal events occur, context and knowledge change, monitoring and review of risks take place, new risks emerge, some change, and others disappear.

***Stress and Work-related wellbeing risk management facilitates continual improvement of the Organisation and all stakeholders***

The approach to stress and work-related wellbeing risk management is *developmental* and *inclusive* and the focus is on *improvement* of workplace processes at all levels in order to optimise the potential of staff and the organisation at large.

#### **4. Contextual Issues**

The South African Stress and Health (SASH) Survey was conducted between 2002 and 2004. Findings revealed that the most prevalent (lifetime) mental conditions in South Africa were the following:

- Alcohol abuse

- Major depressive disorders,
- Anxiety disorders,
- Alcoholism

This finding of SASH is also representative of Public Servants as they are part of the broader community. It is however noted that some occupations are more stressful than others, for an example occupations such as police, correctional services, healthcare workers emergency services, etc. Employees in these occupations may be exposed to situations of extreme emotional stress; as a result they may suffer from Post-Traumatic Stress Disorder (PTSD). Special measures need to be in place to help these workers cope with this kind of stress.

The South African Public Service has put in place measures to deal with the health and wellbeing of public servants. Such measures include:

- The launch of the Employee Health and Wellness Strategic Framework for the Public Service in 2008.
- The framework also recognizes the integrated approach to employee health and wellness and the importance of individual health, wellness and safety and its linkages to organisational wellness and productivity in the Public Service.
- Subsequent to the framework, the Wellness Management Policy for the Public Service was developed to address psychosocial problems within the Public service.

The current stress management programmes in the Public Service are not integrated and do not take into consideration the inter-relatedness of psychosocial factors. These guidelines seek to correct the current situation and prevent the generation process of psychosocial problems.

It is important to note that some stress is normal and necessary. But if stress is intense, continuous or repeated, if the person is unable to cope or if support is lacking, then stress becomes a negative phenomenon leading to physical illness and psychological disorders. The harmful consequences of stress cover a broad range, including:

- Chronic fatigue
- Depression
- Insomnia
- Anxiety
- Migraine
- Emotional upsets
- Stomach ulcers
- Allergies
- Skin disorders
- Heart attack
- Accidents and even

- Suicide

**Work-related stress** can be defined as the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker. Job stress can lead to poor health and even injury<sup>iii</sup>. Work-related stress is determined by work organization, work design and labour relations. It emerges when the knowledge and abilities to cope of an individual worker or of a group are not matched with the expectations of the organizational culture of an organization.

**A stressor** is referred to as a stimulus event, either an internal or external condition that places a demand on an organism or on a person for some kind of adaptive response. The effect of a stressor on an individual depends on what the stressor is and what it means to that particular individual<sup>iv</sup>

## 5. Inter-relationships of stress with other psychosocial factors

Psychosocial problems are interrelated: suffering from one of them can provoke or contribute to another. Stress is particularly related to **violence and to addiction**, but also to lifestyle issues **like nutrition, exercise and sleep**, financial stress, HIV&AIDS stigma and Discrimination

### 5.1 Violence and stress

There is clearly a close relationship between violence and stress. Workplace violence in SOLVE is seen as including both psychological and physical violence. In stressful situations, many people begin to be bad-tempered towards those around them. Of the many sources of workplace stress, the three main sources which contribute significantly to the likelihood of violence (particularly physical violence) occurring at the workplace is:

- Perceived injustice (i.e. being passed over for promotion or unfair punishment),
- Electronic monitoring, and
- Job insecurity.

Equally, where workplace violence happens, there is likely to be more stress. Interestingly, this can affect the witnesses of violence as much as the victims. This is particularly true in jobs involving a great deal of team work and customer orientation.

### 5.2 Addictions and stress

There is considerable evidence that stress fuels addictive habits, but also that addictions can result in increased stress. For example, stressed employees working long hours have been shown to **smoke more** and **drink more** alcohol than those working shorter hours. Many of those who suffer from addictions also suffer from forms of stress such as anxiety and depression. Often the addiction results from an attempt to cope with difficulties in life and work, but mostly it only makes things worse. Smokers for example, often cite a “smoke to cope” reason for their habit, but there is evidence to suggest that

smokers' stress levels between one cigarette and another are higher than those of non-smokers. Smokers therefore have to smoke in order to achieve a "normal" level of stress as experienced by non-smokers.

### **5.3 Lifestyle (nutrition, exercise and sleep) and stress**

Many lifestyle choices today, such as what people eat and how they organize their sleeping patterns, are affected by the stress they may experience at work or elsewhere. Many people can be so stressed that they are unable to fall asleep. When this situation carries on repeatedly, it can lead to severe health consequences because the body is unable to recover and recuperate.

Eating habits are also affected by stress. Time pressure can mean eating at irregular intervals rather than at set meal times. The food which is available in this way tends to be highly processed, containing much fat and sugar and little fibre. Some people eat healthier food when they feel good, but prefer junk food when they don't.

Exercise is a well-known positive response to stress, which not only improves health but also mood and ability to cope with difficult situations.

## **6. INTERVENTIONS**

Stress Management interventions should follow the **APIME** (Assessment, Planning, Implementation, Monitoring and Evaluation) approach:

### **6.1. ASSESSMENT**

The following steps should be followed when conducting an assessment in the workplace; this assessment is also referred to as a stress audit.

#### **Step 1: Identify the hazards/stressors (Risk Identification)**

The purpose is to gather information about occupational stress in the organization. The actions that could be undertaken include:

- examining stress-related absence from work to identify if some groups or individuals within the organization have higher absenteeism than others (HR records, Health Risk Managers reports, GEMS)
- Asses how this contribute to stress, recognizing and recording conflict measures, such as grievance procedures, workplace harassment claims, performance management programs and industrial action to identify if issues that contribute to occupational stress are also showing up in other indicators.

- Examining stress related occupational health and safety incident reports and staff reporting of stress or related illness
- Examining employees' compensation claims to identify which individuals or group/s or workers are making accepted stress claims and the reasons for their claims e.g. Post Traumatic Stress Disorder (PTSD) (consult Department of Labour; Compensation Commissioner for more details).
- interviewing the supervisors of claimants for compensation to identify what could have been done to prevent the absence from the workplace or to minimize the length of absence
- conducting employee opinion survey to obtain qualitative feedback from staff
- conducting interviews with focus groups and managers to obtain qualitative feedback on issues, such as the organization's management of change

The data collected should then be arranged into a brief report which summarizes the data collected and describes how the organization currently manages employees that experience stress. Look for patterns and highlight any in the report.

### Identification of symptoms of stress

Some of the symptoms of stress at workplace are as follows:

- Absenteeism, escaping from work responsibilities, arriving late, leaving early, etc.
- Deterioration in work performance, more of error prone work, memory loss, etc.
- Over-reacting, arguing, getting irritated, anxiety, etc.
- Deteriorating health, more of accidents, etc.
- Improper eating habits (over-eating or under-eating), excessive smoking and drinking, sleeplessness, etc.

Symptoms of stress are categorized into physical, psychological, and behavioral in the table below:

Physical symptoms	Psychological symptoms	Behavioral symptoms
<ul style="list-style-type: none"> <li>• Sleeplessness</li> <li>• Fatigue</li> <li>• Reduced immunity to infection</li> <li>• High blood pressure</li> <li>• Chest pain</li> <li>• Thirst</li> <li>• Weight disorders</li> <li>• Increased cholesterol</li> <li>• Skin disorders</li> <li>• Back pain</li> </ul>	<ul style="list-style-type: none"> <li>• Anxiety</li> <li>• Memory loss</li> <li>• Confusion</li> <li>• Discouragement</li> <li>• Frustration</li> <li>• Isolation</li> <li>• Insecurity</li> <li>• Pessimism</li> <li>• Depression</li> </ul>	<ul style="list-style-type: none"> <li>• Hypersensitivity</li> <li>• Anger</li> <li>• Withdrawal</li> <li>• Risk-taking</li> <li>• Absenteeism</li> <li>• Drug or alcohol abuse</li> <li>• Impatience</li> <li>• Problems with interpersonal relations</li> <li>• Mood swings</li> </ul>

<ul style="list-style-type: none"> <li>• Loss of libido</li> <li>• Headache</li> </ul>		<ul style="list-style-type: none"> <li>• Gambling</li> <li>• Promiscuity</li> </ul>
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**Step 2: Assess the risk (Risk Profiling and Evaluation)**

The purpose of risk evaluation is to make decisions, based on the outcomes of the risk analysis, about which risks need remedial action, whether an activity should be undertaken, and where are the priorities for intervention. Risk profiling and evaluation would entail norm benchmarking (reasonable workplace benchmarking) as well as external and internal benchmarking.

At this stage, there is need to assess the likelihood of the identified stressors actually causing harm. By assessing the **risk level**, the organization gains an indication of which causes of stress should be prioritized and controlled. If the organization already has control measures in place to control some of the identified stressors, their presence and effectiveness should also be considered at this point. To **determine the level** or severity of the risk, the organization needs to consider the following:

**Outcomes**

For each identified stressor, consider the worst likely outcome from exposure, e.g. fatality, major injury, minor injury or no injury. The term ‘injury’ includes harm caused to mental health.

**Likelihood**

For each identified stressor, consider the likelihood of harm occurring if a worker is exposed to it. This could range from ‘rare’ to ‘almost certain’.

Below is the methodology to rate the **likelihood** of risk/harm occurring:

Rare	The likelihood of occurrence of harm/stress is almost impossible.
Unlikely	The likelihood of harm/stress is low.
Moderate	Harm/stress can reasonably be expected to occur.
Major	The likelihood of harm/stress is high.
Almost certain	The likelihood of harm/stress is almost certain.

**Exposure**

For each identified stressor, consider how many workers are exposed to it. The more the number of employees who are exposed to that stressor, the Department should prioritize the intervention of limiting the exposure to that stressor.

### **Step 3: Gain management commitment**

This is a vital component necessary for the success of the program. Demonstrated commitment by management will ensure that supervisors and employees perceive the program as important. EHW managers and practitioners initiating the program can gain management commitment by:

- Having a clear understanding of the reason for and value of the program derived from the assessment conducted above.
- Discussing with key managers, the risks to the organization if the program is not implemented and the opportunities which may arise if the program is implemented (systematic review) see guidelines for details on systematic review.
- Develop a costed operational plan which sets out the reasons for and benefits of the program in a clear M&E plan and submit them for approval before the next financial year.

## **6.2 PLANNING**

The following steps should be followed when planning a workplace stress management programme:

### **Step 1: define the expectations of the program**

A committee or team should be established to oversee the program (wellness committee/occupational health and safety committee).

Together, members of the committee should agree on a number of objectives for the program, which may include:

- Reducing occupational stress
- Improving staff wellbeing
- Improving productivity.
- Improving the work environment.
- Improving organizational culture and function

### **Step 2: develop a plan**

It is important that a plan be developed to communicate to staff and others, the steps the Department plans to take in order to achieve its objectives. The details of the plan could include the following headings:

- Background to the development of the program
- Aims and objectives
- Expected outcomes
- Allocation of resources
- Consultation
- Roles of management and employees
- Program activities
- Program timeframe
- Monitoring and Evaluation.

### **6.3 IMPLEMENTATION**

Implementation of stress management programme should happen at the levels of both the individual and the organization. This implies implementation at three different levels:

- **At the primary level**, action is needed to identify and address stressors at the level of the organization, with a view to preventing stress at work;
- **At the secondary level**, through interventions to help individual employees or groups of employees, coping strategies and higher resistance to stress can be developed through education and training; and
- **At the tertiary level**, assistance can be provided to stressed employees to help cure the symptoms of stress.

#### **6.3.1 Interventions at the primary level**

This level focuses on identifying and addressing stressors at the level of the organization, with a view to preventing stress at work. The key activity at this level is risk control. Good stressor controls are changes that reduce the risk of causing harm. Based on the stressors identified and the risks they pose to employees, managers/coordinators should consider implementing some or all of the following common controls:

- Nurture a workplace environment that demonstrates to staff that management genuinely cares about their wellbeing and that their personal and professional lives are not artificially separated.
- Establish effective formal and informal communication within the organization to ensure that managers, supervisors and workers have a clear understanding of all workplace issues and processes.
- Clearly define priorities so that workers can avoid wasting time.
- Clearly define roles so that people know who is responsible for various workplace activities and understand decision-making latitude.
- Ensure there is adequate staffing to avoid either under or overstaffing problems.
- Provide skill development activities to enable staff to become competent with new systems and technology.
- Provide adequate resources to avoid the frustration that arises when employees are required to achieve goals with inadequate supplies, machinery and other resources.
- Establish human resource management systems to support effective proactive management. Components of such systems should include performance management programs, occupational health and safety plans, grievance resolution processes, as well as discipline and inability to perform procedures.
- Implement a conflict and grievances resolution process that includes mechanisms for employees to give feedback to their managers, which will help to relieve a build-up of resentment or frustration.
- Establish ways for managers and supervisors to gain skills in the use of human resource management systems.
- Establish ways for employees with legitimate concerns about safety or productivity to be heard.
- Implement a change management process so that when major changes are planned, employees are properly consulted with, informed and prepared through retraining.
- Promote and market the EHW services to employees.
- Develop a critical incident plan if your organization is such that employees may experience a major traumatic incident. Preparation should include staff training and access to a counseling service for post-trauma debriefing.
- Encourage social and sporting activity within the workplace, where staff from all levels can get to know each other and develop positive relationships. This can reduce the incidence of misunderstandings during work.
- Provide meal-break facilities and a place where employees can go during their break to sit quietly, relax and unwind.

### **6.3.2 Interventions at the secondary level**

At this level focus is on identifying interventions to help individual employees or groups of employees with coping strategies and higher resistance to stress; this can be achieved through education and training sessions. The following elements of a workplace stress management programme should be considered:

#### **Reducing individual vulnerability**

Stress management programmes should help individuals to cope with stress by reducing their vulnerability. These can be done through series of seminars and workshops, supplemented pamphlets or other publications that educate employees to cope with stress more effectively. Their common denominators are these:

- Training in self-awareness and problem analysis to detect signs of increasing stress and identify the stressors that are responsible
- Assertiveness training enabling workers to become more dynamic in dealing with them
- Techniques that will reduce stress to more tolerable levels

#### **Building Resilience in the workplace through workshops or training (liaise with DPSA and PALAMA)**

Challenges in the workplace cannot be avoided, but resilience to them can be built. The most meaningful, practical and successful way to build resilience in the workplace is by capacitating staff with skills needed to identify and maintain healthy levels of stress, and to quickly recover from challenging situations if and when they arise.

#### **Key benefits of building personal resilience:**

- Reduced workplace/home anxiety (regarding their job)
- A more flexible/adaptable approach to change
- Enhanced **realistic optimism** and can-do attitude
- Learn how to build and restore important relationships
- Greater commitment and enthusiasm
- Improved problem solving/creativity skills
- Enhanced assertiveness and decisiveness
- Become more level-headed and calm under pressure
- Enhanced hardiness and self-esteem
- Improved understanding of personal boundaries

#### **Resilience Skills**

A resilience training programme should cover the following topics:

### **Realistic Optimism**

- Teach employees to have a realistic and optimistic view of the world.
- Optimism should not be fantastical but should be based on reality.
- Persist in seeking goals despite obstacles and setbacks.
- Operate from hope of success rather than fear of failure.
- View setbacks as due to manageable circumstance rather than personal flaw.

### **Emotional Awareness and Regulation**

- Teach employees to have the ability to identify their feelings and where necessary, have the ability to control their feelings.
- To take responsibility for their feelings
- To recognize how their feelings affect their performance
- To understand the links between their feelings and what they think and say.

### **Empathy**

- Teach employees not only identify and understand their own emotions; but to identify and understand the emotions of others.
- To be attentive to emotional cues and listen well.
- To show sensitivity and understand another person's perspective.
- To acknowledge and reward people's strengths and accomplishments and offer useful feedback whilst identifying peoples' needs for further growth.
- To build social relationships and to give out social support.

### **Reaching Out**

- Teach employees to be willing to try new things and view occasional failures as essential stages in the process towards ultimate success.
- To have the ability to take on new opportunities and challenges in order to maximize their potential, and
- To deepen relationships with those important in not just business but also family life.
- To be able to ask for help when required without feelings of anger, resentment, inadequacy or intimidation.

### **Problem Solving (Causal Analysis)**

- Teach employees to have the ability to look at problems and challenges from a comprehensive perspective.

- To view problems and challenges are from many different perspectives, with many factors given consideration.

### **Self-Efficacy**

- Teach employees to have confidence in their ability to successfully solve problems.
- To recognize their strengths and weaknesses and use their strengths to help them cope with adversity.
- To develop deeper interest in the activities in which they participate and forming a stronger sense of commitment to their interests and activities.

### **Impulse Control**

- Teach employees to tolerate ambiguity well so they do not rush to make judgments or snap decisions.
- To step back and think about things before acting, to have the ability to stop and choose whether to act on a desire to take action.
- To control their impulses to help finish what they set out to do and to plan for the future.

### **6.3.3 Interventions at the tertiary level**

This level deals with individuals already suffering from the effects of stress. Labelled the “medical model,” an attempt should be made to identify individuals with signs and symptoms and persuade them to come forward voluntarily or accept referral to professionals.

#### ***Early intervention is the key to effective stress management***

Once a manager becomes aware that a worker is exhibiting signs of stress, they should take urgent action to address the issue. Early intervention can include:

- Conflict resolution,
- Job evaluation
- Counseling for those who report or manifest symptoms (can be provided by EHW Practitioner, Services Provider or through referral)

The manager/practitioner should try and understand why a particular employee is responding to a certain stressor in a way that is causing harm. It will be the manager’s response to the employee’s stress that will be a critical factor in successfully resolving the problem. Only registered counseling professional should provide therapeutic services as outlined in the table below:

<b>Psychologist</b>	Psycho-therapy Counselling Psychological Assessment Hypnotherapy
<b>Social Worker</b>	Psycho-therapy Counselling
<b>Lay counsellors</b>	Basic counselling and referral

***Managing stress-related symptoms:***

- Assess the problems and the causes
- Offer appropriate intervention or refer
- The programme can be based in the internal Employee Health and Wellness unit or outsourced as per service model used in the Department.
- The services should cover a broad range extending from one-on-one interviews to telephone “hot-lines” for emergency situations.
- Referral can be made to comprehensive centres with multidisciplinary staffs of qualified professionals.

**Relaxation** also works as a stress and anxiety cure, because it induces the opposite of the fight-or-flight response, and as a result causes the *opposite* symptoms. The relaxation response is the process of de-escalating the stress response and inducing relaxation through activation of the parasympathetic nervous system. Relaxation is a skill that can be learned and practiced.

Here are some of the relaxation techniques that can be conducted in the workplace:

- **Progressive Relaxation:** progressively tensing and then relaxing muscle groups, one muscle group after the other through the body.
- **Physical Techniques:** includes stretching, yoga, pilates etc.
- **Meditation:** focusing the mind on a word, phrase, or idea and letting go of other thoughts with an attitude of passive acceptance for relaxation or making positive changes.
- **Deep breathing:** breathing slowly and regularly and taking sufficiently deep breaths.
- **Visualization:** visualizing something for relaxation or making positive changes, such as picturing in your mind a relaxing scene.
- **Guided Imagery:** the process of being guided through calming or helpful mental images, such as calming scenes, the healing process, or positive changes.

- **Autogenics:** imagining that your limbs are warm and heavy, your heart rate is slow and steady, and your forehead is cool.
- **Sensory:** experiencing or imagining the sensations of sight, sound, smell, taste, and/or touch.
- **Other methods:** exercise, massage, hypnosis, self-hypnosis, crafts, hobbies, dance, music, conscious mental rest, artwork, walking etc.

Implementation of stress management programme should follow the APIME approach as outlined in the table below:

Stress Management in the Workplace								
Functional Objectives	Inputs	PROCESSES / ACTIVITIES				INDICATORS FOR IMPLEMENTATION		
		Capacity Building Initiatives	Organizational Support Initiatives	Governance and Institutional Development Initiatives	Economic Growth and Development Initiatives	Output	Outcome	Impact
		<p><b>1. Assessment</b></p> <p>Conduct organizational stress audit by examining:</p> <ul style="list-style-type: none"> <li>• Stress-related absence from work</li> <li>• Grievance procedures</li> <li>• Workplace harassment claims</li> <li>• Performance management programs</li> <li>• Industrial action</li> <li>• Stress related occupational health and safety incident</li> </ul>	<p>Human resources</p> <p>Financial resources</p>	<p>Train managers, coordinators on how to conduct stress audit</p>	<p>Information Management System,</p> <p>Database on HR record.</p>			

<ul style="list-style-type: none"> <li>• Reports and compensation claims for PTSD.</li> </ul> <p>Conduct Individual Stress Risk Assessment Survey.</p>	<p>Human resources</p> <p>Financial resources</p>	<p>Train managers, coordinators on how to conduct stress audit</p>	<p>Individual Stress Risk Assessment Tool</p>	<p>SOLVE guidelines</p>	<p>Use best practices as benchmark</p> <p>Updated evidence-based research</p>	<p>No. of employees who participated in the survey</p>	<p>% of employees who identify stressors, stressful relationships and lifestyle that interfere with personal functioning and interpersonal relationships.</p> <p>% of employees who identify physical manifestation of stress.</p> <p>% of employees who describe feelings related to anxiety state, and accepts assistance in coping with anxiety as necessary.</p> <p>% of employees who describe and use at least one strategy to avoid stressor.</p>	<p>Effective stress management programmes in the Public Service,</p>
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							<p>% of employees who describe at least one situation whereby a stressful situation is perceived as challenging or positive rather than distressful.</p> <p>% of employees who describe and practice one method of relaxation.</p> <p>% of employees who describe and practice one positive health habit and one other method to prevent disease and promote health.</p> <p>% of employees who describe characteristics about self and lifestyle.</p> <p>% of employees who demonstrate improved interpersonal relationships; changed</p>	
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							behaviour is validated by significant others.  % of employees who set priorities and goals appropriate to all strategies leading to excessive stress.	
<b>2. Planning</b>  Develop stress management plan  Establish committee or team to oversee the programme	Human resources	Train managers, coordinators on how to develop stress management plan	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of targeted employees for intervention in the plan.	% of employees who express the need to participate in stress management programme.	Effective stress management programmes in the Public Service,
3. Implement stress management programme.	Human resources	Train managers/ coordinators on stress management.	Information Management System,  Database on usage of stress management programme.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees participating in the programme	% of employees who participated in the programme who expressed to have obtained coping mechanism.	Effective stress management programmes in the Public Service,

4. Develop and implement M&E plan for stress management.	Human resources	Train managers/ coordinators on implementation of nutrition management programme	Information Management System,	SOLVE guidelines	Use best practices as benchmark Updated evidence-based research	No. of Managers trained on M&E	% of managers and coordinators submitting Reports.	Effective stress management programmes in the Public Service,
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## 6.4 MONITORING AND EVALUATION

The M&E system within a programme should be structured to ensure the most efficient use of resources to generate the data needed for decision-making. An M&E plan for stress management programme should be developed with measurable indicators. It should guide data collection and analysis, increase the consistency of the data and enable managers/practitioners to track trends over time. Implementation of the M&E plan should yield an implementation report to be submitted to DPSA.

## 7. ORGANIZATIONAL SUPPORT INITIATIVES

### Organizational Stress Diagnosis

One of the first steps when considering the development of a programme for the prevention of work-related stress is an assessment or diagnosis of the incidence of stress, its effects and costs. This is often carried out through a **stress audit**, when conducting a stress audit the following should be taken into consideration:

- Each stress audit needs to be carefully adapted to the situation in the individual organization, and its various branches or sections.
- It may be a relatively formal process, or alternatively can be more informal and smaller in scale.
- In all cases, care should be taken in establishing the aims and objectives of the audit.
- Identify a survey sample which is representative of the workforce and sufficiently large to make the survey findings meaningful.
- After the results of the audit have been analyzed, it is very important to ensure that results are made known to those who have taken part in the survey, as well as the workforce as a whole.

An example of a tool for stress audit (checklist of workplace stressors) is outlined in the table below:

<b>Work characteristic</b>	<b>Stressors</b>	<b>Likelihood of stress occurring:</b> Rare/ Unlikely/ Moderate/ Major/ Almost certain
<b>Organizational function and culture</b>	Poor communications	
	Organization as poor task environment	
	Poor problem-solving environment	
<b>Participation</b>	Low participation in decision-making	
<b>Career development and job status</b>	Career uncertainty	
	Career stagnation	
	Poor status work	
	Work of low social value	
	Poor pay	
	Job insecurity or redundancy	
<b>Role in organization</b>	Role ambiguity: not clear on role	
	Role conflict	
	Responsibility for others or continual contact with other people	
<b>Job content</b>	Ill-defined work	
	High uncertainty	
	Lack of variety	
	Fragmented work	
	Meaningless work	

	Under-utilization of skills	
	Physical constraint	
<b><i>Workload and work-pace</i></b>	Work overload	
	Work under load	
	High levels of pacing	
	Lack of control over pacing	
	Time pressure and deadlines	
<b><i>Working time</i></b>	Inflexible work schedule	
	Unpredictable hours	
	Long hours or unsocial hours	
	Shift/Night working	
<b><i>Interpersonal relationships at work</i></b>	Social or physical isolation	
	Lack of social support from other staff	
	Conflict with other staff	
	Violence	
	Poor relationships with supervisors and managers	
<b><i>Home-work interface</i></b>	Conflicting demands of work and home	
	Low social or practical support from home	
	Dual career problems	
<b><i>Preparation and training</i></b>	Inadequate preparation for dealing with more	
	Difficult aspects of job	

	Concern about technical knowledge and skill	
<b>Other problems</b>	Lack of resources and staff shortages	
	Poor work environment (lighting, noise, bad postures)	

Adapted from: T. Cox and A. Griffith: *Manual on Occupational Stress in Nursing*, ILO (1994).

## 8. GOVERNANCE INITIATIVES

If an organization has not yet taken action to address the issue of work-related stress, this is almost certainly due to a lack of understanding of the true costs of stress and of the benefits which could be obtained from its prevention. There are many options available for the prevention of stress, but that the most effective involve a certain amount of **organizational change**. Few employers would be prepared to commit themselves to such a programme without being convinced of its necessity and having a means of evaluating its effectiveness.

To tackle the causes of stress, well-designed work should include:

<b>Well-designed work</b>	
<b>Clear organizational structure and practices</b>	Workers should be provided with clear information about the structure, purpose and practices of the organization.
<b>Appropriate selection, training and staff development</b>	Each employee's knowledge, skills, and abilities should be matched as much as possible to the needs of each job. Candidates for each job should be assessed against that job's requirements. Where necessary, suitable training should be provided. Effective supervision and guidance is important and can help protect staff from stress.
<b>Job descriptions</b>	A job description will depend on an understanding of the policy, objectives and strategy of the organization; on the purpose and organization of work, and on the way performance will be measured.
<b>Job descriptions must be clear</b>	It is important that an employee's manager and other key staff are aware of the relevant details of the job and make sure that the demands are appropriate. The better workers understand their job, the more they will be able to direct the appropriate efforts towards doing it well.
<b>Communication</b>	Managers should talk to their staff, listen to them and make it clear that they have been heard. Communication of work expectations should be comprehensible, consistent with the job description and complete. Commitments made to staff should be clear and should be kept.

<b>Social environment</b>	A reasonable level of socializing and teamwork is often productive as it can help increase commitment to work and to the work group.
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*Source: WHO protects workers' health series No.3: Work organization and stress, 2004.*

## 1. Aims

Over and above the overall objective of developing knowledge and skills for Wellness Managers and Practitioners to enable them to integrate psychosocial and health promotion issues into a comprehensive workplace programme, the specific aims for this section on tobacco are to:

- Guide Wellness Managers and Practitioners on how to manage tobacco use in the workplace.
- Guide Wellness Managers and Practitioners on how to develop effective tobacco cessation programmes.
- Promote tobacco free workplaces in the Public service.
- Operationalize the Wellness Management Policy for the Public Service.

## 2. Scientific Evidence

Workplace smoking can be a serious safety and health hazard and a cause of conflict at work. Promotion and implementation of a smoke-free work environment therefore fall under the ILO's mandate to create healthy and safe workplaces (ILO: 2009).

Historically, in the early 1900s, when smoking was banned at work it was done more to **prevent fires** and **explosions** rather than for health reasons. Later during the century, from 1950s to 1980s, bans on smoking at workplaces focused more on the protection of vulnerable workers, mostly in the **healthcare** and **education sectors**. Today, with the growing awareness of the danger of second-hand or environmental tobacco smoke, more and more workers are being protected by legislation and policies banning smoking at work(ILO:2009)..

The need for action is still great: Tobacco use kills 5.4 million people a year - an average of one person every six seconds - and accounts for one in 10 adult deaths worldwide, according to the WHO (World Health Organization). Worryingly, the epidemic is shifting to the developing world. More than 80% of the world's smokers live in low- and middle-income countries (ILO: 2009).

According to the World Health Association (1992), tobacco kills at least 3 million people each year worldwide: in countries where smoking has been a long-established behaviour.

### ❖ Smoking has killed more than:

- 90% of all lung cancer ;
- 30% of all cancers;
- over 80% of cases of chronic bronchitis and emphysema;
- and some 20 to 25% of coronary heart disease and stroke deaths.

Smoking also attribute to numerous other adverse health conditions, including

- respiratory diseases,
- peptic ulcers and
- pregnancy complications, ([http://www.who.int/nmh/publications/ncd\\_report](http://www.who.int/nmh/publications/ncd_report)).

There are more than 4000 chemicals found in the tobacco products. Of these, nicotine, first identified in the early 1800s, is the primary reinforcing component of tobacco. Nicotine is a highly **addictive drug**. **Addiction keeps people smoking** even when they want to quit. Breaking addiction is harder for some people than others. Many people need more than one try in order to quit(<http://m.drugabuse.gov/publications/research-reports/tobacco-addiction>)

Nicotine induces pleasure and reduces stress and anxiety. Smokers use it to control mood and tend to take in the same amount of nicotine from day to day to achieve the desired effect. However, the acute effects of nicotine dissipate quickly, as do the associated feelings of reward. This causes the smoker to continue dosing to maintain the drug's pleasurable effects and prevent withdrawal (NIDA: 2009).

**Nicotine withdrawal symptoms** begin a few hours after the last cigarette, quickly driving people back to tobacco use. Symptoms peak within the first few days after stopping smoking, and usually subside within a few weeks. For some people, however, symptoms may persist for months (NIDA: 2009).

Cigarette smoking is the most popular method of using tobacco; however, there has also been a recent increase in the use of smokeless tobacco products, such as snuff and chewing tobacco. These smokeless products also contain nicotine, as well as many toxic chemicals.

Smoking is the leading course of death from Cancer; it also causes the different types of cancer namely:

- cancers of the lung
- oesophagus, larynx, mouth, throat,
- kidney, bladder,
- Pancreas, stomach, and cervix.

Inhaling tobacco smoke causes several immediate responses within the heart and its blood vessels; **within 1 minute of starting to smoke**, the **heart rate begins to rise** and Nicotine stimulates the body to **produce adrenaline**, which makes the **heart beat faster and raises the blood pressure**, causing the **heart to work harder**. The carbon monoxide in tobacco smoke exerts a negative effect on the heart by reducing the blood's ability to carry oxygen.

Smoking causes **chronic obstructive pulmonary disease**, or **COPD**. There is no cure. People with COPD slowly die from lack of air. COPD includes the **diseases emphysema** and **chronic bronchitis**.

### 3. Rationale

According to the WHO Millennium Development Goals and Tobacco Control 2004 **poor people** are especially vulnerable to harm from tobacco use. In addition to long-term health risks, tobacco use among low income groups can **have immediate, insidious effects, through diverting scares family resources away from beneficial uses**. Household survey data show that poor families are more likely to include one or more smokers than richer families, and **often allocate a substantial part of the families total expenditures** to these harmful products. If a bread winner becomes ill as a result of tobacco use, the cost of health care and the loss of earnings and productivity can worsen poverty or push families living precariously into poverty.

Cigarette smoking accounts for a large burden of preventable disease in South Africa. While the government has taken bold legislative action to discourage tobacco use since 1994, it still remains a major public health priority.

Cigarette smoking prevalence: Over the past decade, prevalence rates for adult daily cigarette smoking have continuously inched downward. Adult (15+ years) daily smoking rates fell by a fifth, decreasing from 30.2% in 1995 to 24.1% in 2004, according to the South African Advertising and Research Foundation surveys.<sup>4</sup> An estimated 2.5 million smokers stopped smoking during this period. Data from other national surveys confirm that between a fifth to a quarter of adults smoke cigarettes. The South African Social Attitude Survey in 2003 found that 21.4% of adults smoked, including 35.8% of men and 8.1% of women,<sup>5</sup> while the earlier South African Demographic and Health Survey reported a prevalence rate of 24.6% in 1998.<sup>3</sup>

There is increasing recognition of the need to restrict smoking in the workplace for medical, legal and financial reasons, including recognition of the health effects of passive smoking, of the need to manage the risk of liability from diseases caused by passive smoking, and of encouraging smoking cessation as part of health promotion in the workforce.

### 4. Contextual Issues

The cigarette is a very efficient and highly engineered drug delivery system. By inhaling tobacco smoke, the average smoker takes in 1–2 mg of nicotine per cigarette. When tobacco is smoked, nicotine rapidly reaches peak levels in the bloodstream and enters the brain. A typical smoker will take 10 puffs on a cigarette over a period of 5 minutes that the cigarette is lit. Thus, a person who smokes about 1½ pack (30 cigarettes) daily gets 300 "hits" of nicotine to the brain each day. In those who typically do not inhale

the smoke such as cigar and pipe smokers and smokeless tobacco users nicotine is absorbed through the mucosal membranes and reaches peak blood levels and the brain more slowly.

Benefits of cessation extend to quitting at older ages. According to the WHO Millennium Development Goals and Tobacco Control 2004, a healthy man aged 60 to 64 smoking a pack of cigarettes or more a day **reduces the risk of dying by 10% during the next 15 years if he quits smoking. After 10 years of abstinence, the risk of lung cancer is about 30% to 50% of the risk for continuing smokers.** This risk continues to decline with further abstinence. Smoking cessation reduces the risk of cancers, this reduction occurs in the first few years after cessation. **The excess risk of Coronary Heart Disease (CHD) from smoking is reduced by 50% after one year of abstinence and then declines gradually. After 15 years of abstinence,** the risk of CHD is similar to that of people who have never smoked. Within five to fifteen years of abstinence, the risk of stroke returns to the level of people who have never smoked.

According to the WHO Millennium Development Goals and Tobacco Control 2004 tobacco kills one in two long-term users 4.9 million such deaths occurring each year. Tobacco is responsible for more deaths worldwide than any other risk factor except high blood pressure. While total consumption of cigarettes remained stable in the developed world between 1970 and 2000, it trebled in the developing world. Over the next 25 years, total cigarette consumption will rise by 60% in the countries with medium levels of human development and by 100% in countries with low levels of human development. This latter group of nations will by then consumes more tobacco than either medium or high human development countries.

Smoking in the workplace affects the health and income of the smoker. Scientific evidence has shown that exposure to second-hand tobacco smoke is a potential source of the same illnesses as smokers are liable to contract, such as cancer, heart and lung diseases. The cost of smoking is incurred not only by employers and employees but by civil society in its entirety. These costs include: smoking-related illnesses and premature death; higher levels of sick absences from work; higher health insurance premiums; increased maintenance costs of premises and equipment; higher insurance premiums because of the risk of fires or explosions; and lower productivity due to a badly implemented or absence of a clear .

### **Smoking affects everyone**

When a person is in the same room as someone who is smoking, the breathable air is contaminated with second-hand tobacco smoke (SHS), or environmental tobacco smoke (ETS). This is a combination of the smoke from the burning tip of the cigarette and the smoke that is exhaled by the smoker. Being exposed to second-hand tobacco smoke means being exposed to the same toxic gases as if one was actively smoking. Non-smokers who breathe second-hand smoke suffer many of the same diseases as regular smokers. A passive smoker is therefore at risk of the same cancers, heart and lung diseases as the active smoker.

## Why do people smoke?

One reason why so many people smoke, although they know it is dangerous, is that it is very difficult to stop smoking once one has become dependent on the addictive substance in cigarettes: nicotine. Smoking is also part of the cultural heritage in many countries; it is considered “normal” to smoke. Cigarettes are also appealing to many young people, to whom cigarettes are marketed with an image of being grown-up and “cool”. Smoking is also considered by many a way of coping with stressful situations, such as problems at home or an excessive workload.

### Daily adult smoking prevalence rates by ‘race’ and gender, 1998

	% Male	%Female
African	33.9	4.2
Asian	47.7	7.6
Coloured	57.0	40.6
White	33.4	23.2

## Why smoking is a workplace issue

In addition to being bad for smoking workers’ own health, exposure to tobacco smoke can cause serious illness to workers’ families and colleagues. Smoking can also cause fires, explosions and accidents. In some workplaces the issue of smoking cause’s tension and conflicts between workers and this negative stress is brought from the workplace to workers’ families and society. Introducing a smoke-free workplace is a way of demonstrating that the employer cares about the health and well-being of all workers and their families; smokers as well as non-smokers. It also gives a positive signal to clients and the surrounding society. The health hazards of passive smoking make it a health issue at home and at work, especially for people with allergies or asthma, children and pregnant women. Some 40 per cent of children worldwide have at least one smoking parent (WHO Fact sheet, 2010).

### Second-hand smoke in the workplace

Second-hand smoke also poses a threat in the workplace. Toxins and carcinogens spread quickly throughout offices, hotels, restaurants and other indoor places of work. Most workers are not in a position to change their work environment or leave their jobs to protect their health. In many cases, where smoke-free workplaces are not guaranteed, employees find themselves obliged to spend the majority of their waking hours in a health-threatening situation. In the case of a restaurant employee, the table below shows a selection of chemicals he or she would inhale directly in a 300 square meters area during a single eight hour shift!

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

Exposure to second-hand smoke is a widespread problem that affects people from all cultures and countries. This exposure occurs throughout ordinary situations in daily life: in homes, at work and school, on playgrounds and public transport, in restaurants and bars—literally everywhere people go. Surveys conducted around the world confirm widespread exposure. Recent data from South Africa shows that 64 per cent of children below age five in Soweto live with at least one smoker in the house.

## **Smoking is costly**

Although the prices of cigarettes are increasing in many countries, the majority of smokers are low-income workers or the unemployed. To make this situation worse, smoking is increasing most in the poorer countries and is most prevalent among the very poorest of a country. Additional costs for the smoker include higher medical costs and lower earnings caused by illness and a shorter productive life. Quitting smoking, or smoking less, can therefore be economical not only for workers and their families, but for society as a whole (Efroymsen, 2001).

## **MANAGING TOBACCO AT WORK**

Employers can also save money with a non-smoking workplace strategy. A non-smoking Workforce has lower absenteeism, lower maintenance and cleaning costs, lower fire risks, and lower health-care costs, lower property insurance costs, as well as lower fire, life and health insurance costs. A smoke-free workplace is also at a lower risk of having to pay workers' compensation payments in cases of disability stemming from exposure to second-hand tobacco smoke.

## **Assistance programmes**

It is important that assistance programmes are in place for all tobacco users who wish to quit. As a manager, one needs to be aware about the assistance programmes available for the organization. The principles of confidentiality and non-discrimination must be maintained.

## **Is ventilation a solution?**

There is no safe level of exposure to second-hand tobacco smoke. Therefore, ventilation cannot be recommended as a solution to the problem. A simpler and lower cost option is to provide outdoor smoking areas. These areas should be made comfortable and safe. Ashtrays, seats, shelter, and

perhaps heating could be provided for outdoor smoking areas which should be located away from entrances or windows of the building in order to avoid the smoke from entering the building.

### **What can be done?**

- **Inform and educate:** Awareness is the foundation upon which a strategy dealing with workplace smoking should be built. During a preparatory phase, an assessment of the workers smoking habits and attitudes towards smoking can be useful. During this phase there could also be an awareness campaign about the impact of smoking on workers' health and how everyone will benefit with a non-smoking policy in the work areas. As the strategy develops and is integrated into the workplace policy, all workers should be informed about what changes will take place and what the new policy entails in terms of smoking areas, smoking breaks and, if possible, assistance to those who wish to stop smoking.
- **Introduce a policy of non-smoking in all work areas:** All workers should be protected from second-hand tobacco smoke in the area where they work and other areas where they spend time during working hours such as the canteen, corridors, restrooms, and elevators. Smoking should only be allowed in safe outdoor or indoor smoking areas that are separated and ventilated in such a way that no tobacco smoke can drift into the work areas through entrances, windows, doors, etc.
- **Prevent discrimination:** One way of avoiding that smokers are stigmatized when making a workplace smoke-free is to stress that tobacco smoke and not the smoker is the problem. The change should be presented as a positive development towards better working conditions, not as a negative action against the smokers. Discrimination and stigmatization of smokers during the recruitment process or while employed should not be tolerated. Nor should workers demanding smoke-free workplaces be stigmatized. By including smokers and non-smokers in the development of the non-smoking strategy, to give information about the effects of smoking, and to give support to smokers who wish to quit, tensions between smokers and non-smokers can be reduced.
- **Give encouragement:** A good way of reducing tensions in making the change to a smoke-free environment easier could be to connect the new policy with a positive occurrence; for example smokers could be invited to join a quit-smoking competition. The declaration of a smoke-free company can be made at the same time as an official launch of a new product. Or all workers could be invited for a retreat where non-smoking is promoted. Quitting smoking is easier if one does regular exercise and when not feeling stressed. A non-smoking campaign could be carried out in combination with a more general well-being campaign.

### **Legislation**

The decline in cigarette consumption, after tobacco control legislation was enacted in the 1990s, is perhaps the real test of the effectiveness of the government's tobacco control programme. Nonetheless, it is important to measure the implementation, enforcement, compliance and economic effects of the law.

In 2002, the compliance of public places in Gauteng, Limpopo and the Northern Cape with the restrictions on smoking in public places was studied. The study found that varying levels of compliance with the law at pubs, restaurants and shebeens: one in three establishments was smoke-free; another 26% had separate smoking sections, but 44% still allowed smoking anywhere. The majority of the latter were small informal establishments, situated in rural areas. Encouragingly, nine out of ten workplaces had a policy regulating smoking.

Public support for the law was widespread and a sizeable fraction demanded the right to smoke free environments. Over 80% of smokers and non-smokers agreed that restaurants and bars should have separate smoking and non-smoking areas. One in three non-smokers had complained about smoking in prohibited areas. The outcome of the complaint in 43% of cases was for the smoker to either stop smoking or go outside the building. In a minority of instances (21%) the smoker became argumentative or aggressive.

## **INTERRELATIONSHIPS**

### **Smoking and stress**

Employees experience mainly two types of stress related to workplace smoking. One type comes from the addiction itself, as smokers experience withdrawal symptoms when they have not smoked for a while; the other type of stress is the type of irritation experienced by non-smokers who work in an environment filled with tobacco smoke. These effects can include eye and nose irritation, headaches, sore throat, dizziness, nausea, cough, and respiratory problems. It is also quite common for smokers and/or non-smokers to experience stress because of tensions or conflicts related to smoking; and this brings us to the next issue: smoking and violence.

### **Smoking and violence**

Tension between smokers and non-smokers, coupled with a sense of injustice caused by stigma or discrimination, can lead to aggression. Psychological violence can take the form of harassment and open conflict, but it can also take the form of exclusion and isolation.

## **Smoking and lifestyle**

Well-being initiatives that promote regular exercise, a balanced diet, and regular sleeping habits are very beneficial for smokers. A healthier lifestyle reduces stress, which makes it much easier to quit smoking or to smoke less. For persons who exercise, it is also an incentive to smoke less or not at all because of the negative effect of smoking on the lung and heart capacity. A smoker easily loses his or her breath when exercising. The average smoker tends to have other lifestyle factors that could lead to bad health.

## **Addictions and smoking**

Studies have shown that those who take up smoking are more likely to take up other drugs. The following study made by the United States' Department of Health and Human Services confirms this theory.

## **5. INTERVENTIONS**

### **Assessment**

Assess the effects of smoking in the workplace; the different diseases caused by tobacco and how they are distributed in the department. How many people are addicted to smoking and how many people are willing to stop smoking. This can be done through a survey which is department specific.

**Assess the needs.** You can maximize the effectiveness of a tobacco programme by assessing employees' needs and expectations.

- focus groups;
- surveys conducted by online questionnaire;
- tying-in the assessment with existing similar actions
- reviewing the existing data: company statistics, such as work force demographics, absenteeism, turnover rates, and other health data from occupational health surveillance or
- voluntary health screening might indicate areas where action is needed.

### **Planning**

**Decide on priorities.** Identify the specific goals of the tobacco programme and set priorities accordingly e.g. promoting a healthy lifestyle in general.

**Connect to risk prevention activities.** Tobacco planning programmes and interventions should be integrated into risk prevention activities.

**Integrate existing successful health activities,** such as running groups, into the tobacco programme.

**Implement a coordinated programme** rather than running several disconnected interventions.

**Involve intermediary departments,** if necessary, and take advantage of any offers, materials or initiatives; e.g. taking advantage of medical aid cover to treat employees for tobacco dependence

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

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

## Implementation

Tobacco management in the Workplace								
Functional Objectives	Inputs	PROCESSES / ACTIVITIES				INDICATORS FOR IMPLEMENTATION		
		Capacity Building Initiatives	Organizational Support Initiatives	Governance and Institutional Development Initiatives	Economic Growth and Development Initiatives	Output	Outcome	Impact
1. Conduct a smoking cessation survey	Human resources  Financial resources	Train managers, coordinators on how to conduct a survey	Information Management System,  Database on HR record.	Guidelines on smoking cessation	Use best practices as benchmark  Updated evidence-based research	No. of employees who participated in the survey.	% of employees willing to quit smoking	Decrease in the number of people who smoke.

2. Develop a plan for tobacco management	Human resources	Train managers, coordinators on how to develop a tobacco management plan	Information Management System,	Guidelines on smoking cessation  Work plan on tobacco management programme	Use best practices as benchmark  Updated evidence-based research	No. of targeted employees for intervention in the plan.	% of employees willing to quit smoking	Decrease in the number of people who smoke
3. Implement tobacco management programme.	Human resources  Financial resources	Train managers/ coordinators on implementation of tobacco management programme	Information Management System,  Database on usage of tobacco management programme.	Guidelines on smoking cessation  Work plan on tobacco management programme	Use best practices as benchmark  Updated evidence-based research	No. of employees utilizing the programme	% of those employees who utilized the programme and eventually quit smoking.	Decrease in the number of people who smoke
4. Develop and implement M&E plan for tobacco management.	Human resources	Train managers/ coordinators on M&E of tobacco management programme	Information Management System,	Guidelines on smoking cessation	Use best practices as benchmark  Updated evidence-based research	No. of Managers trained on M&E	% of managers and coordinators submitting Reports.	Decrease in the number of people who smoke

Get active and visible support from senior, middle and ground management to implement your tobacco operational plan. Engage the employees as much as possible. The better you match the tobacco programme with employees needs, the less you will need to promote it. Incentives tailored to your departments can be useful for changing to a healthy culture within your department e.g. competitions and prizes to honor and reward participation in tobacco programmes. Implementation must have a time frame, e.g. within a specific financial year. The degree of complexity, detail, and reading level should be appropriate for your audience. Ask for feedback.

### **Monitoring and evaluation**

Develop a monitoring plan. Monitor progress annually, half yearly; quarterly and monthly according to your monitoring plan. Reports should be sent to departmental heads, provincial offices and to the DPSA on a quarterly base.

## **6. DEPARTMENTAL SUPPORT INITIATIVES**

It has already been suggested that smoking needs to be dealt with as a workplace issue, and not merely as a life-style or well-being issue. An important element of this re-orientation is to involve occupational health services. This can be done through cooperation with local primary health care teams, providers of counselling and cessation advice, and pharmacists. Routine medical check-ups can be used to discuss and promote the benefits of smoking cessation.

There is evidence showing that workplace interventions are effective in stopping tobacco use in adults. Effective interventions for adults include one or more of the following components:

- Group counseling, with a fellow employee as a facilitator
- Individual counseling
- Telephone counseling
- “Buddy” system established between the participant and a non-/ex-smoker friend
- Maintenance sessions
- Offsite programs to employees that frequently change job sites (e.g. construction employees)

## **7. GOVERNANCE INITIATIVES**

This shows that the development and implementation of strategies to promote smoke free workplaces and as well as assistance in the cessation of smoking can lead to a considerable reduction in avoidable deaths attributable to cigarette smoke. As a considerable percentage of the population spend most of their time at work, the workplace can be used to inform and educate employees about the dangers of environmental tobacco smoke. According to the WHO, seven out of ten smokers want to quit and admit that a smoke-free workplace would provide a supportive environment for employees trying to quit.

## 1. Aims

Over and above the overall objective of developing knowledge and skills for Wellness Managers and Practitioners to enable them to integrate psychosocial and health promotion issues into a comprehensive workplace programme, the specific aims for this section on Alcohol and Drugs are to:

- Guide Wellness Managers and Practitioners on how to develop effective Alcohol and Drug prevention programmes.
- Guide Wellness Managers and Practitioners on how to recognize warning signs of Alcohol and Drug abuse at work.
- Guide Wellness Managers and Practitioners on how to manage Alcohol and Drug problems in the workplace.
- Promote Alcohol and Drug free workplaces in the Public service.
- Operationalize the Wellness Management Policy for the Public Service.

## 2. Scientific Evidence

Excessive consumption of alcohol puts employees at risk for developing a range of costly health problems, such as:

- liver disease, heart disease,
- cancer,
- pancreatitis,
- breast cancer in women, and
- Foetal alcohol syndrome in children.

Non-communicable diseases (NCD's) accounted for 29% of all deaths in South Africa, of which 18% were due to cardiovascular diseases and cancers. Alcohol and Substance abuse does contribute to the increase in NCD due to direct effect on other vital organs (kidney, liver, diabetes, hypertension, brain and nervous system etc.) Injuries are also included as part of the NCD, s (DOH: 2012). Unhealthy diets and harmful use of alcohol are among four major risk factors for NCD's. (DOH: 2012)".

It is also one of the primary causes of workplace and automobile injuries, as well as family and workplace violence. It's important to note that high expenditures for physical health care often mask substance abuse. In fact, individuals who abuse alcohol use four times as many hospital days as non-drinkers. Excessive use of alcohol and other substances is also associated with untreated depression or other mental illnesses (IssueBrief, 2003).

According to the Medical Research Council (MRC) Comparative Risk Assessment (2008), in Gauteng province alone the total number of patients on chronic dialysis both haemodialysis and peritoneal

dialysis is 561. Those on the waiting list for an opportunity to avail itself the total number is 238. 40-60% of people with end stage renal failure is due to high blood pressure at an average age of 39 years.

The main risk factor for high blood pressure is:

- *smoking,*
- *lack of exercise and*
- *high salt intake.*

So instead of demanding more dialysis machines and subsequently demanding new kidneys, there is a need to reduce the prevalence of hypertension by eliminating the risk factors. The need for targeting tobacco and alcohol has already been outlined.

### 3. Rationale

There is a long tradition of programmes to address the problem of substance abuse by employees through the Employee Assistance Programme (EAP). These have traditionally focused on the identification and rehabilitation of employees with severe alcohol and, more recently, drug abuse problems. However, as understanding of the sheer scope, nature and costs of the problem has deepened, more progressive organizations have placed a much greater emphasis on the development of broad consensual partnerships at the workplace and beyond designed to achieve a real improvement in the situation. The NCD's are preventable through attention to the major risk factors, including unhealthy diets and harmful alcohol abuse.

Addressing alcohol and drug-abuse is also addressing the other social factors such as:

- spread of HIV&AIDS epidemic,
- violence, including intimate partner violence,
- unhealthy diets,
- road and workplace accidents, and
- Economic impact and poverty associated with unregulated spending on these addictive substances.

There is a growing science and clinical research base that points the way to practical solutions for addressing substance abuse. **Employers** can take advantage of this to decrease health care costs, **reduce workplace injuries**, and **improve productivity**. There also is an increased understanding of the steps that can be taken to prevent substance abuse in the first place.

There is evidence, too, of low-cost interventions that can reduce the risky use of alcohol and other substances. In addition, there is a growing understanding that substance addictions are chronic conditions not unlike asthma, diabetes or hypertension.

### 4. Contextual Issues

Substance use by young people is of major concern in South Africa. Most common used Substances by young people are:

- Alcohol,
- Tobacco and
- Cannabis.

Most of those who use illegal drugs, such as cannabis, will usually have first used alcohol and/or tobacco.

Professor Charles Parry, Director of the Medical Research Council's (MRC) Alcohol and Drug Abuse Research Unit says that the Western Cape has the highest proportion of binge drinkers in high school - 34% versus 23% for the national average. A third of adolescents aged 11 to 17 from nine districts in Cape Town report having been drunk at least once in their lifetime ([www.capetown.gov.za](http://www.capetown.gov.za)).

According to the MRC, the number of people seeking treatment for methamphetamine (commonly known as 'tik') has now overtaken those with alcohol problems. Among patients under 20 years, six out of ten use tik as a primary or secondary substance of abuse. Recent statistics also show that Cape Town has one of the highest number of heroin users in the country - in excess of 15 000 ([www.capetown.gov.za](http://www.capetown.gov.za)).

(Morojele *et al*, 2009) further explain that not only does substance abuse carry significant health risks, but it can also be associated with serious – and often devastating – social problems. These include:

- **Crime and violence.** Adolescents who use substances (such as tobacco, alcohol and cannabis) frequently are more likely than those who rarely or never use them to experience multiple violent acts. Young people who are involved in criminal activities seem to be disproportionately involved in using substances. Another study found that younger arrestees were more likely than their adult counterparts to test positive for the use of various drugs, such as cannabis, mandrax and cocaine.
- **Accidents and injury.** Adolescents increase their risk of being injured unintentionally and sometimes fatally in road accidents and fights when under the influence of alcohol and/or other drugs.
- **Risky sexual behavior.** Adolescents who drink alcohol and/or use other drugs are more likely to be sexually active than are those who do not, and also more likely to engage in unprotected sex which is associated with having unplanned pregnancies and contracting sexually transmitted infections, including HIV. The use of substances is reported to decrease adolescents' inhibitions and safer sex negotiation skills, thereby increasing their already-present vulnerability to engaging in sexual risk behavior.

- **Scholastic problems.** A longitudinal study among high school learners in Cape Town found a strong association between binge drinking, school dropout and low academic aspirations over a period of two years.

- **Mental and physical health problems according to** (Morojele *et al*, 2009) symptoms of depression (e.g. disturbed sleep, appetite and pleasure) is associated with adolescents' use of alcohol, cannabis and cigarettes. International research has also found links between cannabis use and schizophrenia and between methamphetamine use and various psychiatric disorders.

In research conducted in the Western Cape (Wellington), the prevalence of FAS among Grade 1 learners was found to be 46 per 1000 in 1997 and 75 per 1000 in 1999. Similar research conducted in Gauteng and De Aar in 2001, and Upington in 2003 found FAS prevalence rates of 19, 103 and 75 (estimate) per 1000 respectively.

The national Know Your Epidemic and Know Your Response identified Alcohol drinkers as some of the Most at Risk Population.

## **5. Interventions**

**The workplace intervention against alcohol and substance abuse should follow APIME approach,**

### **5.1. Assessment**

Early identification of individual risks through targeted screening programmes, will inform strategies to assist individuals to change harmful behaviours. Prior to embarking on prevention intervention projects in any particular community/workplace, it is important to conduct an initial baseline situation assessment to determine the particular drugs that are abused in that community, the substance abuse-related problems that are of most concern, and the risk and protective factors that are likely to apply to people in that community.

### **Early Intervention: Screening and Brief Interventions**

**Screening and Brief Interventions (SBI)** offer low-cost, but highly effective, solutions for identifying and reducing risky use of alcohol or other substances among employees.

**Screening:** During a routine medical or specialty care visit, a physician, other health care professional or EHW Practitioners asks a series of brief questions about alcohol use. There are a number of effective screening tools, most notably the Alcohol Use Disorders Identification Test (AUDIT), which is recommended for use by the World Health Organization. The primary goal of the screening is to:

- Determine the employee's pattern of substance use,
- Identify the consequences of the employee's substance use, such as missing work or important family responsibilities, and
- Inform the employee about possible adverse health consequences of his/her level of alcohol use.

**Effectiveness of Screening and Brief Interventions.** There is a substantial body of clinical research supporting the effectiveness of screening and brief interventions in primary care or other health care settings. In follow-up studies six to twelve months after the use of brief interventions, heavy drinkers who received the interventions were almost twice as likely as those receiving no treatment to reduce or moderate their drinking behaviour (WHO 2008).

- SBI offers immediate improvements in alcohol use behavior for those high-risk employees responsible for a significant share of health, productivity and disability costs.
- Include screening as an intervention through your departmental policy/programme
- SBI can also be offered in the workplace, conducted by appropriately trained health or counseling professionals with appropriate safeguards for confidentiality.

The National Institute on Alcohol Abuse and Alcoholism uses the following definitions of alcohol misuse: **Alcohol misuse** describes alcohol consumption that puts individuals at increased risk for adverse health and social consequences. It is defined as excess daily consumption (more than 4 drinks per day for men or more than 3 drinks per day for women), or excess total consumption (more than 14 drinks per week for men or more than 7 drinks per week for women), or both. (<http://www.cdc.gov>)

The Centre for Disease Control and Prevention (CDC) Alcohol Team uses the following definitions of alcohol misuse:

- Alcohol misuse
  - For women, more than 1 drink per day on average
  - For men, more than 2 drinks per day on average
- Binge drinking
  - For women, 4 or more drinks during a single occasion
  - For men, 5 or more drinks during a single occasion
- Excessive drinking includes heavy drinking, binge drinking or both
- Alcohol misuse is a pattern of drinking that results in harm to one's health, interpersonal relationships or ability to work
- Alcohol dependence, also known as alcohol addiction and alcoholism, is a chronic disease and is associated with experiencing withdrawal symptoms, loss of control, or alcohol tolerance

## 5.2. Planning-(Employee Health Plan)

Effective treatments for employees who are addicted to alcohol or drugs need to incorporate disease management techniques similar to those proven to be effective in treating other chronic conditions. This issue brief offers employers solutions that have the potential to reduce substance abuse-related health care costs and improve outcomes for employees by doing the following:

- Using workplace health and wellness programs to prevent substance abuse;
- Offering employees access to low-cost, highly effective screening and brief interventions, and self-screening tools; and
- Providing for employees with addictions treatment that maximizes positive outcomes.

**Brief Interventions:** For individuals who are engaging in risky use or may be dependent on alcohol or other substances, the professional conducting the screening immediately employs a brief intervention. The intervention raises the awareness of substance use problems, and recommends specific changes, such as reducing consumption of alcohol or referral for treatment. Brief interventions can range in length from a few minutes for providing simple suggestions on reducing drinking to a series of interventions provided within a treatment program.

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#### **Early Intervention Solutions**

- Require employee health plans to include, as part of primary care, screening and brief interventions for alcohol and other substance problems.
- Offer self-screening tools to employees on company, EAP or health plan websites.
- Make sure that EAPs and behavioral health plans offer practical health information and respond promptly to employees who need information and treatment.

### 3. Implementation

Alcohol and Drug Abuse Management in the Workplace								
Functional Objectives	Inputs	PROCESSES / ACTIVITIES				INDICATORS FOR IMPLEMENTATION		
		Capacity Building Initiatives	Organizational Support Initiatives	Governance and Institutional Development Initiatives	Economic Growth and Development Initiatives	Output	Outcome	Impact
1. Conduct workplace Alcohol and Drug Abuse prevalence survey.	Human resources  Financial resources	Train managers, coordinators on how to conduct workplace Alcohol and Drug Abuse prevalence survey	Information Management System,  Database on HR record.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees who participated in the survey.	% those of employees who participated in the survey and are willing to undergo Alcohol and Drug abuse prevention and rehabilitation programme.	Decreased alcohol and Drug abuse prevalence in the Public Service

2. Develop a Alcohol and Drug Abuse Management plan	Human resources	Train managers, coordinators on how to develop Alcohol and Drug Abuse Management plan	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of targeted employees for intervention in the plan.	% of employees who want to go on Alcohol and Drug Abuse Management programme.	Decreased alcohol and Drug abuse prevalence in the Public Service
3. Implement Alcohol and Drug Abuse Management programme.	Human resources	Train managers/ coordinators on implementation Alcohol and Drug Abuse Management programme	Information Management System,  Database on usage of Alcohol and Drug Abuse management programme.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees utilizing the programme	% of those employees who have utilized the programme who have quit alcohol and Drug abuse	Decreased alcohol and Drug abuse prevalence in the Public Service.
4. Develop and implement M&E plan on Alcohol and Drug Abuse Management Programme.	Human resources	Train managers/ coordinators on M&E of Alcohol and Drug Abuse Management Programme	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of Managers trained on M&E	% of managers and coordinators submitting Reports.	Decreased alcohol and Drug abuse prevalence in the Public Service

## Employees with Addictions: Treatments for Optimizing Outcomes

For the small share of employees who have serious or addictive substance use problems, it is vital that they:-

- Receive access to effective treatment programs that provide immediate control of addiction,
- Reduce the adverse symptoms, and
- Address the behavioral/psychological causes.

There are many treatments proven effective. They include counselling or psychotherapy, medications, medical services, individual, group or family therapy, and disability programs designed to facilitate prompt return to work. Individual needs and circumstances are crucial in deciding what approach to take; no one treatment can be said to be the most effective. Because of the chronic, relapsing nature of substance addictions, treatments must incorporate disease management approaches, such as patient education, support for behaviour change, monitoring for relapse, and periodic intervention.

The typical course of treatment for addiction should include three stages: **detoxification**, a medical procedure to reduce the physical effects of withdrawal from substances; followed by **acute care**, consisting of behavioural and medication-assisted therapies; and then **maintenance or continuing care**. There are many accepted behavioural therapies that have been evaluated and found to be effective for treating addictions to substances, including the following:

- Cognitive/behavioral;
- Motivational enhancement;
- Strategic/interactional;
- Humanistic;
- Existential;
- Psychodynamic;
- Interpersonal;
- Family;
- Group; and,
- 12-step programs or other self-help/peer support programs, such as Alcoholics Anonymous (AA).

Studies suggest that the following factors are most important:

- Degree of alcohol or substance abuse;
- Extent of associated mental illness;
- Need for anger management; and
- Strength of social support networks.

**Medication-Assisted Treatment:** Medications also can play an important role in treatment during detoxification, as an adjunct to behavioural therapy during the acute care stage, and to help prevent subsequent relapse. Neuroscience has begun to identify the many mechanisms at work in developing addictions. This information has led to the creation of medications aimed at reducing the pleasurable effects of substances, as well as the neurological changes that cause craving and relapse. For example, naltrexone, an opiate antagonist, binds with the brain's receptors for endogenous opiates, blocking the attracting effects of heroin and similar drugs. It has a similar effect for alcohol. When given naltrexone, patients with alcohol use problems "report feeling less euphoria or 'high'. By reducing the stimulant effects, naltrexone decreases the brain's positive reinforcement for drinking and increases unpleasant responses. It also helps abstinent individuals who have relapsed refrain from heavy drinking. At present, many employee health or prescription drug plans limit coverage of medications solely to detoxification in hospital settings. However, it can be anticipated that as clinical evidence of their effectiveness becomes increasingly known, medications will be used more frequently to assist behavioural therapies.

**Optimal Treatment Settings and Duration:** Treatments for addictions must be of sufficient duration and intensity to maximize the likelihood that the employee will remain abstinent following acute care. For most individuals, the "threshold of significant improvement is reached at about three months of treatment." Additional gains during the acute care stage can be made from further treatment, and premature termination of treatment reduces its effectiveness. There is a range of treatment settings, including:-

- Inpatient care,
- Residential treatment programs,
- Intensive outpatient care,
- Outpatient care, and
- Community support programs, such as 12-step programs.

With increasing use of managed behavioural health care and the focus on using the most cost-effective treatments, outpatient rather than inpatient care has become more prevalent. In fact, studies have shown the long-term outcomes for outpatient alcohol treatment are similar to those of inpatient treatment. However, there is emerging evidence that the intensity of therapy at the outset of treatment positively affects the speed with which an individual with alcohol addiction achieves some control over his or her drinking during treatment. So there may be a case to be made that more intensive initial treatment can at times be more cost-effective.

**Brief Therapies:** There is also considerable evidence to support the effectiveness of brief therapies. These therapies use the same techniques as long-term therapy, but are of shorter duration and lower cost, lasting typically between six and twenty sessions. They are geared to providing patients with the tools to change their attitude toward themselves and their use of substances. Brief therapies are the most effective for individuals with:-

- Strong family, work and community ties,
- Substance use problems of short duration,
- Strong motivation to change, and
- Confidence in their therapy to reduce their substance use.

Brief therapies are especially suitable for employees who:-

- Have ready access to treatment,
- Have support from EAPs or other employee programs, and
- Wish to minimize disruption of their work and family life.

### **Using Effective Techniques to Maintain Positive Outcomes from Treatment.**

Following the completion of acute care, employees should continue to receive maintenance or continuing care. The period following discharge from an acute care treatment program is one of “great vulnerability.” Approximately 50 percent of those who enter treatment will resume substance use. Sixty percent of those individuals do so in the first four months. Poor outcomes can be significantly improved by offering employees the opportunity to participate in activities that promote self-management and reduce relapse, such as monitoring, counselling, and participation in peer support groups like AA/NA. There is evidence that techniques used to treat other chronic disorders can improve health outcomes for substance use disorders by helping to maintain abstinence, address needed behavioural changes and prevent relapse in addictions. These techniques include:-

- Patient education,
- Counseling and support,
- Case management, and
- Physician monitoring for warning signs of relapse.

Primary care practitioners could play an important role in helping individuals with substance use disorders maintain abstinence and achieve other self-management goals, by such approaches as:-

- Telephone monitoring,
- Scheduling of check-ups on a regular basis or at times of unusual stress, and
- Prescribing of anti-craving medications.

#### **5.4. Monitoring and evaluation**

Remaining abstinent may call for mandatory monitoring of treatment compliance through, for example, random testing. Although there has been little study of effective maintenance programs for individuals with addictions, programs such as long-term methadone maintenance, as well as long-term AA peer support programs have been shown to be successful in preventing relapse and in enabling participants to continue working. A number of large employers currently include participation in continuing care as part of their overall treatment benefits. They expect that employees will participate in long-term treatment including peer social support like AA.

## **6. Organizational Support Initiatives**

### **Prevention: Workplace Health and Wellness Programs**

Employers can play an important role in preventing the unhealthy and hazardous use of substances, especially alcohol, by:-

- Sending the message that drinking and illicit drug use are not condoned,
- Combating the stigma against seeking help and telling employees they can seek treatment without jeopardizing their jobs,
- Providing factual information on the harmful health effects of excessive use of alcohol, and
- Providing reminders that excessive or binge drinking outside of work has an impact on worker safety and job performance while at work.

Studies of organizations' workplace policies and corporate culture demonstrate that communicating clear policies prohibiting alcohol use in the workplace and discouraging excessive use of alcohol in company social events is an effective deterrent. Incorporating information on the appropriate use of alcohol and legal substances like prescription medications into overall wellness and risk prevention strategies, along with other positive steps such as education in seatbelt use, weight control, exercise, nutrition, and blood pressure control, is another important approach. Most organizations already address substance use through:-

- Drug-free workplace and other written substance abuse policies,
- Employee education and awareness initiatives,
- Training programs for managers and supervisors on identifying and handling substance use problems, and
- Drug testing programs.

#### **Solutions for Prevention of Substance Abuse**

- Wellness management programs inform employees about the health and productivity hazards of drinking excessively and using illicit substances.
- Safe use of alcohol is included in workplace wellness strategies, such as learning about good nutrition, exercise, seat belt use, etc.
- Drug-free workplace policies are publicized, and employees are clear that use of alcohol is never permitted in the workplace.
- Information about the health risks of alcohol and drug use are communicated through company websites, and health and wellness initiatives.
- Alcohol use is not promoted at workplace-related functions.

## **7. Governance Initiatives**

Based on an increasingly widespread recognition of this successful experience with a consensual approach, the ILO adopted in 1995 its Code of practice on the management of alcohol and drug related issues in the workplace. This code applies to all types of public and private employment including the informal sector. The following constitute the key points in this code of practice:

- Alcohol and drug policies and programmes should promote the prevention, reduction and management of alcohol- and drug-related problems in the workplace.
- Alcohol- and drug-related problems should be considered as health problems, and therefore should be dealt with, without any discrimination, like any other health problem at work and covered by the health care systems (public or private) as appropriate.
- Employers and workers and their representatives should jointly assess the effects of alcohol and drug use in the workplace, and should cooperate in developing a written policy for the organization.
- Employers, in cooperation with workers and their representatives, should do what is reasonably practicable to identify job situations that contribute to alcohol and drug related problems, and take appropriate preventive or remedial action.
- The same restrictions or prohibitions with respect to alcohol should apply to both management personnel and workers, so that there is a clear and unambiguous policy.
- Information, education and training programmes concerning alcohol and drugs should be undertaken to promote safety and health in the workplace and should be integrated where feasible into broad-based health programmes.
- Employers should establish a system to ensure the confidentiality of all information communicated to them concerning alcohol and drug-related problems. Workers should be informed of exceptions to confidentiality which arise from legal, professional or ethical principles.
- Testing of bodily samples for alcohol and drugs in the context of employment involves moral, ethical and legal issues of fundamental importance, requiring a determination of when it is fair and appropriate to conduct such testing.
- The stability which ensues from holding a job is frequently an important factor in facilitating recovery from alcohol and drug-related problems. Therefore, the social partners should acknowledge the special role the workplace may play in assisting individuals with such problems.
- Workers who seek treatment and rehabilitation for alcohol- or drug-related problems should not be discriminated against by the employer and should enjoy normal job security and the same opportunities for transfer and advancement as their colleagues.
- It should be recognized that the employer has authority to discipline workers for employment-related misconduct associated with alcohol and drugs. However, counseling, treatment and rehabilitation should be preferred to disciplinary action. Should a worker fail to cooperate fully with the treatment programme, the employer may take disciplinary action as considered appropriate.

- The employer should adopt the principle of non-discrimination in employment based on previous or current use of alcohol or drugs, in accordance with national law and regulations.

## 1. Aims

Over and above the overall objective of developing knowledge and skills for Wellness Managers and Practitioners to enable them to integrate psychosocial and health promotion issues into a comprehensive workplace programme, the specific aims for this section on HIV & AIDS are to:

- Guide Wellness Managers and Practitioners on how to develop effective HIV & AIDS workplace programmes.
- Guide Wellness Managers and Practitioners on how to manage HIV & AIDS in the workplace.
- Promote AIDS free workplaces in the Public service
- Operationalize the HIV&AIDS, STI and TB Management Policy for the Public Service.

## 2. Scientific Evidence

HIV&AIDS affects employees and their families, the organization and the communities which depend on them. In doing so, it also weakens national economies, individual household incomes, and interferes with sustainable development in general.

**The following are the factors which undermine efforts for HIV prevention and care:**

- **Unwillingness for employees to test for HIV**, thereby facilitating early diagnosis and treatment of HIV related conditions<sup>v</sup>
- **Discrimination and stigmatization** against employees with HIV, which threaten fundamental principles and rights at the workplace.
- Absence and poor implementation of relevant workplace **policies and programmes** which addresses HIV&AIDS as the workplace issue<sup>vi</sup>

**Factors contributing to transmission of HIV&AIDS among employees**

- **Socio-cultural** (*cultural practice, stigma and stereotypes*)
- **Biological** (*age and sex of person*)
- **Socio-economic** (*access to education, access to health services, race, class and gender inequalities, globalisation e.g Free Trade*)
- **Individual behaviour** (*Unprotected sex ,multiple concurrent partners, substance abuse, gender-based violence ,health seeking behaviour and attitude towards VCT, and MCC*)<sup>vii</sup>

**The impact of HIV&AIDS in the World of Work**

HIV&AIDS epidemic has the following undesirable outcomes in the workplace:

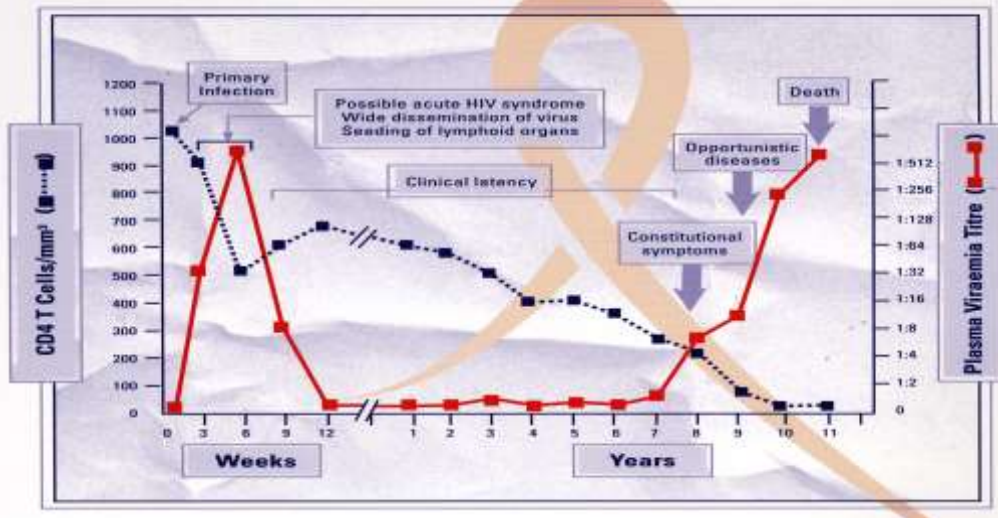
- **On individual employees**
  - Stress
  - Ill-health and absenteeism
  - Mental illness
  - Financial problems related to increased health cost
  - Early retirement (loss of income ) and death (loss of life)
- **On the organization**
  - Unhealthy workforce and absenteeism rate
  - Decline in productivity
  - Increased staff turnover
  - Increased costs of replacement staff, pension pay-out and medical aid.
  - Loss of institutional memory
- **On service delivery**
  - Decline in quantity and quality of service delivery
  - Decline in efficiency and effectiveness
  - Poor ROI, and value for money (PALAMA: 2009)

### **Common signs and symptoms of HIV Infection**

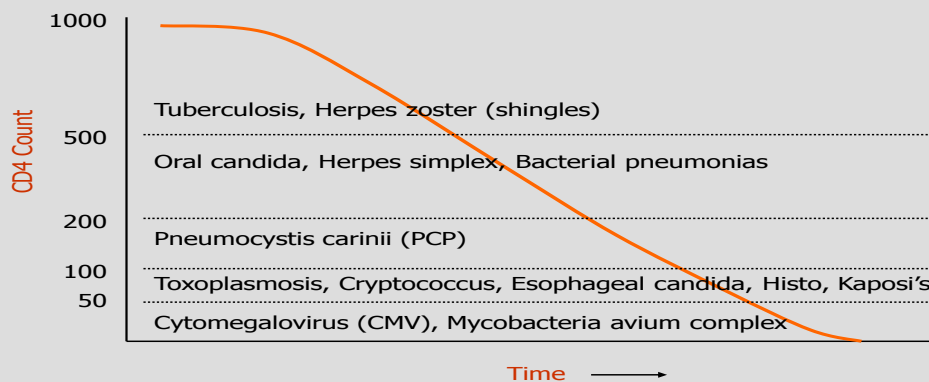
The signs and symptoms varies in relation to the stage of the disease progression in the body. The most common signs are:

- Progressive Loss of weight, more than 10kg
- High fever of more than 39.5 degrees Celsius
- Frequent upper respiratory chest infection
- Loss of Appetite (DOH:2008)

## Clinical Course Of HIV Infection



## CD4 Count and OIs



### 3. Rationale

HIV & AIDS should therefore become part of workplace health promotion policies because the workplace has a vital role to play in the wider struggle to control the epidemic. The Workplace programmes can play an important role in reducing the spread of HIV & AIDS in the Public Service, and should undertake to:

- Raise awareness,
- Support prevention efforts,
- Expand access to information and health services and
- Prevent discrimination of infected or sick employees.

- Clear and coherent workplace policies should be developed that address the prevention of HIV & AIDS; the management and mitigation of the impact of the illness in; and the reduction of discrimination and stigma faced by HIV positive employees.<sup>viii</sup>

The workplace is one of the most important and effective points for tackling the HIV epidemic. Together, employers and workers can support prevention through workplace education programmes and provide care, even treatment. Keeping affected employees at work contributes to their wellbeing, maintains productivity and morale, and sets an example of non-discrimination.

The HIV&AIDS control strategies, policies and programmes, targeting prevention and management of TB and other opportunistic infections, should be developed and implemented taking into consideration the Gender and Human rights dimensions of the epidemic and aligned to the National Strategic Plan for HIV&AIDS, STI and TB 2012-2016.

#### 4. Contextual Issues

- **HIV Prevalence** is 17.8% among those aged 15-49 years with the prevalence being higher in women 25-29 years and men aged 30-34 years.<sup>ix</sup> These are the age groups which are likely to dominate the Public Service world of work.
- **TB co-infection among PLHIV in general** was around 75% in 2009. <sup>x</sup>and is the leading cause of death among PLHIV.<sup>xi</sup>HIV positive people are at higher risk of developing active TB due to weakened immune system; TB, on the other hand, accelerates the course of HIV infection.
- **In the Public Service**, several research studies have been undertaken to assess HIV prevalence among educators and among health care workers in South Africa. In these studies the prevalence rate was found to range between 11% and 15, 7% for educators and Health Care Workers respectively.
- One other department studied is that of Correctional Services (DCS), for both offenders and employees. In the prevalence study conducted by Limúvune Consulting on South African Prisons, Muntingh reported that: of a total of 1098 staff members participated in the survey, 109 individuals, or 9.9%, tested HIV-positive. Based on these results the report concludes that the national HIV infection rate amongst DCS staff is between 6.7% and 13.9%. Of those who tested positive, 94% were production-level staff, with the balance being from middle management and top management. The study also shows consistence with other literature identifying the risk of HIV as being higher among 25-34 years (45% of age distribution in the study). Higher knowledge score on HIV, awareness of a place nearby where one could test for HIV, and impact of HIV on one's household was found to be associated with Knowing one's HIV status. These determinants indicate the need for targeted prevention and behavioural change and communication (BCC) messages to be inherent in the HCT Intensification campaign.
- **The Key Health trends reported by GEMS annually** reflects HIV&AIDS and TB being among the top ten cost drivers for Medical Claims made annually. GEMS further reported that

employees are accessing disease management package at an advanced stage of their HIV infection, usually with low CD4 counts which may have great impact on their chances of responding well to antiretroviral treatment. This problem of late diagnosis for HIV and TB infection is common even for the general public.

- Enrolment into GEMS disease management programme has increased from the 2010 baseline by 65% (from 32,243 in 2009/10 to 53,495 in 2010/11 FY) as measured by Aid for AIDS (AFA) registration data (GEMS'2010). This is an encouraging milestone, however this enrolment does not occur early enough in the course of the HIV disease progression, before the CD4 count drops below 350. The findings show that 34% of beneficiaries are enrolled at the CD4 of <200 and a further 22% at a moderately severe immunosuppression. Majority (76%) of AFA registered beneficiaries is principal members (GEMS, 2010); this is a proxy indicator for employees accessing treatment care and support for HIV&AIDS in the Public Service.

## **5. Interventions**

**HIV&AIDS interventions should follow the CAPIME implementation model.**

### **5.1. C-Commitment**

The Public Service, in partnership with private sector, should address the epidemic in accordance with the Strategic Plan for HIV&AIDS, STI and TB 2012-2016. The Government Departments should display commitment to implement both internal (as an employer) and external (in partnership with private and civil society) HIV&AIDS response. Eight principles of HOD commitments are applicable, as documented in the Gender-sensitive, Rights-based HIV&AIDS and TB Mainstreaming Guidelines -2012.

### **5.2. Assessment**

Departments should conduct systematic review to assess the following:

- The burden of the disease (epidemiology) in the department, using variety of sources like KYE/KYR, biannual HSRC Population Survey reports, GEMS Key Health Trends, Departmental Specific KAP survey, Integrated Health Risk Assessment and Incapacity leave reports, and any other relevant epidemiological /programme management data. This assessment should include identification of the most vulnerable groups within the department, with focus on youth and adolescents, women, orphans and persons with disability.
- Impact analysis to assess the impact of the epidemic on the efficiency of the department, with focus on service delivery and agreed outcomes, productivity, human capital and staff morale. Response analysis to assess where the department's capacity to respond and mitigate effects of HIV&AIDS and TB on the world of work including its customers. Focus should be on its policies, strategies and EH&W management system, using SMT tool.

### **5.3. Planning**

The findings of the systematic review should inform the planning phase, whose main focus will be to develop, implement preventive workplace programmes, with set objectives and targets which are costed, and measurable through clear indicators of efficiency and effectiveness. Plan should reflect clear coordination, compliance monitoring and reporting mechanism.

#### 4. Implementation

HIV & AIDS Management in the Workplace								
Functional Objectives	Inputs	PROCESSES / ACTIVITIES				INDICATORS FOR IMPLEMENTATION		
		Capacity Building Initiatives	Organizational Support Initiatives	Governance and Institutional Development Initiatives	Economic Growth and Development Initiatives	Output	Outcome	Impact
1. Conduct HIV&AIDS prevalence baseline assessment	Human resources Financial resources Equipment	Train managers, coordinators on how to conduct workplace HIV&AIDS prevalence baseline assessment	Information Management System, Database on HR record.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees who are willing to participate in HIV&AIDS prevalence study.	% of employees who have tested HIV positive  .	Decreased HIV&AIDS prevalence in the Public Service.

2. Develop a workplace costed, mainstreamed, HIV&AIDS operational plan.	Human resources  Financial	Train managers, coordinators on how to develop a costed, mainstreamed, HIV&AIDS operational plan.	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of targeted employees for costed, mainstreamed, HIV&AIDS operational plan.	% departmental budget committed for HIV&AIDS workplace programme.	Decreased HIV&AIDS prevalence in the Public Service.
3. Implement workplace HIV&AIDS programme in line with the costed, mainstreamed, HIV&AIDS operational plan.	Human resources  Financial	Train managers/ coordinators on implementation of the workplace HIV&AIDS programme	Information Management System,  Database on usage of nutrition management programme.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees utilizing the programme	% of those employees who have utilized the workplace programme and accessing the relevant treatment, care and support.	Decreased HIV&AIDS prevalence in the Public Service.
4. Develop and implement M&E plan for workplace HIV&AIDS programme.	Human resources  Financial	Train managers/ coordinators on implementation of M&E plan of HIV&AIDS workplace programme	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of Managers trained on M&E	% of managers and coordinators submitting reports on workplace HIV&AIDS programme.	Decreased HIV&AIDS prevalence in the Public Service..

#### 5.4.1. Workplace HIV & AIDS Programme

Workplace programmes translate paper policies and commitments into practical action. Lessons from good practice show the most effective programmes are both comprehensive and targeted:

- **Comprehensive programmes** include prevention, care and protection of rights. These three components complement and reinforce each other. If your company can only provide some services in-house, refer staff to public health services for others.
- **Targeted programmes** (e.g. for mobile workers, women, young people, or specific economic sectors) work with defined groups, taking into account their particular needs and the factors affecting their knowledge, attitudes and behaviours. Programmes may have activities for men and women separately as well as together, but should in any case be sensitive to gender issues.

#### Implementing the policy and programme

Both management and workforce representatives need to be on board: this may require an information or training workshop. A meeting for all employees can start to raise awareness generally, and demonstrate the employer's commitment to taking action on HIV&AIDS. Hold consultations on the content, make sure it's clearly expressed, then launch the policy and publicize it widely. Use notice boards, mailings, pay slip inserts, special meetings, induction courses, and training sessions.

The details of the programme will depend on the local situation, for example HIV prevalence in the community and modes of transmission; knowledge, attitudes and behaviour of staff; services already available in the workplace or nearby. You should:

- Assess the impact of the epidemic on your workplace and find out the needs of workers by carrying out a confidential baseline survey;
- Find out what health and information services are already available both at the workplace and in the community;
- Agree a plan of action which identifies objectives, strategy, target groups and methods of delivery; establish a budget; monitor the impact of your programme and revise as necessary;
- Set up an HIV/AIDS committee or steering group to take responsibility for the process and report regularly to the highest decision making body in the organization. This is important as otherwise there is a risk that nothing will happen. There may be an existing committee that could do the job, for instance one on occupational health and safety.

## 6. Organizational Support Initiatives

## **Workplace HIV & AIDS Policy**

A policy should be developed through employer-worker collaboration, with the involvement of people living with HIV where possible. It may be a detailed policy or collective agreement just on HIV, part of a broader policy or agreement, or a short statement of commitment, for instance:

***'this company pledges to combat discrimination on the basis of HIV status, to respect confidentiality and to protect health and safety through programmes on prevention and care.'***

The policy should:

- Provide a statement of commitment and a framework for action,
- Lay down a standard of behaviour and give guidance to supervisors and managers,
- Help employees living with HIV understand what support and care they can expect.

## **7. Governance Initiatives**

### **Five golden rules for workplace action**

- Use the programmes and structures that are already in place (occupational safety and health, in-service training, workplace committee).
- Through worker-management consultation, agree a policy that commits the workplace to action with 'zero tolerance' for discrimination.
- Get baseline information on your workplace, and map what's available in the community so you know what's needed.
- Agree a programme and make an action plan for carrying it out.
- Make sure a committee, team or individual has responsibility to implement the programme.

## 1. AIMS

Over and above the overall objective of developing knowledge and skills for Wellness Managers and Practitioners to enable them to integrate psychosocial and health promotion issues into a comprehensive workplace programme, the specific aims for this section on Violence are to:

- Guide Wellness Managers and Practitioners on how to develop effective workplace violence prevention programmes.
- Guide Wellness Managers and Practitioners on how to identify risk factors for violent situations in the workplace.
- Guide Wellness Managers and Practitioners on how to manage violent incidences in the workplace (immediate and long-term response).
- Promote violence free workplaces in the Public service.
- Operationalize the Wellness Management Policy for the Public Service.

## 2. SCIENTIFIC EVIDENCE

- Violence at work has become an alarming phenomenon worldwide.
- The enormous cost of violence at work for the individual, workplace and the community , is becoming more apparent.
- Violence includes both physical and non-physical violence.
- Violence is defined as being destructive towards another person.
- It finds its expression in
  - ❖ physical assault,
  - ❖ homicide,
  - ❖ verbal abuse,
  - ❖ bullying,
  - ❖ sexual harassment
  - ❖ and mental stress. <sup>xii</sup>
- aetiology, revolves around
  - ❖ the part played by rational choice and
  - ❖ emotional states in the psychological underpinnings of violence<sup>xiii</sup>
- From the rational choice perspective, violence is purposeful and goal-directed.
- A person will act violently or aggressively towards another if it helps to achieve
  - ❖ a valued outcome
  - ❖ or reward

and the costs of so doing are not too high.

Aggression, in this sense, is to some extent at least, instrumental.

The 'rationality' that this implies is, of course, highly subjective and open to error. When drunk, for example, someone might make very careless decisions, but they are decisions nevertheless (<http://www.bis.gov.uk>).

- From the emotional states perspective,
- aggression and violence are a reactive response to any form of 'aversive stimuli', They are environmental conditions that generate negative emotional states, e.g. extreme temperatures,
  - ❖ overcrowding,
  - ❖ and situational frustration.
- violence is instigated by a biological urge to harm others when one 'feels bad', e.g. angry, frustrated or ignored<sup>xiv</sup>

Workplace violence is seen as the product of a host of interacting variables including:

- individual appraisals and concomitant physiological and emotional reactions; decisions about how to respond;
- individual,
- social and cultural expectations;
- environmental conditions;
- and prevailing social, organisational and cultural norms.
- In short, the aetiology of workplace violence can only be understood by embedding it in its full
  - ❖ individual,
  - ❖ interpersonal,
  - ❖ organisational,
  - ❖ social
  - ❖ and cultural context.<sup>xv</sup>

### 3. RATIONALE

Violence at work has just been recently accepted as

- ❖ a serious safety and health hazard which has a high cost for victims and departmental performance alike.

It was considered to be a harsh reality which just has to be accepted as part of life.

Recently it is considered as a serious safety and health hazard which has a high cost for victims and departmental performance alike.

Violence manifests itself both in the form of

- ❖ physical and

- ❖ Psychological violence.
- ❖ Physical ranges from
- ❖ physical attacks to verbal insults,
- ❖ bullying,
- ❖ mobbing,
- ❖ harassment,
- ❖ Including sexual and racial harassment.

Fresh information is now emerging which shows that what we see is only the tip of the iceberg: the real size of the problem is still largely unknown.

The enormous cost of violence at work for the individual, the workplace and the community at large is also becoming progressively more apparent.<sup>xvi</sup>

- ❖ It is reported that bullying and mobbing in the corporate workplace is expected around 25% during a 12 month period.
- ❖ About 78% of all employees had experienced some form of victimization and abuse in the workplace.
- ❖ Psychological violence is more frequent than physical violence and 40% - 70% of the victims report significant stress symptoms.
- ❖ Stress and violence account for approximately 30% of the overall costs of ill-health.<sup>xvii</sup>

The response should therefore be directed at tackling the causes, rather than the effects of violence at work through the adoption of a preventive, systematic, participative and targeted approach.

#### **4. CONTEXTUAL ISSUES**

##### **Definition**

**SOLVE considers both physical and psychological violence when addressing violence in the workplace.**

##### **PHYSICAL VIOLENCE**

- The use of physical force against another person or group that results in physical, sexual or psychological harm. It includes
  - ❖ beating,
  - ❖ kicking,
  - ❖ slapping,
  - ❖ stabbing,
  - ❖ shooting,
  - ❖ pushing,
  - ❖ biting, and

- ❖ Pinching among others.
- Assault/Attack: intentional behavior that harms another person physically, including sexual assault (i.e. rape).

### **PSYCHOLOGICAL VIOLENCE (Emotional abuse)**

- Intentional use of power,
  - ❖ including the threat
  - ❖ of physical force,
- against another person or group, that can result in
  - ❖ harm to physical,
  - ❖ mental,
  - ❖ spiritual,
  - ❖ moral
  - ❖ or social states or development.
  - ❖ Includes
    - ❖ verbal abuse,
    - ❖ bullying/mobbing,
    - ❖ harassment, and
    - ❖ threats.
  
- **Abuse:** behavior that humiliates degrades or otherwise indicates a lack of respect for the dignity and worth of an individual.
  
- **Bullying / Mobbing:** repeated and offensive behavior through vindictive, cruel, or malicious attempts to humiliate or undermine an individual or a group of employees.
  
- **Harassment:** any conduct towards somebody based on
  - ❖ their age,
  - ❖ disability,
  - ❖ HIV status,
  - ❖ domestic circumstances,
  - ❖ sex,
  - ❖ sexual orientation,
  - ❖ gender reassignment,
  - ❖ ethnic background,

- ❖ colour, language,
  - ❖ religion,
  - ❖ political opinion,
  - ❖ trade union affiliation
  - ❖ or other opinion or belief,
  - ❖ national or social origin,
  - ❖ association with a minority,
  - ❖ property,
  - ❖ birth or other status that is unreciprocated or unwanted and which affects the dignity of women and men at work.
- **Sexual harassment:** any unwanted, unreciprocated and unwelcome behavior of a sexual nature that is offensive to the person involved, and causes that person to be threatened, humiliated or embarrassed.
- **Racial harassment:** any threatening conduct that is based on
    - ❖ ethnic diversity,
    - ❖ colour,
    - ❖ language,
    - ❖ national origin,
    - ❖ religion,
    - ❖ association with a minority,
    - ❖ birth or other status that is unreciprocated or unwanted and which affects the dignity of women and men at work.
- **Threat:** statement of intention to use physical force or power (i.e. psychological force) resulting in fear of physical, sexual, psychological harm or other negative consequences in the targeted individuals or groups.

## **What forms does violence at work take?**

The range of behavior which may be included under the general heading of violence at work is very broad. But the borderline of what constitutes acceptable behavior is often vague and cultural attitudes as to what amounts to violence are so diverse that in practice violence at work can be a very complex matter to identify. It may take the form of a wide variety of often overlapping behaviors, including non-physical and psychological violence.

## **Women at special risk**

- Women are at particular risk of violence, both in and outside the workplace.
  
- Why is it that women are at high risk of violent behavior in the workplace?
  - ❖ women are concentrated in many of the high-risk occupations,
  - ❖ working in contact with the public and in solitary settings,
  - ❖ particularly as teachers,
  - ❖ social employees,
  - ❖ healthcare employees, etc.
  
- Women are particularly vulnerable to incidents of a sexual nature.

## **Causes of violence at work**

To decide how to prevent violence at work, it is important to understand where it comes from.

Media images are often dominated

- ❖ by images of disgruntled employees,
- ❖ angry spouses,
- ❖ or unhappy,
- ❖ desperate,
- ❖ often psychiatrically-impaired people venting their anger on colleagues.

These images affect public and official perceptions of violence and the policies which are adopted to address it.

It is essential to recognize and understand the various and complex factors that contribute to violence at work.

- Violence and aggression are deeply ingrained in the behavioral repertoire of humans.

**child development** and the influence of the family:

- ❖ it is within the family that aggressive behaviour is first learnt and/or non-violent values instilled in children;

**cultural factors:**

- ❖ the shared beliefs within a culture or sub-culture help define the limits of acceptable or tolerable behaviour.

**societal factors**

- ❖ Factors which can lead to a higher level of violence in a society include widespread poverty and inequality.
- ❖ In societies where some groups are particularly alienated, where there often is discrimination and where attitudes to gender inequality are deeply embedded, the risk of violence is high;

**personality factors:**

- ❖ including past aggressive behaviour, lack of empathy for the
- **feelings of others**, impulsiveness (or the inability to defer gratification) or, in contrast, unusually strong internal controls (over-controlled personalities);
- **substance abuse:** while there is a close association between substance abuse and violence, the relationship is complex involving many factors including:
  - ❖ the inability to control one's impulses,
  - ❖ coexisting psychological,
  - ❖ social and cultural factors and,in the case of illicit drugs,
  - ❖ the violence associated with their trafficking and distribution,
  - ❖ as well as the pharmacological effects of the drugs or alcohol consumed;
- **biological factors:**
  - ❖ although violent behavior does not appear to be an inherited characteristic,
  - ❖ some conditions (such as autonomic nervous system dysfunction) may lead to psychopathic behavior,
  - ❖ hormones (particularly testosterone) may also play a part in violent behavior
  - ❖ most violent behavior has been associated with males aged between 15 and 30;
- **mental illness:** some forms of mental illness, notably paranoid schizophrenia, may occasionally result in violent acts,
- **media influence:** research indicates that the relationship is bi-directional the viewing of violence on
  - ❖ television,
  - ❖ on video or at
  - ❖ the cinema

may give rise to aggression, while aggression may engender violence viewing;

**Working alone**

- Working alone means there are no witnesses to any potential violence and it increases the risk of violence.

- High risk solitary work situations include work in small cleaners and maintenance staff working after hours particularly at night.
- More and more people are now working alone in a variety of sectors, as a result of new types of work arrangements such as
  - ❖ sub-contracting,
  - ❖ outsourcing,
  - ❖ tele-working,
  - ❖ networking
  - ❖ and self-employment.

### **Working in contact with the public**

- Working with the public adds an element of unpredictability as employees can be exposed to
  - ❖ individuals with a history of violence,
  - ❖ mental illness or
  - ❖ those who are intoxicated.
- Violence by members of the public can be triggered by
  - ❖ by poor quality of service or
  - ❖ a perception of it,
  - ❖ dismissive or uncaring conduct by an employee

### **Working with valuables and cash handling**

- Whenever valuables are, or seem to be, within “easy reach”, there is a risk that crime, particularly violent crime, may be committed.
- While employees in many sectors face this problem, employees who handle cash, are at higher risk.

### **Working with people in distress**

- Violence is so common among employees in contact with people in distress that it is often considered an inevitable hazard of the job.
- Frustration and anger arising out of
  - ❖ illness and pain,
  - ❖ problems related to advancing age,
  - ❖ psychiatric disorders,
  - ❖ as well as alcohol and substance abuse
 can affect behavior and make people verbally or physically violent.

- The risk of violence is increased by:

- ❖ poverty and marginalization in the community in which the aggressor lives;
- ❖ poor organization or equipment where care activities are performed;
- ❖ insufficient training and weak interpersonal skills of staff providing services;
- ❖ a general climate of stress and insecurity in the workplace.

### **Working in an environment increasingly “open” to violence**

Teachers; nurses and the police have been exposed to the risk of violence for a long time; however, the level of risk to which they are now exposed to is becoming disturbing.

### **Where does violence concentrate?**

No single occupation is immune from violence at work, though workplace violence tends to be clustered in certain occupations; e.g. education, health and SAPS.

### **Who is affected?**

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

At the **individual** level, the suffering and humiliation resulting from violence often leads to a

- ❖ lack of motivation,
  - ❖ loss of confidence,
  - ❖ reduced self-esteem,
  - ❖ depression,
  - ❖ anger,
  - ❖ anxiety
  - ❖ and irritability.
- The symptoms of violence at work can develop into
    - ❖ physical illness,
    - ❖ psychological disorders,
    - ❖ tobacco addiction
    - ❖ alcohol and drug abuse addictions
    - ❖ and other addictions.
  - They may affect other areas of life such as
    - ❖ eating and sleeping habits.
    - ❖ may even culminate in occupational accidents,
    - ❖ long-term ill-health and an inability to work,
    - ❖ or even suicide.

At the **workplace** level, violence causes immediate and often long-term disruption of interpersonal relations, the organization of work and the overall working environment.

- Effects on employer
  - ❖ Employers bear the direct cost of lost work,
  - ❖ increased security measures,
  - ❖ absenteeism,
  - ❖ turnover,
  - ❖ accidents,
  - ❖ illness,
  - ❖ disability and death
  - ❖ difficulties in recruiting and retaining staff.
  - ❖ indirect costs of reduced efficiency and productivity,
  - ❖ the deterioration of product quality,
- The department pay more attention on
  - ❖ departments image
  - ❖ motivation and commitment
  - ❖ loyalty to department
  - ❖ creativity,
  - ❖ working climate,
  - ❖ openness to innovation,
  - ❖ knowledge-building and learning.

At the **community** level,

- the costs of violence include health care and long-term rehabilitation costs for the victims,
- unemployment benefits and retraining costs for victims who lose their jobs as a result of such violence
- and disability and invalidity costs where the working capacities of the victims are impaired by violence at work.

## **POLICY INTERGRATION**

### **The workplace**

- The enterprise needs to make a commitment to organizing work in such a way that it does not encourage violence.
- This means ensuring that stress levels do not get out of hand, by matching demand and control to the job and employee.
- The physical organization of the working space can also help to reduce the potential for violence.

### **Information**

- Ensuring that there is clarity about the policy and strategies for managing violence
- all concerned know what to expect if they adhere to the policy or if they do not.
- Clear and sufficiently detailed information about all areas of work,
- including information for clients where appropriate,

### **Training and education**

- Sufficient training and education is key to equipping employees and managers with the skills they need to prevent violence.
- This may include recognizing potentially dangerous situations,
- Training to do the job better and prevent aggression by dissatisfied customers and co-workers.

### **Risk assessment**

- Violence can be seen as a risk resulting from putting certain employees in certain positions.
- With careful and ethical use of screening tools, it can be possible to assess that risk at recruitment and put the right employee in the right job.

### **Employee involvement and consultation**

It is important to involve all parties concerned (including employees and managers) in the development of policy and prevention strategies on violence to ensure that all needs are being recognized and met.

### **Assistance and treatment**

The workplace violence policy should foresee what assistance and treatment will be made available to victims, bystanders and possibly to perpetrators.

### **Confidentiality**

- Any recording system for keeping track of violent and potentially violent incidents needs to be kept confidential to avoid the spread of inappropriate information and unfounded gossip.
- Any medical information recorded in the process of dealing with workplace violence must remain absolutely confidential.

### **Ethics**

- A culture of openness and transparency should be enshrined in the enterprise policy at all levels, so that employees feel they have been justly treated.

- A perception of injustice is one of the most common precursors of violence at work.

## **INTERRELATIONSHIPS**

Violence at work is often linked with other psychosocial problems.

### **Stress and violence at work**

- Stress can be both a consequence of violence and a cause of violence.
  - ❖ typical stress-related consequences of violence are
  - ❖ a lack of self-confidence,
  - ❖ difficulty concentrating
  - ❖ and fear.
- Mental health can also be affected, resulting in illnesses like anxiety and depression. Some work-related violence is caused by stress.
- stressors are likely to result in physical assaults on co-workers:
  - ❖ limited job control;
  - ❖ high levels of responsibility for people;
  - ❖ limited alternatives in finding a new job;
  - ❖ skill under-utilization.
- Economic stress, for example fear of losing one's job or actual termination, is very often linked to one of the most dramatic forms of work-related violence: mass-shootings at work, often ending with the suicide of the aggressor.

### **Substance abuse and violence at work**

- Drug use, alcohol, are closely connected with violence.
- The pharmacological properties of alcohol, other factors play an important role in determining whether a person becomes violent, such as:
  - ❖ personality and temperament;
  - ❖ expectations of the effects of alcohol;
  - ❖ social setting where the events take place.
- However, the reasons underlying drug use and violent behavior is the same; the inability to control one's impulses.

### **Violence at work and other psychosocial hazards**

- As smoking becomes less and less acceptable in some cultures, there can be tensions between smokers and non-smokers which may lead to psychological violence.

- Knowing that a co-employee is HIV-positive can provoke a negative reaction from an unknowledgeable co-employee.
- Lack of sleep is well-known to increase irritability and therefore the potential for unreasonable and possibly violent actions at work.
- Physical activity for health, such as exercise, can have a positive impact on the incidence of violence.
- It can be used as a means of venting aggression and reducing tension, thus removing the potential for violence.

## **5. INTERVENTIONS**

### **Assessment**

Assess the violence in the workplace; what are the types of violence in your workplace; what are the different causes of violence in your workplace; who are the perpetrators of this violence. This can be done through a survey which is department specific.

### **Planning**

The following steps should be followed when planning a workplace stress management programme:

#### **Step 1: define the expectations of the program**

A committee or team should be established to oversee the program (wellness committee/occupational health and safety committee).

Together, members of the committee should agree on a number of objectives for the program, which may include:

- Reducing the effects of workplace violence
- Improving staff wellbeing
- Improving productivity.

#### **Step 2: develop a plan**

It is important that a plan be developed to communicate to staff and others, the steps the organization plans to take in order to achieve its objectives. The details of the plan could include the following headings:

- Background to the development of the program

- Aims and objectives
- Expected outcomes
- Allocation of resources
- Consultation
- Roles of management and employees
- Program activities
- Program timeframe
- Monitoring and Evaluation.

## Implementation

Management of Workplace Violence.								
Functional Objectives	Inputs	PROCESSES / ACTIVITIES				INDICATORS FOR IMPLEMENTATION		
		Capacity Building Initiatives	Organizational Support Initiatives	Governance and Institutional Development Initiatives	Economic Growth and Development Initiatives	Output	Outcome	Impact
1. Conduct workplace violence audit	Human resources Financial resources	Train managers, coordinators on how to conduct workplace violence audit	Information Management System, Database on HR record.	Solve Guidelines.	Use best practices as benchmark Updated evidence-based research	No. of employees who participated in the survey.	% of employees willing to report violence in the workplace.	Decrease d workplace violence in the public service.
2. Develop a workplace violence management plan	Human resources	Train managers, coordinators on how to develop a workplace violence management plan	Information Management System,	Solve Guidelines. Work plan on violence management programme	Use best practices as benchmark Updated evidence-based research	No. of targeted employees for intervention in the plan.	% of employees willing to participate in the violence prevention programme	Decrease d workplace violence in the public service.

3. Implement violence management programme.	Human resources	Train managers/ coordinators on implementation of a violence management programme	Information Management System, Database on usage of violence management programme.	Solve Guidelines. Work plan on violence management programme	Use best practices as benchmark Updated evidence-based research	No. of employees capacitated on the violence prevention programme	% of those employees who utilized the programme.	Decrease d workplace violence in the public service.
4. Develop and implement M&E plan for violence management.	Human resources	Train managers/ coordinators on implementation of violence management programme	Information Management System,	Solve Guidelines. Work plan on violence management programme	Use best practices as benchmark Updated evidence-based research	No. of Managers trained on M&E	% of managers and coordinators submitting Reports.	Decrease d workplace violence in the public service.

**Monitoring and evaluation**

Develop a monitoring plan. Monitor progress annually, half yearly; quarterly and monthly according to your monitoring plan. Reports should be sent to departmental heads, provincial offices and to the DPISA on a quarterly base.

### 1. AIMS

Over and above the overall objective of developing knowledge and skills for Wellness Managers and Practitioners to enable them to integrate psychosocial and health promotion issues into a comprehensive workplace programme, the specific aims for this section on Nutrition are to:

- Guide Wellness Managers and Practitioners on how to develop effective programmes on promotion of good nutrition in the workplace.
- Guide Wellness Managers and Practitioners on identification of workplace meal options and management thereof.
- Operationalize the Wellness Management Policy for the Public Service.

### 2. SCIENTIFIC EVIDENCE

Nutritionists have established the energy expenditure for men and women for a variety of activities. Sedentary office work requires 1.8 kcal per minute; sitting requires 1.39 kcal per minute; farming, mining, forestry and construction can require 5 to 10 kcal per minute worked (ILO, 2005). Poorer nations are more likely to rely on manual labour; and workers in poorer nations are more likely to consume inadequate calories for these labour-intensive tasks. Consuming more calories than expended will result in weight gain. Consuming fewer calories than expended will lead to weight loss, fatigue, low productivity and accidents (ILO, 2005).

### MACRONUTRIENTS

**Macronutrients** are broadly defined as those food components present in the diet in quantities of one gram or more. They include

- proteins,
- carbohydrates and
- fats.

### Energy

- Recommended daily intake of protein for adults is 0.8–0.9 grams per kilogram of body weight; 8–15 per cent of the total energy consumption should come from protein.
- In regions where diarrhea is prevalent, health experts recommend increasing the protein intake by 10 per cent.

### Proteins

Protein deficiencies may lead:

- to mental retardation or
- stunted growth among children,

- or a loss of muscle mass among adults.

### **Fats**

- **Fats** contain more than twice the number of calories compared with equal measures of carbohydrates or proteins – on average, 9 kcal per gram.
- **Active, non-obese adults** may derive up to 35 per cent of their energy from fat and
- **Sedentary adults** may consume up to 30 per cent as long as no more than 10 per cent of the energy intake is from saturated fats.
- **Recommended intake of carbohydrates** is 50–70 per cent of total calories.
- **Healthy fats and complex carbohydrates** are associated with **lower rates of circulatory disease and certain cancers**.
- **Unhealthy (saturated) fats and simple carbohydrates** are associated with circulatory disease and diabetes, respectively (ILO, 2005).

### **MICRONUTRIENTS**

#### **Micronutrients,**

- present in minute quantities,
- are vitamins and minerals that are essential for proper growth and metabolism.
- More than one billion people are ill or disabled as a result of a micronutrient deficiency and billions more are at risk.
- **Illnesses and conditions brought about by a micronutrient deficiency include**
  - ❖ mental retardation,
  - ❖ depression,
  - ❖ dementia,
  - ❖ low work capacity,
  - ❖ chronic fatigue,
  - ❖ blindness
  - ❖ and loss of bone and muscle strength.
- Iron deficiency anaemia alone affects hundreds of millions of workers. Anaemia, and more mild levels of iron deficiency, decrease physical work capacity and work productivity in repetitive tasks, yet can be inexpensively remedied (ILO,2005).

Food at work is inextricably linked to the pillars of the ILO's Decent Work Agenda. It touches not only on questions of nutrition, food safety and food security, although these in themselves are important enough. But it also calls into question other basic issues of working and employment conditions: wages and incomes, since workers – and their families – cannot eat decently if they do not receive an adequate income; working time, since workers cannot eat decently if their meal break is too short, or if their shift requires them to work at times when food is not available; and work-related facilities, since workers' health will be affected both by the quality of what they eat and drink at work and the conditions in which they consume it (such as protection from workplace chemicals and other hazards) (ILO, 2005).

The importance of food at work is reflected in the Millennium Development Goals which set targets of halving, by 2015, the proportion of people who suffer from hunger and those without sustainable access to safe drinking water and basic sanitation. These targets are not only to be met at the workplace, but the workplace is an essential place to make a start (ILO, 2005).

Scientific evidence has long linked good nutrition to overall health and well-being. To have proper nutrition means that a person's diet is supplying all the essential nutrients needed in order for the body to carry out normal tissue growth, repair, and maintenance. If the body receives too much or is deficient of any nutrient it could lead to serious health problems.

A problem that is seen in the communities is overconsumption. A typical diet is too high in calories, saturated fat, sugar, and salt, with a lack of fiber in the diet. A diet high in saturated fat and cholesterol increases the risk for atherosclerosis and coronary heart disease. For those individuals whose bodies are sensitive to salt intake, too much in the diet has been linked to high blood pressure. Other studies have shown that as many as 30-50% of all cancers may be diet-related. Other diseases that have been associated with faulty nutrition are obesity, diabetes mellitus, and osteoporosis.

There is strong scientific evidence available that shows that following a healthy lifestyle with a good eating plan, regular physical activity, management of stress and non smoking is an essential way to promote good health, prevent and manage chronic diseases, and improve productivity at work.

As economies grow and urbanization increases, lifestyles are changing. Countries are experiencing a "nutritional transition", moving away from traditional diets to diets which may be more varied but contain more processed food, more animal products, more added sugar and fat, and possibly more alcohol. Countries in nutritional transition have a higher risk of nutrition related diseases. Parts of the population may suffer from conditions related to malnutrition such as iron and iodine deficiency. Other parts of the population may have made a radical and rapid switch from traditional diets to high energy high fats diets, accompanied by a reduction in physical activity. This will result in people being overweight or obese with higher risks of high blood pressure and diseases such as type 2 diabetes.

### **3. RATIONALE**

Humans are indeed a diverse species with vastly different body types suited to vastly different environments. Yet despite the differences that human beings have; they require a uniform set of nutrients. Thus, it is possible to characterize proper nutrition at its chemical level proteins, lipids, vitamins, minerals and provide universal guidelines on how best to attain good health through nutrition (ILO, 2005).

According to (DOH, 2007) more and more South Africans are not as healthy as they could be. In many cases a contributing factor is poor eating habits. These habits can result in:

- Over nutrition, for example too much food intake in total or a diet high in fat and sugar leading to overweight and related chronic diseases such as diabetes, cardiovascular heart disease and hypertension.
- Under nutrition, too little food intake, leading to underweight. Children who are underweight do not grow properly and get ill easily.
- Micronutrient malnutrition, yes - even people who have a plentiful food supply can be malnourished due to a lack of certain nutrients in their diet, for example iron and vitamin A.

Healthy eating plays a major role in the

- reduction of chronic disease and
- the promotion of overall health and well-being.

Workplace nutrition guidelines make it easier for employees to make food choices that support healthy eating.

#### **4. CONTEXTUAL ISSUES**

##### **NUTRITION**

- Nutrition and food safety are as important a right as occupational health and safety.
- Many workers spend at least a third of their day or half of their waking hours at work.
- Employees should not go a long time without eating, particularly when the task is arduous.
- Health workplaces can be supported through the availability of healthy good choices from
  - ❖ vending machines,
  - ❖ through the distribution of vouchers,
  - ❖ or through the provision of mess rooms,
  - ❖ kitchenettes
  - ❖ or safe local food
- This is especially important when workers do not eat well outside work.
- Surveys have shown that over 70 per cent of employees support employer involvement in workplace health promotion programmes and 85 per cent believe that workplace programmes can increase health and lower health costs.
- Also when surveyed, employees report that the workplace is an appropriate place to promote health (Nutrition Resource Centre, 2002).

##### **Nutrition and work productivity**

The health consequences of an imbalanced nutritional intake vary considerably, depending on whether people are

- eating too much,

- or too little,
- or eating the wrong proportions of macro and micronutrients and these all have an impact on work.

Nutrition-related impairment and ill-health affect workers' lives, employers see productivity decrease and governments and society have higher health-care expenses and poorer economic returns.

- Inadequate nutrition may lead to
  - ❖ an increase of psychosocial hazards such as stress or violence.
  - ❖ Tiredness due to lack of iron can make people irritable.
  - ❖ The body's immune system suffering nutrition-related diseases.

As people become too sick to work, they may even lose their jobs. Iron deficiency and anemia can have a severe impact on health and work productivity.

A lack of iron means less oxygen is transported in the body and consequently less energy is produced. Iron supplements (for example provided with balanced meals at work) can help to reduce fatigue and increase productivity.

Over-eating also results in immense costs to individuals and to employers. The **costs** are a result of the diseases related to overweight such as diabetes and coronary heart disease.

Changes in **lifestyles**, such as improving nutrition and exercise habits, as well as reducing alcohol and cigarette consumption can lead to less risk of heart disease and type 2 diabetes as well as improved productivity.

The benefits are immense for all concerned.

- ❖ Better health means better quality of life and less spending on medications.
- ❖ For employers it means higher productivity and less absenteeism.
- ❖ If employers are bearing some healthcare costs, these are also reduced.
- ❖ For governments, there are fewer burdens on the healthcare system, and the national economy is boosted by higher productivity.

## **Managing Nutrition at Work**

### **What can be done?**

As everyone benefits from improvements in workers' nutrition, it makes sense for all to contribute to them. Having looked at inadequate nutrition and its impact on the workplace, the following text contains suggestions about what governments, employers, workers and their representatives can do to improve nutrition by workplace measures.

## Departments

### Departments should

- Departments set the national policy framework for managing nutrition at work.
- Send strong health message, through its health care provision and health promotion activities can create an environment which facilitates positive behavioral change.
- Develop policies to encourage workplaces to improve nutrition.
- Include food supplements where they are needed in order to reach low income employees
- Provide subsidies for workplace food initiatives.
- Regulate food labeling to ensure that correct, accurate and comprehensive nutritional information is available.
- Promote initiatives, such as voucher systems, which are discussed below.

## Employers

- Employers are in a key position to influence workplace nutrition.
- Using an integrated OSH policy covering the basic elements common to all areas of health promotion, employers can create a framework for the enterprise which encourages healthy eating, healthy workers and a healthy business.
- Employers can also contribute to food provision at work.
- By providing food on the premises employers can help to enable workers to eat well, contributing to worker health and productivity.
- Employers can implement low-cost solutions, such as food supplements or making healthy food available on the premises and then reap the benefits in productivity.
- The provision of food in the work environment can have a number of advantages:
  - ❖ saves time, as workers do not have to leave the premises to eat;
  - ❖ improves workers' health, because the employer can choose to provide the right type of nutrition for the workers concerned;
  - ❖ makes the enterprise a more attractive place to work, which can reduce turnover; can benefit community health too.

## Trade Unions

- Worker consultation and involvement in OSH policy development and implementation through worker's representatives also contributes to the implementation of health promotion measures. This should help to ensure workers' adequate nutrition.
- A trade unions' advocacy role is particularly important concerning nutrition, but also psychosocial factors.
- Trade unions can play a vital role in raising that awareness, particularly if they can do so in collaboration with employers.
- Trade unions can also be key deliverers of education, training and information about nutrition issues at work. They will be looking after the health of their members.

## Working Together

Working together with employers, the following initiatives can be developed:

- initiate canteen improvements;
- set up a kitchen;
- change *ad hoc* food supplies;
- negotiate with mobile vendors;
- move to a voucher system.

## Canteens (cafeterias)

The advantages of a canteen are:

- workers save time by eating on-site;
- Influence on what is available, so healthy eating options can be promoted.
- workers can be provided with the opportunity to eat healthily on a regular basis;
- the employer can subsidize food.

Subsidizing meals has a number of advantages:

- workers eat the food provided which may be healthier and safer than food available outside the worksite;
- for the employer, this is a social benefit and can be regarded as an enticement to employment, which may improve the company's corporate image and the pool of for the employer, this is a social benefit and can be regarded as an enticement to employment, which may improve the company's corporate image and the pool of potential job applicants.

## **Snacks at meetings and vending machines**

- Snacks provided at meetings, or vending machines are a low-cost way of making food available to workers.
- Paying attention to health and healthy eating, it makes sense to ensure that the snacks and foods in vending machines meet the dietary needs of the workers.
- this means
  - ❖ replacing soft drinks with high-sugar content, serving water and fruit juices instead
  - ❖ serving high-grain content snacks, rather than biscuits made from refined white flour and with a high sugar content at meetings.
- Vending machines can also serve hot soups and have the capacity to keep meals hot for hours, increasing the convenience and availability of hot meals, both of which is particularly useful for shift workers.
- Vending machine meals are less expensive to serve than canteen meals, because staff need not be present.
- Enterprises which cannot afford a full canteen could indeed opt for a vending machine as one of the main mechanism for worker meal provision.

## **Personal lifestyle**

While employers and trade unions need to create the right framework of what is available in terms of nutrition, in the long run it is up to the individual to either eat healthy or not. People need first of all to know what constitutes a healthy diet.

## **INTERRELATIONSHIPS**

### **Links with psychosocial factors**

Psychosocial hazards rarely occur in isolation. In fact, risk behaviors, like smoking, drinking, eating junk food, and lack of exercise, tend to cluster. Changes in the workplace to reduce any one of these behaviors (or ideally all at once) could reduce the occurrence of the multiple unhealthy lifestyle behaviors and significantly improve the health and productivity of the workforce.

### **Nutrition and stress**

- When people are stressed, they eat differently.
- What we eat and how often we eat seems to be affected.
- Some people tend to consume healthy foods during positive emotions and to prefer junk food during negative emotions.

- When some people are angry, they eat more impulsively and consequently eat fast, irregularly and carelessly.

### **Nutrition and alcohol and drugs**

- Drinking alcoholic beverages increases appetite.
- Binge drinking is accompanied by the consumption of junk food to meet that extra hunger. the quantity but the quality of what drinkers eat is problematic.
- It is well known that consumption of marijuana produces feelings of hunger.
- Food taken at irregular times and immediately available is more likely to be junk food.
- Users of hard drugs more often are underweight, typically a physiological consequence of drug use, as well as a result of spending money on drugs rather than food.

### **Nutrition and smoking**

- Many smokers, particularly women, claim that smoking suppresses appetite and helps them to lose weight.
- There is little evidence to suggest that smoking reduces caloric intake.
- In fact, there is little difference in how many calories are consumed by smokers and non-smokers.
- What smokers observe is a tendency to eat more calories and therefore gain weight in the first few weeks after stopping smoking.
- Some smokers come to the false conclusion that smoking keeps them thin.

### **Nutrition and HIV and AIDS**

- With a virus affecting the immune system like HIV, improved diet can slow down the progression of HIV and AIDS.
- People with HIV need to take specific combinations of vitamin supplements, because the HIV retrovirus and HIV medicines can use up some nutrients, particularly B vitamins, magnesium and zinc.

### **Nutrition and exercise**

- It goes without saying that eating a healthy diet is only half of the story when it comes to achieving and maintaining a healthy weight.
- Without appropriate exercise, efforts to manage nutrition are unlikely to bear fruit.
- If a department addresses nutrition as part of its health promotion activities, they must also address exercise or other physical activity for health to have a good chance of success.

## 5. INTERVENTIONS

### Assessment

- Assess
  - ❖ the effects of nutrition in the workplace;
  - ❖ the different diseases caused by unhealthy eating habits
  - ❖ how the diseases are distributed in the department.
  - ❖ How many people are absent from work due to diseases caused by unhealthy eating.
  - ❖ What is the cost of being absent from work for the employer
  - ❖ Medical costs to the individual.
- This can be done through a survey which is department specific.

### Planning

The following steps should be followed when planning a workplace stress management programme:

#### **Step 1: define the expectations of the program**

A committee or team should be established to oversee the program (wellness committee/occupational health and safety committee).

Together, members of the committee should agree on a number of objectives for the program, which may include:

- Reducing the effects of malnutrition in the workplace
- Improving staff wellbeing
- Improving productivity.

#### **Step 2: develop a plan**

It is important that a plan be developed to communicate to staff and others, the steps the organization plans to take in order to achieve its objectives. The details of the plan could include the following headings:

- Background to the development of the program
- Aims and objectives
- Expected outcomes
- Allocation of resources
- Consultation
- Roles of management and employees
- Program activities
- Program timeframe
- Monitoring and Evaluation.

## Implementation

Nutrition in the Workplace								
Functional Objectives	Inputs	PROCESSES / ACTIVITIES				INDICATORS FOR IMPLEMENTATION		
		Capacity Building Initiatives	Organizational Support Initiatives	Governance and Institutional Development Initiatives	Economic Growth and Development Initiatives	Output	Outcome	Impact
1. Conduct workplace BMI assessment.	Human resources Financial resources Equipment	Train managers, coordinators on how to conduct workplace BMI assessment	Information Management System, Database on HR record.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees who participated in the assessment.	% those of employees who want to go on nutritional therapeutic programme.	Increase in over-all health and well being.

2. Develop a nutrition management plan for	Human resources	Train managers, coordinators on how to develop a nutrition management plan	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of targeted employees for intervention in the plan.	% those of employees who want to go on nutritional therapeutic programme.	Increase in over-all health and well being.
3. Implement nutrition management programme.	Human resources	Train managers/ coordinators on implementation of nutrition management programme	Information Management System,  Database on usage of nutrition management programme.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees utilizing the programme	% of those employees who have utilized the programme who have reached the ideal BMI.	Increase in over-all health and well being.

4. Develop and implement M&E plan for nutrition management.	Human resources	Train managers/ coordinators on implementation of nutrition management programme	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of Managers trained on M&E	% of managers and coordinators submitting Reports.	Increase in over-all health and well being.
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**Monitoring and evaluation**

Develop a monitoring plan. Monitor progress annually, half yearly; quarterly and monthly according to your monitoring plan. Reports should be sent to departmental heads, provincial offices and to the DPSA on a quarterly base.

### 1. Aims

Over and above the overall objective of developing knowledge and skills for Wellness Managers and Practitioners to enable them to integrate psychosocial and health promotion issues into a comprehensive workplace programme, the specific aims for this section on Healthy Sleep are to:

- Guide Wellness Managers and Practitioners on how to develop effective programmes on promotion of healthy sleep.
- Guide Wellness Managers and Practitioners on how to manage shift work in the workplace.
- Operationalize the Wellness Management Policy for the Public Service.

### 2. Scientific Evidence

Sleep is a basic human need and is essential for good health, good quality of life and performing well during the day.

The following are stressors that increasingly cause difficulties in sleeping:

- **lifestyle** (*daytime sleepiness*),
- **Psychological** (*mental distress*) and
- **Environmental** (*temperature, noise*) factors. Sleep disturbance is frequently considered the most serious consequence of environmental noise (WHO, 2004).

Indicators/ Symptoms of sleep disorders are:

- 1) Sleep latency
- 2) Number and duration of nocturnal awakenings;
- 3) The total sleep time
- 4) Rapid Eye Movement sleep (REM sleep), together with modifications in the autonomic functions (heart rate, blood pressure, vasoconstriction and respiratory rate);
- 5) Repetitive nights of sleep disruption among one week or one month.
- 6) No refreshing sleep.

There are several types of sleep disorders.

- Insomnia,
- sleep apnoea,
- and restless leg syndrome

These are some examples of clinical sleep disorders that can affect adults and interfere with normal functioning. These sleep disorders can contribute to medical or emotional problems.

According to the Diagnostic and Statistical Manual of Mental Disorders there are four categories of sleep disorders,

- i) Primary sleep disorders including dyssomnias,

- ii) Parasomnias,
- iii) Sleep disorders related to medical/psychiatric disorders including insomnia and hypersomnia;
- iv) and other sleep disorders including disorders due to a general medical condition or a Substance- induced sleep disorder.

The main effects of sleep deprivation include:

- **Physical effects** (sleepiness, fatigue, hypertension)
- **Cognitive impairment** (deterioration of performance, attention and motivation; diminishment of mental concentration and intellectual capacity and increase of the likelihood of accidents at work and during driving) and
- **Mental health complications.** Inadequate rest impairs the ability to think, to handle stress, to maintain a healthy immune system, and to moderate emotions.

Poor sleep habits also put psychological and physical well-being at risk. Not getting enough sleep can make one more emotionally reactive to stressful events), and negatively affects the overall mood and well-being (Hamilton *et al*, 2007). Inconsistent sleep (e.g., varying bed times, wake times, and sleep duration) can also lead to poorer sleep quality and increased fatigue (Fuligni & Hardway, 2006). Even more importantly, modest sleep deprivation can also lead to dangerous dips in cognitive performance that may have serious safety consequences. For example, people who drive after being awake for 17-19 hours are poorer drivers than individuals over the legal alcohol limit (Williamson & Feyer, 2000). This means that going to work sleep-deprived is not much different than going to work drunk! Even more troubling, only minor variations in sleep can be associated with safety risks. Therefore, sufficient sleep is needed to ensure a safe work environment and healthy employees.

Given the abundance of research linking sleep to various health and well-being outcomes, why does wellness programs take sleep for granted? The answer is that the negative consequences of sleep are often indirect and multi-faceted, leading individuals to mistake the symptoms of unhealthy sleep practices for the primary issues to be addressed (e.g., the “unhealthy sleeper” effect). This misattribution is common, given that sleep is often perceived as an outcome of stress and other health behaviours rather than an antecedent.

### 3. Rationale Sleep loss can lead to

- more exhaustion and
- Detachment from work which may hamper the employee’s ability to fully contribute to organizational activities ((Papp *et al.*, 2004). Even when the employee do engage at work, he/she is more likely to be
- Unproductive (individual and group level) without proper sleep. Insufficient sleep causes

- Poorer decision making and performance on complex tasks that require logic/reasoning, reading comprehension, and knowledge extrapolation (Schemeichel *et al*, 2003).

This loss of productivity is not only problematic on an individual level, but it can be exacerbated at the group or organizational level. In work situations requiring high interdependence or complementary areas of expertise among team members, just one or two sleep deprived individuals can undermine the whole group's performance (Barnes & Hollenbeck, 2009).

Health promotion initiatives are gaining popularity in the workplace in efforts to maximize employee health and well-being. These programs often emphasize exercise, nutrition, weight loss, and reducing substance use (e.g., smoking and alcohol) as the central points of intervention for improving employee health. Surprisingly, sleep gets little attention in these programs, if any at all. However, sleep habits may ultimately be the source of struggling job performance, strained professional and personal relationships, fading health, and work-life imbalance.

#### 4. Contextual Issues

The consequences of insomnia can be

- **Behavioural** manifesting in poor performance at work, fatigue, memory difficulties, concentration problems, car accidents,
- **Psychiatric problems** - depression, anxiety conditions, alcohol and other substance abuse
- **Medical** - cardiovascular, respiratory, renal, gastrointestinal, musculoskeletal disorders, impaired immune system function and an **increased** risk of mortality.

Insomnia increases the **mortality risk**, but in fact there are no accurate data, it's most probably linked with **work-related accidents** among sleep disturbed people. The "simple" fact of not sleeping does not lead to increased mortality associated with intrinsic health conditions (WHO, 2004).

**Categories for most at risk populations:** (Åkerstedt ,2004) explain further that there is a Specific population groups linked by behaviour, life style, age, and gender, among other factors, can be at increased risk of having health problems from sleep disturbance. **Stress due to work or family** seems to be one of the major causes of disturbed sleep. The effect of stress on the risk of insomnia is well established, but reduced sleep in itself seems to yield the same physiological changes as stress. This suggests that several of the major civilization diseases in Europe and the US (diabetes, cardiovascular disease, and burnout) could be mediated via disturbed sleep. This link clearly warrants longitudinal studies with interventions.

Shift workers constitute a group that suffers from disturbed sleep for most of their occupational life. The reason is the interference of work hours with the normal timing of sleep. This leads to an increased risk of accidents, directly due to excessive sleepiness, but also to cardiovascular and gastrointestinal

disease, although it is not clear whether the latter effects are sleep related or due to circadian factors - or to a combination.

Data suggests that the risk of disturbed sleep increases with age but there also seems to be a recent stress related increase in sleep disturbances in young adults. The long term health consequences are not understood.

A basic human necessity, sleep, is as important to health, well-being and productivity as a well-balanced diet and regular exercise. Whether lack of sleep is caused by shift work, by working long hours or is the result of stress at work, the impact is considerable. Sleep-deprived adults have been shown to have lowered emotional resilience, greater irritability, increased obesity, and higher risk of cardiovascular disease. Controlling for most other relevant factors, sleeping too little is associated with a 40% increased chance of earlier death. Safety and productivity are also compromised because of the effect that lack of sleep has on mental alertness, accuracy and ability to learn. Most people know that inadequate sleep decreases alertness and increases sleepiness, irritability, and fatigue. However, many do not know that a single sleepless night can impair performance as much as a blood alcohol level of 0.08-0.1% (the legal limit in many places).

According to Kenton's (1994:128) 10 Day De-stress Plan identifies sleep as the greatest healer of stress and sleep can help regenerate one's body, clear emotional conflicts, and render the individual able to think better and work more efficiently. Sleep is believed to afford the human body a period of recovery and rest from a busy, challenging working day and most sources recommend 6 to 8 hours of sleep for a healthy adult (Hudak et al, 1998:99).

## **5. Interventions**

Just as working practices can be the cause of insufficient and poor quality sleep, they can often be altered to help reduce the problem. Well-managed shift work can minimize the impact of disrupted sleep patterns, and well-managed employees are less likely to lie awake all night worrying about work. Employees need to be well-informed about the importance of good sleep and what they can do as individuals to develop good sleep practices. Any workplaces activities addressing quality sleep need to be conducted by consulting with workers to ensure they respond to their needs. Healthy sleep practices should be a central concern in organizations because poor sleep has hidden negative psychological, physical, and performance costs for employees (e.g., the "unhealthy sleeper effect").

Given the emerging link between self-regulation and sleep, healthy sleep practices should be a key component in health promotion and intervention programs, as they provide the foundation for employees to successfully engage in all other health promotion endeavours. Such interventions should encourage employees to:

**Get Sufficient Amount of Sleep:** We are all familiar with the suggested “eight hours a day,” but we may not realize that this is only an average estimation. Individuals drastically differ on true sleep need, with some people only needing six hours a day to feel refreshed and others needing closer to nine hours (Klerman & Dijk, 2005). To identify one’s sleep need, he/she should take a “sleep vacation” where he/she can allow him/herself at least five days with an unrestricted sleep schedule. When people are chronically sleep deprived, their bodies often initially overcompensate for sleep need. Thus, it may take up to three days of “paying off” your sleep debt before settling on optimal amount of sleep.

**Maintain Consistent Sleep Schedule:** When people vary the times they go to bed and wake up, they create a physiological disruption to their natural biological rhythms (called circadian rhythm disruption) that is identical to symptoms of “jet lag”: lower concentration and alertness, higher fatigue and sleepiness, and sharp drops in mood (Fuligni & Hardway, 2006;). Much like fitness routines, keeping a consistent sleep schedule around a sufficient amount of sleep can help boost energy to manage demands and decrease feelings of stress (Barber & Munz, 2010).

**Prepare for Bedtime:** Ensuring high quality sleep takes quite a bit of preparation and self-awareness. Strenuous mental or physical activity should be avoided right before bedtime (e.g., exercising, working), as well as substance use. Caffeine and nicotine before bedtime can make falling asleep difficult, while excessive alcohol can impair overall sleep quality (Roehrs & Roth, 1997). Allow 30-60 minutes to do a relaxing activity (e.g., take a shower/bath, listen to music, reading material unrelated to work) in dimmer lighting. Psychologically and physiologically transitioning to bed prevents thinking about work or other demands right before bedtime, which interferes with the ability to fall asleep.

### **5.1. Assessment**

Employees should be assessed for sleep-habits, and sleep deprivation, especially those on shift work. Accident trends for drivers should be assessed for relationship to sleep deprivation.

### **5.2. Planning**

A Healthy sleep management programme should be developed, in line with the findings of the audit or baseline assessment. There might be a need to plan for working hours or shift work in such a way that impact of disrupted sleep patterns is minimized.

### 5.3. Implementation

Healthy Sleep Management								
Functional Objectives	Inputs	PROCESSES / ACTIVITIES				INDICATORS FOR IMPLEMENTATION		
		Capacity Building Initiatives	Organizational Support Initiatives	Governance and Institutional Development Initiatives	Economic Growth and Development Initiatives	Output	Outcome	Impact
1. Conduct Sleep Habits audit.	Human resources  Financial resources	Train managers, coordinators on how to conduct sleep habits audit	Information Management System,  Database on HR record.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees who participated in the audit.	% of employees who are willing to participate in the Healthy Sleep therapeutic programme.	Increase in over-all health and well being.

2. Develop a Healthy Sleep self-awareness programme	Human resources	Train managers, coordinators on how to develop a Healthy Sleep self-awareness programme	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of targeted employees for intervention in the Healthy Sleep self-awareness programme	% of employees who expressed the need to participate in Sleep Habits remedial programme.	Increase in over-all health and well being.
3. Implement Healthy Sleep management - programme.	Human resources	Train managers/ coordinators on implementation of Healthy Sleep management - programme.	Information Management System,  Database on usage of Healthy Sleep management - programme.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees utilizing the programme	% of those employees who have utilized the programme and have improved sleeping habits.	Increase in over-all health and well being.

4. Develop and implement M&E plan for Healthy Sleep management - programme..	Human resources	Train managers/ coordinators on implementation M&E plan for Healthy Sleep management - programme.	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of Managers trained on M&E	% of managers and coordinators submitting Reports on Healthy Sleep management - programme.	Increase in over-all health and well being.
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#### **5.4. Monitoring and evaluation**

Conduct regular surveillance for common signs of sleep disorders among employees. Develop and define indicators for chronic and temporary insomnia, plan and implement interventions according to the findings.

Encourage affected employees to keep a sleep diary, and arrange for weekly review of their recordings to identify early signs of improvement or worsening of the status.

#### **6. Organizational Support Initiatives**

Healthy sleep practices should be a central concern in organizations because poor sleep has hidden negative psychological, physical, and performance costs for employees (e.g., the “unhealthy sleeper effect”

#### **7. Governance Initiatives**

Healthy sleep is greatly affected by shift work; therefore the employer needs to adhere to the Code of Good Practice on the arrangement of working time to promote healthy sleep for day and night shift workers. The code states the following factors should be taken into account in the design of rosters for semi-continuous and continuous shift work:

- The frequency of night work, weekend work and work on public holidays should be limited as much as possible for each worker.
- The frequency of shift rotation should take account of the difficulties workers may have in adapting to night work.
- It is preferable that shifts be rotated in a forward direction (morning to afternoon to night), bearing in mind workers' preferences, local conditions and difficulties in scheduling a long period of rest after spells of night shifts.
- Night shifts should be no longer than morning and afternoon shifts. Where long night shifts are used they should be carefully reviewed to find ways to avoid excessive fatigue. Successive long night shifts should be avoided to the extent practicable.
- Rest periods for shift workers should be scheduled to fall on weekends-a certain minimum number of times during a given period.

### 1. Aims

Over and above the overall objective of developing knowledge and skills for Wellness Managers and Practitioners to enable them to integrate psychosocial and health promotion issues into a comprehensive workplace programme, the specific aim for this section is to increase habitual levels of physical activity in the Public Service and to promote health and prevent disease through:-

- Creating knowledge and awareness concerning the importance of regular physical activity for health and wellbeing and in the prevention of disease.
- Increasing and promoting inter-departmental collaboration in order to increase opportunities to be physically active.
- Implementing physical activity programmes and related interventions to promote physical health.

### 2. Scientific Evidence

It has been proven that exercise lower the risk of heart disease and has a favourable effect on virtually ***all risk factors of cardiovascular diseases***. What really happens when a person exercises?

- The heart muscle contracts forcefully and frequently, increasing blood flow through the arteries.
- This leads to subtle changes in the autonomic nervous system, which controls the contraction and relaxation of these vessels.
- This fine-tuning leads to a lower resting heart rate (fewer beats to pump blood through the body),
- Lower blood pressure and a more variable heart rate,
- All these factors lower the risk of developing cardiovascular diseases.

The benefit of exercise:

- It limits inflammation associated with heart trouble
- It limits arteriosclerosis or hardening of the arteries around the heart, which may lead to heart attacks.
- It reduces the C-reactive protein (a marker of inflammation), one of the key risk factors for cardiovascular disease.

Effects of physical fitness:

- Improved cardiovascular health
- Improved strength and muscular endurance
- Resistance to fatigue
- Enhanced mental health and function
- Improved wellness

- Opportunity for successful experience social interaction
- Improved appearance
- Greater lean body mass and less body fat
- Improved flexibility
- Bone development
- Reduced cancer risk
- Reduced effects of acquired aging.

### 3. Rationale

The majority of South Africans have at least one modifiable risk factor for chronic disease<sup>xviii</sup>. Moreover, in cross-sectional studies, over 40% of historically, socio-politically disadvantaged persons living in urban communities reportedly do not participate in any leisure or occupational physical activity<sup>xix</sup>.

According to a study on Physical Activity and Chronic Diseases of Lifestyle (CDL) in South Africa between 1995 and 2005<sup>xx</sup>, CDL accounts for nearly 40% of adult deaths, and the majority of South Africans have at least one modifiable risk factor for chronic disease. More specifically, conditions such as hypertension and diabetes in older South African adults are very common. For example, prevalence of hypertension in black South Africans (> 65 years) living in urban and peri-urban communities has been found to be greater than 43% in men and more than 66% in women. Similarly, older adults of mixed racial ancestry from the Western Cape region have a reported prevalence of hypertension of 66.7% in men and 76.5% in women. Moreover, those individuals with hypertension are generally poorly controlled.

According to the Government Employee Medical Scheme (GEMS) Key Healthcare Trends Report of 2009, **Mental Health conditions** and **lifestyle-related conditions** (diabetes, hypercholesterolemia and hypertension) were among the predominant cost drivers for 2008/2009.

A sedentary lifestyle, obesity, dietary deficiencies and smoking are modifiable risk factors for premature and severe disease and premature death. There are significant positive outcomes associated with lifestyle change. For relevant subpopulations, maintained improvement in lifestyle, with smoking cessation, **moderate exercise** and weight loss is associated with up to 25% reduction in diabetic, cardiovascular and cancer morbidity and mortality rates.

The Department of Health Annual Performance Plan 2012/13-2014/15 sets the following targets for life expectancy:

- It must increase from the current 54.0 years for males to 56.0 years by 2014
- It must increase from the current 59.0 years for females to 61.0 years by 2014

To achieve this target there *must* be a reduction in premature deaths from non-communicable diseases and this can be achieved through attaining a “healthy life”. Attaining a healthy lifestyle means prevention of disease but also, in accordance with the WHO definition of health, the promotion of physical, mental and social “wellbeing” in the population.

Achieving a long and healthy life for all requires interventions that promote the health of the population and prevent diseases due to Non-Communicable Diseases (NCDs). Effective prevention necessitates a broad multi-sectoral approach involving different government departments, civil society organizations, the private sector, media as well as commitment to health and wellness from individuals themselves.

The South African Declaration for Prevention and Control of Non-communicable diseases commits to reduce by 10% the percentage of people who are obese and/or overweight by 2020<sup>xxi</sup>. The Public Service should contribute towards the attainment of this target through workplace programmes.

#### 4. Contextual Issues

The following are statistics with regards to Non-Communicable Diseases and (NCDs) and inactivity in South Africa:

- NCDs accounted for 29% of all deaths in South Africa in 2008.
- Non-communicable diseases contribute 33% of the total burden of disease.
- According to WHO<sup>xxii</sup>, 51% of South Africans are physically inactive.
- The SA Youth Risk Behaviour Survey found that 38% of all school children participated in less than the recommended levels of physical activity, with more than a third of the boys and 43% of the girls being sedentary.
- The National Youth Risk behavior Survey indicated that 19.7% of learners were overweight, with significantly more female (27.8%) than male (11.2%) learners.
- The national prevalence of obesity was 5.3% with significantly more female (7.2%) than male learners obese (3.3%).
- Globally, physical inactivity is responsible for 6% of deaths, overweight and obesity is responsible for 5% of deaths.

One of the central priorities of government is “**A long and healthy life for all**”. To achieve this objective clear strategies and plans are needed to address each of the four areas that constitute South Africa’s quadruple burden of diseases:

- A maturing and generalized HIV and AIDS epidemic and high levels of tuberculosis
- High maternal and child mortality
- Violence and injuries and
- **Non-communicable diseases**

These conditions are mostly preventable through modification of four main risk factors, namely:

- Tobacco use
- **Physical inactivity**
- Unhealthy diets
- Harmful use of alcohol

Physical activity and health promotion initiatives in South Africa have been fragmented, with little central government coordination. This may be attributed in part to:

- Emphasis within the formal health sector on primary healthcare delivery,
- The collapse of health education within public schools and historical absence of such programs in disadvantaged communities,
- A lack of basic infrastructure in many peri-urban communities, and
- A high prevalence of urban violence and risk to personal safety.

The South African government has recently begun the following initiatives promoting physical activity in certain target populations:

- National guidelines incorporating physical activity was released by the department of Health, targeting older adults.
- There are several national campaigns aimed at increasing awareness regarding physical activity and health, such as National Wellness Day.

However, this initiatives lack a broad-based infrastructure for implementation, as well as financial support and community awareness for sustainability.

The benefits both to employees and to employers of a fit and healthy workforce are multiple:

- Less absenteeism,
- More productivity and
- Higher staff morale.

The workplace can contribute to the goal of having a fit and healthy workforce in many ways, some work involves much physical activity, and it is important that this activity be conducted in a way that it does not cause injury or excessive fatigue. Some work involves little or no physical activity. Regular moderated physical activity increases productivity in the workplace and lower worker absenteeism and turnover. Physical activity is fundamental to:

- Energy balance
- Weight control
- Contributes to social and mental well-being.
- It reduces the risk of coronary heart disease and stroke,

- It reduces the risk of type II diabetes,
- It reduces the risk of colon cancer and
- It reduces the risk of breast cancer among women.

Many employers recognize that they have a responsibility to protect the health and well-being of their employees. It may be possible for large organizations to provide sport facilities on their premises. Most of the options for encouraging physical activity are much less expensive. For example:

- Adjusting work organization to allow appropriate time slots for physical activity can be very effective
- Physical activity should form part of a wider campaign on health promotion at the workplace
- Including information and education to create a social environment which is conducive to physical activity and exercise.
- Using senior staff as role models may be part of this process.

The South African Public Service has put in place measures to deal with the health and wellbeing of public servants. Such measures include the launch of the Employee Health and Wellness Strategic Framework for the Public Service in 2008. This framework was developed following research and benchmarking of international and local best practices and obtaining inputs from stakeholders. The framework also recognizes the integrated approach to employee health and wellness and the importance of individual health, wellness and safety and its linkages to organisational wellness and productivity in the Public Service.

Subsequent to the framework, the Wellness Management Policy for the Public Service was developed to promote physical wellness within the Public service. However, implementation is still a challenge due to insufficient infrastructure and financial support. It has been noted that several workplaces in the Public Service do provide opportunities for physical activities e.g. gyms and sporting facilities. However, the majority of Departments do not have such facilities in the workplace. This guideline seeks to increase habitual levels of physical activity for all Public Servants and to promote health and prevent disease through workplace programmes.

## **5. Inter-relationships of physical activity with other psychosocial factors**

Physical activity creates beneficial effects on the health of people and can contribute to reduce the health risks related to eating habits, smoking, alcohol consumption and drug use, stress, and even violence, if combined with other health promotion measures. For this reason, physical activity should be a component of workplace health promotion measures.

### **5.1 Nutrition and physical activity**

- Diet and physical activity are both important for many functions of the body and for how the body processes carbohydrates and fats.
- The risk of chronic diseases is influenced by what people eat and how much physical activity they do.
- For muscles to develop and be strong, they need both physical activity and sufficient protein; exercise alone, or just a high-protein diet will not be enough.
- The same is true for bone mass and strength; calcium and vitamin D are required from the diet, and physical activity makes the body incorporate them into bone tissue.
- Carbohydrates and fats are processed by the body especially effectively during physical activity. Without muscular activity, the carbohydrates and fat are stored in the body, making the person put on weight.
- With increased weight, the risk of serious diseases, such as type 2 diabetes and cardio-vascular diseases increases too.
- Physical activity also helps to regulate appetite; the person is able to eat as much food as they need to function, rather than over-eating.
- Regular physical activity may make one conscious about diet; someone who has made the effort to be physically active may not want to destroy the positive effects by eating an unhealthy diet, and vice versa.

## **5.2 Smoking and physical activity**

The general perception is that smoking and physical activity do not go together. This is seen also in reality; physically active people tend to smoke less than inactive people. This is likely to be based on many factors:

- Physically active people are usually more health-conscious, and they feel the harmful effects clearly in their physical performance.
- Their peers are probably also quite active and may oppose smoking.
- Many people find they enjoy physical activity and that it relieves stress, so they have less need and temptation to smoke.
- Sports and exercise are especially important for young members of the workforce, in order for them to develop their own healthy habits and lifestyles.
- Some of the factors mentioned above are helpful also in supporting people who want to stop smoking.
- In addition, regular physical activity can help to counteract the feared weight increase sometimes associated with stopping smoking.

## **5.3 Alcohol and drugs and physical activity**

- Much of what is said above for smoking also holds true for alcohol and drug use.
- In general, regular physical activity contributes to prevent beginning alcohol and drug use, and can also help prevent excessive use of alcohol later on.
- However, in some sports, drinking, and sometimes heavy drinking, is seen as an integral part of the sport's culture.
- The leaders and coaches of sport teams can act responsibly in working against this practice without destroying the attraction of the activity.

#### **5.4 Stress and physical activity**

- Physical activity is an effective way to combat stress.
- Relieving stress and frustration in a healthy way, even if only for short periods, may help considerably in avoiding unhealthy activities such as smoking, overeating, drinking alcohol, using drugs or behaving violently.
- In the long run choosing physical activity over other stress release options may have significant positive consequences.

#### **5.5 Violence and physical activity**

- Violence is related to physical activity via stress and frustration.
- Somebody who is stressed may end up being violent, whereas they could relieve their stress through physical activity.
- For example, boxing can be an acceptable channel to vent anti-social and violent behavior.
- Particularly young workers may be able to make effective use of this type of physical activity to establish a healthy social attitude.

### **6. Interventions**

Interventions for Physical Activity in the workplace should follow the APIME approach:

#### **6.1 Assessment**

Prior to embarking on physical activity programme implementation, it is important to conduct an initial baseline situational assessment to determine the level of fitness among employees. This can be done through fitness assessment which can be conducted internally by inviting relevant service providers. This can also be done through referral to external service providers.

Indicators of health-related physical fitness:

- Cardiovascular endurance
- Muscular endurance
- Muscular strength

- Flexibility
- Body composition

## 6.2 Planning

Workplace interventions should include a physical activity plan with the concepts of frequency, duration, intensity, type and total amount of physical activity needed for health enhancement and prevention of Non-Communicable Diseases. The physical activity plan should clarify the following:

- **Type of physical activity (what type):** The mode of participation in physical activity. The type of physical activity can take many forms: aerobic, strength, flexibility, balance.
- **Duration (for how long):** The length of time in which an activity or exercise is performed. Duration is generally expressed in minutes.
- **Frequency (how often):** The number of times an exercise or activity is performed. Frequency is generally expressed in sessions, episodes, or bouts per week.
- **Intensity (How hard a person works to do the activity):** Intensity refers to the rate at which the activity is being performed or the magnitude of the effort required to perform an activity or exercise.
- **Volume (how much in total):** Aerobic exercise exposures can be characterized by an interaction between bout intensity, frequency, duration, and longevity of the programme.
- **Moderate-intensity physical activity:** On an absolute scale, moderate intensity refers to activity that is performed at 3.0–5.9 times the intensity of rest. On a scale relative to an individual's personal capacity, moderate-intensity physical activity is usually a 5 or 6 on a scale of 0–10.
- **Vigorous-intensity physical activity:** On an absolute scale, vigorous intensity refers to activity that is performed at 6.0 or more times the intensity of rest for adults and typically 7.0 or more times for children and youth. On a scale relative to an individual's personal capacity, vigorous-intensity physical activity is usually a 7 or 8 on a scale of 0–10.
- **Aerobic activity:** Aerobic activity, also called endurance activity, improves cardio respiratory fitness. Examples of aerobic activity include: brisk walking, running, bicycling, jumping rope, and swimming.

### The Global Recommendations on Physical Activity for Health

For adults between 18–64 years old, physical activity should include recreational or leisure-time physical activity, transportation (e.g. walking or cycling), occupational (e.g. work), household chores, play, games, sports or planned exercise, in the context of daily, family, and community activities. In order to improve cardio, respiratory and muscular fitness; bone health and reduce the risk of NCDs and depression; the following are recommended:

- Adults aged 18–64 years should do at least 150 minutes of moderate-intensity aerobic physical activity throughout the week,
- At least 75 minutes of vigorous-intensity aerobic physical activity throughout the week,
- An equivalent combination of moderate- and vigorous-intensity activity.
- Aerobic activity should be performed in bouts of at least 10 minutes duration.
- For additional health benefits, adults should increase their moderate-intensity aerobic physical activity to 300 minutes per week,
- Engage in 150 minutes of vigorous-intensity aerobic physical activity per week,
- An equivalent combination of moderate- and vigorous-intensity activity.
- Muscle-strengthening activities should be done involving major muscle groups on two or more days a week.

### 6.3 Implementation

Implementation of physical activity programme in the workplace should follow the APIME approach as outlined in the table below:

Physical Activity in the Workplace								
Functional Objectives	Inputs	PROCESSES / ACTIVITIES				INDICATORS FOR IMPLEMENTATION		
		Capacity Building Initiatives	Organizational Support Initiatives	Governance and Institutional Development Initiatives	Economic Growth and Development Initiatives	Output	Outcome	Impact
1. Conduct fitness assessment.	Human resources Financial resources Equipment	Train managers, coordinators on how to conduct fitness assessment	Information Management System, Database on HR record.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees who participated in the assessment.	% of employees who want to participate physical activity programme.	Increase in over-all health and well being.

2. Develop a physical activity plan	Human resources	Train managers, coordinators on how to develop a physical activity plan	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of targeted employees for intervention in the plan.	% of employees who want to participate in physical activity programme.	Increase in over-all health and well being.
3. Implement physical activity programme.	Human resources	Train managers/ coordinators on physical activity programme	Information Management System,  Database on usage of physical activity programme.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees participating in the programme	% of employees who participated in the programme who have reached the ideal fitness level.	Increase in over-all health and well being.

4. Develop and implement M&E plan for nutrition management.	Human resources	Train managers/ coordinators on implementation of nutrition management programme	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of Managers trained on M&E	% of managers and coordinators submitting Reports.	Increase in over-all health and well being.
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The table below describes effective types of physical activity strategies that can be implemented at the workplace.

<b>Elements of a strategy for the promotion of physical activity for health</b>	
<b>Information</b>	Can take the form of leaflets, posters, articles, websites, and presentations. It can cover issues like the benefits of physical activity; different opportunities to be active, such as at the workplace, while commuting to work, during leisure time, or while doing household chores; advice on different exercise programmes, facilities, equipment, and clothing.
<b>Education (Peer)</b>	Provides more formal and thorough knowledge of the issues mentioned above through courses, lectures, articles, websites and discussion groups. Education and training are especially useful when provided by peers who assist colleagues in becoming physically active.
<b>Questionnaires</b>	Collecting information on the health and physical activity habits of the employees, and on the values, attitudes, preferences and obstacles related to physical activity can be used to design a programme and as an evaluation tool to measure its success.
<b>Regular health examinations</b>	Can measure an employee's need for physical activity and identify any health issues that could influence the choice of sport.
<b>Fitness tests</b>	Can measure the levels of various aspects of fitness; the need for physical activity for different purposes; can be used to follow-up the effects of exercise programmes.
<b>Prompts and possibly incentives</b>	Can encourage employees to use opportunities to be physically active during the working day, such as using the stairs instead of lifts and walking to communicate with colleagues instead of using phone or email.
<b>Counseling and guidance</b>	Provides individual help on suitable physical activities; can be motivating.
<b>Exercise groups</b>	Groups of individuals with the same goals, motivation and level of skill provide much social support and sharing of experience that can encourage people to start and then continue exercising; Peers with some training in how to lead exercise groups have been shown to be a good way to provide the necessary leadership.
<b>Exercise events</b>	Either non-competitive or competitive; can provide opportunities to try a new sport, and can encourage more exercise by providing a goal to work towards; can increase social coherence at work. These events can be offered also to family members in order to widen the scope of the promotional efforts.

<b>Facilities, equipment, clothing</b>	Can be organized and paid for by the employer, either in part or in full.
<b>Awards, prizes</b>	Can be provided for either performance or participation.
<b>Incentives to walk or cycle to work</b>	Can include provision of facilities to change clothes and to wash; to park bicycles; improving road safety (in collaboration with relevant stakeholders), financial incentives.
<b>Exercise breaks</b>	Can be provided during the working day.
<b>Monitoring</b>	Of physical activity at work; timely feedback of the findings.

## 6.4 Monitoring and Evaluation

The M&E system within a programme should be structured to ensure the most efficient use of resources to generate the data needed for decision-making. An M&E plan for physical activity programme should be developed with measurable indicators. It should guide data collection and analysis, increase the consistency of the data and enable managers/coordinators to track trends over time. Implementation of the M&E plan should yield an implementation report to be submitted to DPSA.

## 7. Organizational Support Initiatives

### Key elements for Implementing Workplace Health Promotion Strategies

Workplace health programs are implemented to improve the health of individual employees and of the overall organization. The selection of strategies and interventions that make up the overall program can focus on different levels within the organizations including:

- **Individual** – elements of an employee’s lifestyle, such as their health behaviours, health risk factors, and current health status
- **Interpersonal** – elements of an employee’s social network including relationships with managers, co-workers, and family that provide support, mentoring or role models
- **Organizational** – elements of the workplace structure, culture, practices and policies such as health benefits, health promotion programs, work organization, and leadership and management support
- **Environmental** – elements of the physical workplace such as facilities and settings where employees work as well as access and opportunities for health promotion provided by the surrounding community where employees live

Several factors have been identified as essential elements to consider when implementing physical activity and healthy diet strategies in the workplace. The table below presents these key elements, extending along the continuum from organisational to environmental to individual employee levels.

Level	Key elements
Organisational level	<ul style="list-style-type: none"><li>• Linking programs and policies to organizational objectives and values.</li><li>• Integrating with business practices.</li><li>• Organizational policies that support healthy lifestyle to ensure long-term commitment, resources and sustainability.</li></ul>
Management level	<ul style="list-style-type: none"><li>• Management support and involvement, from senior through to middle management, to ensure equal access and support to all workers.</li></ul>

	<ul style="list-style-type: none"> <li>• Optimize use of resources; ensure adequate provision of staff, time and resources for program development and implementation.</li> <li>• Set goals and indicators of success within realistic timeframes.</li> <li>• Ensure long-term commitment to the program.</li> </ul>
Environmental level	<ul style="list-style-type: none"> <li>• Supportive organisational environment.</li> <li>• Provide access to resources and assistance.</li> <li>• Give targeted employees' time to learn how to deliver and use the program components.</li> <li>• Making program accessible or easy to use and redesigning work processes to increase opportunities and facilitate healthy physical activity and diet choices.</li> </ul>
Cultural level	<ul style="list-style-type: none"> <li>• Communication, marketing and promotion of programs to employees.</li> <li>• Clear and frequent messages via multiple communication channels.</li> </ul>
Individual/Employee level	<ul style="list-style-type: none"> <li>• Participatory planning; involve, engage and consult employees.</li> <li>• Conduct needs assessments as part of project planning to identify employee needs, likes, dislikes; help tailor programs to their needs</li> </ul>
Program level	<ul style="list-style-type: none"> <li>• Building effective programs across the individual to environment continuum, to address factors that affect health and productivity at individual, environmental, policy and cultural levels at the same time.</li> <li>• Develop and implement multi-component programs that target several health issues.</li> <li>• Attain high participation rates.</li> <li>• Tailoring programs to focus on employees' needs.</li> <li>• Evaluate program and policies to provide indication of whether programs are achieving their goals; demonstrate value of program and provide accountability to management to influence support and funding for future implementation and sustainability.</li> <li>• Dissemination of outcomes and findings to stakeholders.</li> </ul>

## 8. Governance Initiatives

The Employer should:

- Include physical activity for health as an important part of the integrated workplace policy.
- Contribute to the development of the policy as a collaborative effort with other partners.
- Commit to support the programme financially and symbolically.

### 1. Aims

Over and above the overall objective of developing knowledge and skills for Wellness Managers and Practitioners to enable them to integrate psychosocial and health promotion issues into a comprehensive workplace programme, the specific aims for this section on Economic Stress are to:

- Guide Wellness Managers and Practitioners on how to develop effective Financial Wellness Programmes in the workplace.
- Guide Wellness Managers and Practitioners on how to provide assistance to employees with financial problems.
- Guide Human Resource Managers and Practitioners on how to manage garnishee orders in the workplace.
- Operationalize the Wellness Management Policy for the Public Service.

### 2. Scientific Evidence

Stress is a complex phenomenon, which is reflected in the large number of definitions in circulation (Di Martino, 1992). However, in recent years definitions have tended to converge around a definition that explains stress as an interactive psychological process or a psychological state between the individual and the situation (Di Martino, 1992; Cox, 1993). Stress is seen as the perceived imbalance between internal and external demands facing the individual and the perceived ability to cope with the situation.

As far as stress symptoms are concerned, a useful distinction can be made between short-term behavioural outcomes/maladaptive coping strategies, e.g. taking a sleeping pill, lighting up a cigarette, skipping breakfast, having an extra drink, and the more long-term consequences such as physical and mental ill health.

Stressful characteristics of work are divided into two groups: '**Content of work**' and '**Context to work**'. The first group, '**content of work**' stressors refers to the following:

- Work-environment and work equipment;
- task design,
- Workload/work-pace and work schedule.

The second group, '**Context to work**' is made up of stressors such as:

- Organisational culture and function;
  - ✓ role in organisations,
  - ✓ career development,
  - ✓ decision latitude and control,

- ✓ home work interface,
- ✓ and interpersonal relationships at work.

Interpersonal relationships encompass negative interactions with others in the workplace.

**Interpersonal behaviour stressors in the workplace are:**

- violence, harassment,
- and bullying.

At the same time, any of the above stressors can function as antecedents of violence, harassment and bullying, as well as influencing the stress-coping process (<http://www.ilo.org/wcmsp5/groups/public>).

The science for stress is also true for economic stress; the threat in this context is the uncertainty regarding one's financial situation. When an employee experiences financial problems, the reaction to this situation is similar to that of any stressful event.

**3. Rationale**

While South Africa has historically represented a unique system of oppression, a substantial body of stress research demonstrates that the conditions affecting people in inequitable positions are often translated into a series of foreseeable stressors that result in psychological distress among all who are exposed to stress (Pearlin: 1989). Using recently collected data on a large, representative sample of adults from South Africa (SASH), persistent mental health disparities were prevalent. The results found in this study suggest that eradicating racial disparities in mental health among South Africans will require a multifaceted approach.

**3. Rationale**

The Public Service Commission (PSC) released a report in February 2008 on the over- indebtedness of employees in the Public Service. The report stated that twenty percent (20%) of the work force is in a debt spiral, this could adversely affect productivity leading to poor service delivery. This figure relates to money paid through the government's personnel and salary administration system (Persal) to micro-lenders and because of garnishee orders transactions that took place in the 2006/07 financial year.

The report revealed that the over-indebtedness of public servants has the following implications for the public service: administrative burden on the State; ill-health due to financial distress; low productivity; irregular remunerative work outside the public service; and ethical considerations. Among others, the PSC recommended that a fully-fledged Employee Assistance Programme (EAP) be embarked upon, looking into personal financial wellness with a key focus on legislative framework on micro-lending, procedure for the issuing of garnishee orders, credit rights as well as budgeting, borrowing, saving and how to manage these effectively.

#### **4. Contextual Issues**

Over-indebtedness is a common cause of physical and emotional ills, which lead to strains on personal and family life, as well as on productivity. The problem of over-indebtedness in South-Africa has taken such serious proportions that it needs to be addressed on a personal, organisational and governmental level. In June 2007 the National Credit Act of 2005 replaced the Usury Act, 1968, and the Credit Agreements Act, 1980; to become the umbrella legislation that controls credit in South Africa. Although the impact of the Act remains to be seen, it brings with it immediate and significant changes that could assist

The current debt climate and economic stressors impact negatively, not only on individuals and families, but also on the working environment. Financial problems are perceived as personal failures in a society that places high premium on success and possessions. Economic stress can have a negative psychological and social impact on individuals and families.

**The following Economical Stress effects are observed in the workplace:**

- Anger
- depression,
- anxiety,
- somatic complaints,
- poorer health and
- Increased lowered self esteem.
- Severe stress
- Lack of concentration
- Decreased productivity
- Poor decision making
- Absenteeism
- Low morale and motivation
- Emotional outbursts,
- Inter-personal conflict
- Constant lending
- Reckless spending.
- decreased emotional support

The South African Public Service has put in place measures to deal with the health and wellbeing of public servants. Such measures include the launch of the Employee Health and Wellness Strategic Framework for the Public Service in 2008. This framework was developed following research and benchmarking of international and local best practices and obtaining inputs from stakeholders. The framework also recognizes the integrated approach to employee health and wellness and the

importance of individual health, wellness and safety and its linkages to organisational wellness and productivity in the Public Service.

Subsequent to the framework, the Wellness Management Policy for the Public Service was developed to address psychosocial problems within the Public service. Financial wellness programmes are key in addressing psychosocial problems, hence the development of these guidelines to promote financial wellness in the workplace.

According to a report by the ILO on economic security, economic stress refers specifically to stress that is associated with the risk or uncertainty regarding one's financial situation. In the workplace, economic stress can result from working several jobs in order to make ends meet. Workers may experience economic stress if their company is retrenching, restructuring, or merging with another company. According to the ILO, three of the most important economic stressors are: unemployment, underemployment, and job insecurity. This is however not the case for the South African Public Service due to the fact that retrenchments and job insecurities is not a factor. This section of the SOLVE guideline will therefore focus on promoting financial wellness of employees and providing assistance to those with financial problems.

Living pay-check to pay-check and failing to save money results in a high percentage of stress among employees. According to the Public Service Commission (PSC), twenty percent (20%) of public servants are over-indebted and in a debt spiral. Money is a significant source of stress, financial stress, just like any other kind of stress, leads to health issues and reduced productivity.

When employees show up for work, they bring their financial concerns with them. Even though problems may be primarily financial in nature, they may have implications for functioning in other areas and vice versa. Employers' interest in employee personal financial concerns has increased due to their need to improve productivity and lower other costs. It is in the best interest of employers to focus on their workers' personal financial problems as they have a direct bearing on the workplace.

The health and productivity of employees should be improved through the implementation of financial wellness programmes. Helping employees reduce financial stress can increase productivity and reduce expenses for the organization, resulting in long-term success for both the employee and employer.

## **Inter-relationships with other psychosocial factors**

### **Economic stress and nutrition**

When employees have uncertainty regarding their financial situation, they often begin to cut their spending in an attempt to save money. They may buy less expensive food, or buy less food altogether. In some cases this can lead to malnutrition in those workers who are not eating enough to provide what their bodies need to function and stay healthy.

### **Addictions and economic stress**

When people are stressed, they often turn to smoking, alcohol, and illicit drug use as a means of coping with life's difficulties, such as financial problems. Although these drugs may be used initially to help one cope, they can quickly become a major problem of their own. Smoking, alcohol, and drug use cannot solve the underlying stressor, and in fact, may very well contribute to the problem. For example, many employers have strict policies against alcohol and drug use in the workplace. If caught, workers may find themselves out of a job.

### **Job stress and economic stress**

Although the causes of stress at work and economic stress may differ, they have similar impacts on workers. They also have similar remedies. Whatever the source of stress, it is a result of an imbalance between demands and control. Increasing worker's financial control can lead to lower levels of job stress.

### **Economic stress and violence**

There is clearly a close relationship between violence and economic stress. Workplace violence in SOLVE is seen as including both psychological and physical violence. In stressful situations, be it financial or others, many people begin to be bad-tempered towards those around them. The frustration of not being able to provide for the family financially, may even lead to violence at home.

## **5. Interventions**

Interventions for Economic Stress Management Programme in the workplace should follow the APIME approach:

### **5.1 Assessment**

Starting a quality financial wellness programme is no different than executing any results-oriented employee wellness program. In order to be successful, the manager/coordinator should examine the organization's needs and employee interests through:

- Looking at company data: Check the number of garnishee orders in your Department. Decide on what kind of training or information-sharing will help reduce debt.

- **Conducting Survey:** Make it about employees and their needs, not just the organization. Employee base will be much more receptive to programming and more willing to participate if they have been asked for input.

## **5.2 Planning**

When planning an economic stress management programme, the needs of both the employer and the employee should be taken into consideration. The plan should include:

- A strong communication plan and determine well in advance how the program will be evaluated.
- Reasons why the organization is interested in promoting financial education for employees.
- Imbed financial wellness concepts into other established programs and trainings (e.g stress management programmes). This is an easy way to increase the engagement and credibility of all programs in the organization.
- How programs' success will be measured.
- Tracking of employee participation in and satisfaction with programs offered and continuous review of programme utilization.
- Data dashboard with set goals around intended results in order to stay on track and keep focused.

**An effective workplace financial wellness programme should offer the following services:**

### **Financial Wellness Workshops**

The workshops should offer advice to employees that have garnishee orders or are under debt review. It will also prevent employees from becoming over-indebted.

### **Individual Debt counselling**

Individual on or off-site debt counselling for employees. The status and validity of debt should be investigated. A budget should be drawn up with repayment schedules for all creditors. Interventions should be aimed at minimizing the effect of compound interest on arrears and to maximize on capital reduction. The budget should allow for living expenses as a matter of priority.

### **Individual Psycho-social counselling**

Individual on or off-site psycho-social counselling should be provided to employees. Employees should be counselled on the psycho-social aspects related to spending and financial difficulties (e.g. negative spending behaviour due to depression, substance dependency, marital problems, divorce, gambling, ignorance, impulsiveness)

### 5.3 Implementation

Implementation of economic stress management programme in the workplace should follow the APIME approach as outlined in the table below:

Economic Stress Management in the Workplace								
Functional Objectives	Inputs	PROCESSES / ACTIVITIES				INDICATORS FOR IMPLEMENTATION		
		Capacity Building Initiatives	Organizational Support Initiatives	Governance and Institutional Development Initiatives	Economic Growth and Development Initiatives	Output	Outcome	Impact
1. Conduct workplace economic stress audit.	Human resources Financial resources	Train managers, coordinators on how to conduct workplace economic stress audit.	Information Management System, Database on HR record.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees who participated in the audit.	% of employees who want to go on economic stress management programme.	Improved financial well being in the Public Service.

2. Develop economic stress management plan	Human resources	Train managers, coordinators on how to develop economic stress management plan	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of targeted employees for intervention in the plan.	% of employees who are willing to participate in the programme.	Improved financial well being in the Public Service.
3. Implement economic stress management programme.	Human resources	Train managers/ coordinators on implementation of economic stress management programme	Information Management System,  Database on usage of economic stress management programme.	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of employees utilizing the programme	% of employees who received garnishee orders.	Improved financial well being in the Public Service.

4. Develop and implement M&E plan for economic stress management.	Human resources	Train managers/ coordinators on M&E of economic stress management programme	Information Management System,	SOLVE guidelines	Use best practices as benchmark  Updated evidence-based research	No. of Managers trained on M&E	% of managers and coordinators submitting Reports.	Improved financial well being in the Public Service.
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## **Implementing Financial Wellness Programme**

### **Awareness**

- Distribute financial education materials and articles from reputable vendors via newsletters, handouts, and posters
- Keep employees informed of all changes and options in their benefits plans
- Use success stories from co-workers to inspire and motivate the workforce

### **Education**

- Provide employees with understandable worksheets that help them prepare personal budgets, determine net worth, estimate retirement needs, etc.
- Conduct lunch and learns around topics of interest to both the company and the employee base
- Hold an annual financial fair to give employees open access to a variety of vendors and materials

### **Behaviour Change**

- Utilize existing EHW programmes to encourage people to seek counselling and assistance
- Periodically host a series of comprehensive sessions with experienced financial and benefits advisors

Remember to use a variety of communication methods to reach employees. This may include posting information on Departmental intranet, newsletters, notice boards, in the bathroom stalls, holding seminars, making announcements at staff meetings, etc. Everyone digests information differently and will be more receptive to certain distribution channels. This makes it essential to vary where the information is placed, and to be thorough in the distribution process.

## **5.4 Monitoring and Evaluation**

The M&E system within a programme should be structured to ensure the most efficient use of resources to generate the data needed for decision-making. An M& E plan for economic stress management programme should be developed with measurable indicators. It should guide data collection and analysis, increase the consistency of the data and enable managers/coordinators to track trends over time. Implementation of the M&E plan should yield an implementation report to be submitted to DPSA.

## **6. Organizational Support Initiatives**

## The Administration and Management of Garnishee Orders

Management and administration of garnishee orders should include:

- Pre-validation of all garnishee orders
- The uploading of all new garnishees
- Centralized co-ordination and management of all new garnishees
- Mechanisms to effectively monitor current and future debt levels of all staff
- The monitoring of unlawful collection methods (pre signing of consent to judgments)
- The resolving of “zero pay slips” caused by excessive garnishee amounts
- Forwarding of payment schedules to attorneys on a monthly basis
- Regular validation of fees charged by attorneys and debt collectors
- Validation of all garnishee orders in order to eliminate fraud
- Payments to all creditors
- Management of all queries from judgment creditors

### 7. Governance Initiatives

If an organization has not yet taken action to address the issue of financial stress, this is almost certainly due to a lack of understanding of the true costs of stress and of the benefits which could be obtained from its prevention. The ILO's experience shows that there are many options available for the prevention of stress, but that the most effective involve a certain amount of **organizational change**. Few employers would be prepared to commit themselves to such a programme without being convinced of its necessity and having a means of evaluating its effectiveness.

These guidelines will be implemented in conjunction with the four EHW Policies, specifically the Wellness Management Policy. The guideline serves as one of the tools for implementation of the policy, over and above the Generic Implementation Guide, Systems Monitoring Tool, and Monitoring and Evaluation Plan. Implementation should follow steps based on the **CAPIME** (Capacity Building, Assessment, Planning, Implementation, Monitoring and Evaluation) Model and the Systems Monitoring Tool. Each step describes the **what, who, how**:

## **STEP BY STEP APPROACH**

### **Step 1: Shared Goal and Commitment**

Development of a shared goal and commitment towards the Employee Health and Wellness Strategic Framework for the Public Service is key. For change to happen **change agents or champions** are needed who believe in the cause and who can inspire others to become involved. Effective implementation of these guidelines requires that such commitment transcend the level of a few individuals to become an institutional commitment, shared by the department as a whole. At the same time, institutional commitment needs to become personal commitment for the programme managers tasked with the responsibility to execute its mission and mandate.

The goal and commitment process involves key persons within institutions reaching a common understanding of the overall challenge of psychosocial issues within each Department. The major objective is for the department to identify a set of common goals that reflect the Department's core mandates and responsibilities. These goals should indicate that the Department is prepared to make a serious commitment and actively in addressing psychosocial issues.

### **Step 2: Systematic Review**

Conduct a Systematic Review (meeting of stakeholders convened by DG or a delegated official) of impacts and risks for psychosocial problems before strategic planning session for the workplace. The systematic review is based on analysis of existing data which can be derived from Health Risk Management companies, Service provider/EHW reports, key health trends, HR records etc. The systematic review process should be used to answer the following questions in light of the determinants of psychosocial problems:

- **How psychosocial stressors impact on the Department?**
- **How is the Department contributing to the new cases (risk) and the impact (occupational illness)?**
- **How the departments can respond to both the above?**

An operational plan should then be developed based on the results of the review.

**When?** The Systematic Review should happen at the time of strategic and operational planning sessions of the department, and when planning projects and programmes, during negotiations of service delivery agreements and during strategic planning with other departments and partners.

**How?** The Systematic review should be conducted as a workshop; analyzing and presentation of available studies/data and information about the impacts of psychosocial problems in the workplace.

### **Who Should Participate?**

- Senior Manager and appointed EHW coordinator/ professional, Committee with representation from all levels and from trade unions, partners and stakeholders
- All sections of the Department
- Human Resource Management and other relevant stakeholders.

### **Step 3: Planning**

Planning should be based on the outcomes of the Systematic Review, during regular annual planning and the outcome should be an operational plan, budget and M&E plan. Detailed action planning for implementation can be undertaken based on priority goals, and institutional commitment to respond to psychosocial problems in the workplace. The established profile, as well as opportunities and gaps identified during the previous steps may also inform more detailed planning. It is important that broader consensus and commitment is gained around the planned actions from the employees. This is so for obvious reasons:

- To ensure that all employees throughout the Department share the institutional commitment to tackling psychosocial problems and that there is a shared sense of ownership of the planned actions
- To ensure that the proposed actions are relevant and appropriate and to allow for flexible revision where necessary
- To get the highest level of 'buy-in' and encourage active participation of other stakeholders.

**Cost:** implementation of these guidelines will be borne by the employer (department) as per the Employee Health and Wellness Strategic framework. GEMS and other medical schemes will contribute towards cost for covered conditions such as in-patient care for stress, depression etc.

### **Step 4: Implementation**

Implementation should be Results-Based, with long-term (strategy) and short-term (workplan) plans with and agreed inputs (financial and human), clearly defined activities and roles, and measurable outputs. This should be done at a Departmental/ Project level to determine the efficiency of the

programme immediately or between 6 months and one year period after implementation. The effectiveness of the programme at a national level will be determined through output, outcome (2-5 years) and impact (5 years or more) indicators.

Departments should also identify and provide appropriate specialized human and technological skills (Capacity Building). Advocacy through a clear communication strategy is vital for the effective implementation of these guidelines.

### **Step 5: M&E**

Monitoring of Implementation Process should be done via Process Indicators. Shared goals have been developed, Review has been conducted, Outcome of Review has been documented, Documentation of Operational adaptations and adapted M&E System. Operational Plans should be developed with an M&E Plan, and should be costed with a budget. Annual review and evaluation report reports should be submitted to DPSA.

The M&E system within a programme should be structured to ensure the most efficient use of resources to generate the data needed for decision-making. It guides data collection and analysis, increasing the consistency of the data and enabling managers to track trends over time.

### **EHW Process Pillars**

The implementation of this guideline will also be carried out through the process pillars of the Employee Health and Wellness Strategic Framework for the Public Service:

#### **Capacity Building**

- There should be capacity development programmes for individuals: Wellness Managers and Practitioners.
- There should also be training programmes for the multidisciplinary team involved in the implementation of SOLVE guidelines (e.g Peer Educators, Labour Representatives, Wellness Committee Members etc)
- Curriculum Development will be facilitated by PALAMA

#### **Organizational Support Initiatives**

- **Systems Monitoring Tool:** Will assist Departments with putting systems in place for the effective implementation of SOLVE Guidelines.

- **Generic Implementation/Operational Plan:** Will guide practitioners with effective implementation of SOLVE Guidelines.
- **Budget:** There should be sufficient budget for implementation of SOLVE Guidelines.

#### **Governance**

- The guideline serves as a one of the tools to implement existing EHW policies
- Departments should determine an appropriate model (In-house or outsourced),
- Performance management (absenteeism, hours at work, staff satisfaction, stress audit) to determine the impact of SOLVE Guidelines on the individuals and the organization.
- M&E Framework

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