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HEALTH PROMOTION IN THE WORKPLACE: ALCOHOL AND DRUG ABUSE

Report of a
WHO Expert Committee



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WHO Expert Committee on Health Promotion in the Workplace: Alcohol and Drug Abuse

Geneva, 4–8 November 1991

Members

- Professor S. E. Asogwa, Dean, Faculty of Medicine, Anambra State University of Technology, Enugu, Nigeria
- Dr S. Casswell, Executive Director, Alcohol Research Unit, Department of Community Health, University of Auckland, Private Bag, Auckland, New Zealand (*Rapporteur*)
- Dr K. El Fawal, Director, Alexandria Psychiatric Hospital at Maamoura, Alexandria, Egypt
- Professor J. O'Connor, Director, National College of Industrial Relations, Ranelagh, Dublin, Ireland (*Chairman*)
- Dr H. Sandoval-Orellana, Deputy Director for Preventive Medicine, Asociación Chilena de Seguridad, Hospital del Trabajador, Santiago, Chile
- Professor M. Wongphanich, Occupational Health Department, Faculty of Public Health, Mahidol University, Bangkok, Thailand (*Vice-Chairman*)

Representatives of other organizations

- International Association of Lions Clubs (Lions Club International)*
Dr C. R. Fedele, Liaison Officer with WHO, Geneva, Switzerland
- International Civil Aviation Organization (ICAO)*
Dr S. Finkelstein, Chief, Aviation Medicine Branch, Montreal, Quebec, Canada
- International Council on Alcohol and Addictions (ICAA)*
Mr A. H. Hewlett, President, Alcohol Policy Council, Waterford, VA, USA
- International Federation of Chemical, Energy and General Workers' Unions (ICEF)*
Ms A. Rice, Occupational Health and Safety Office, Geneva, Switzerland
- International Labour Organisation (ILO)*
Mr B. Shahandeh, Vocational Rehabilitation Branch, International Labour Office, Geneva, Switzerland
- Dr J. P. Smith, Conditions of Work and Welfare Facilities Branch, International Labour Office, Geneva, Switzerland

Secretariat

- Professor W. Acuda, Department of Psychiatry, Godfrey Huggins School of Medicine, University of Zimbabwe, Avondale, Harare, Zimbabwe (*Temporary Adviser*)
- Professor J. Brodeur, Department of Occupational Medicine and Environmental Health, Faculty of Medicine, University of Montreal, Quebec, Canada (*Temporary Adviser*)
- Mr H. Emblad, Director, Programme on Substance Abuse, WHO, Geneva, Switzerland
- Dr A. Galzov, Chief Specialist in Alcohol and Drug Dependence, All-Union Research Centre on Medico-Biological Problems of Addiction, Moscow, USSR (*Temporary Adviser*)
- Dr M. Grant, Scientist, Programme on Substance Abuse, WHO, Geneva, Switzerland (*Co-Secretary*)

Dr M. I. Mikheev, Chief Medical Officer, Office of Occupational Health, WHO,
Geneva, Switzerland

Mrs J. Moser, rue de Vermont, Geneva, Switzerland (*Temporary Adviser*)

Dr T. K. Ng, Medical Officer, Office of Occupational Health, WHO, Geneva,
Switzerland (*Co-Secretary*)

Dr S. Tomaszunas, Deputy Director, Institute of Maritime and Tropical Medicine,
Gdynia, Poland (*Temporary Adviser*)

Mr A. Tongue, Consultant, International Council on Alcohol and Addictions,
Lausanne, Switzerland (*Temporary Adviser*)

Dr C. Zenz, Clinical Professor, Department of Preventive Medicine, University of
Wisconsin, West Allis, WI, USA (*Temporary Adviser*)

1. **Introduction**

A WHO Expert Committee on Health Promotion in the Workplace: Alcohol and Drug Abuse met in Geneva from 4 to 8 November 1991. Opening the meeting on behalf of the Director-General of WHO, Dr N. P. Napalkov, Assistant Director-General, pointed out that a previous WHO Expert Committee on Health Promotion in the Work Setting had been convened in 1987 and that, in response to that committee's recommendations, the Office of Occupational Health of WHO planned to hold a series of meetings on health promotion in the workplace, focusing on specific subjects. On this occasion, the meeting, organized jointly by the Office of Occupational Health and the Programme on Substance Abuse, would deal specifically with alcohol and drug abuse. The Secretariat had prepared a working document for discussion at the meeting after consulting some 75 experts, WHO Collaborating Centres, nongovernmental organizations and others.

Dr Napalkov noted that, over the years, the maintenance of safe and healthy working conditions for employees had come to be regarded as essential not only by professionals in the health field, but also by workers, trade unions and management. Legislation and the development of the concept of occupational health had also contributed to general awareness and recognition of the need for health and safety promotion in the employment setting.

The objective of the Expert Committee was to review current approaches to health promotion in the workplace aimed at preventing and controlling alcohol- and drug-related problems and to make recommendations to WHO and its Member States for further action.

2. **Important concepts and definitions**

The definitions provided below were adopted by the Committee for the purposes of its report, but will not necessarily be valid in other contexts.

2.1 **The workplace**

At first sight, the concept of the workplace appears sufficiently clear without definition: it is the place where people work. Nevertheless, in different parts of the world the image evoked by the word "workplace" may differ considerably. For industrialized countries, it may conjure up large enterprises in highly mechanized industries. However, even in these countries the majority of the workforce are actually employed in small enterprises.

In many developing countries, especially in Africa, besides workers in mechanized industries, which are on the increase, the self-employed, engaged mainly in agricultural work, predominate in the workforce. Many of them work with members of their family or with volunteers, or employ a few workers. In rapidly industrializing countries in Asia, migrant workers and homeless workers are rapidly increasing in number.

In the future, it may become increasingly difficult and undesirable to separate work/home or work/family domains in either industrialized or developing countries. As the trend towards smaller workplaces takes hold, for example, a related increase may occur in the number of people who work from within their homes (particularly in the burgeoning service sector). Family businesses have always been a feature of economies in many parts of the world, and this phenomenon clearly demolishes any meaningful boundary between work and home. It has been noted that some seafarers work in an environment (ships) that is both home and workplace to them for long periods of time. In addition, it is important to keep in mind those whose work indisputably takes place in the home or family unit – housewives or homemakers – who in some cultures make up a notable proportion of the workforce. Health promotion in the workplace must therefore be considered from a broad perspective that avoids too limited a definition of the employment setting.

2.2 Health promotion

The concept of health promotion has been described in a special issue of the international journal *Health promotion* (Vol.1, No.4, 1986), which contains a report of the first International Conference on Health Promotion and presents the Ottawa Charter, as adopted by the Conference (see Annex). The concept of health promotion in the workplace has been dealt with in some detail elsewhere, especially in the report of the WHO Expert Committee on Health Promotion in the Work Setting (1). It is important to recall here, however, the scope of the concept as envisioned by WHO at present. Health promotion emphasizes gaining or regaining control over personal well-being and encouraging a psychosocial environment that will foster this control. Applied to the workplace, this idea means that attention must be paid not only to encouraging healthy practices among individuals through education and training programmes, but also to the development and maintenance of working conditions conducive to the well-being of the workforce as a whole and to the prevention of alcohol- and drug-related problems (2).

Recently, the evidence linking adverse working conditions to the likelihood of alcohol- and drug-related problems emerging has become stronger. Health promotion therefore overlaps with the realm of industrial relations, and it becomes legitimate to see it as a strategy for improving the working conditions of employees, not just as a way of curing or preventing the adoption of bad habits. In other words, the Ottawa Charter concept of health promotion requires definition of the relationship between employers and employees as a health issue and as an important influence on the emergence of alcohol- and drug-related problems (3). This concept of health promotion is also relevant to occupational health and safety, in particular in being concerned with employees' influence over the organization of the physical aspects of work.

Health promotion in the workplace can also be seen as an issue of power and status within the enterprise or working group. As such, it is a political

construct that calls for consideration of the way in which workers participate in the running of their workplaces. As applied to alcohol and drug issues, this notion of health promotion means the involvement of workers in identifying problems and in formulating solutions to these problems. From a cross-cultural perspective, the challenge is to decide how far this philosophy of involvement and participation is relevant or adaptable to the diversity of workplaces in countries as widely separated as Chile, Nigeria and Thailand.

2.3 Health protection

In this report the concept of health protection is considered to be encompassed by the Ottawa Charter concept of health promotion. The term “health protection” refers specifically to health promotion activities that influence the environment in order to influence health. This distinction acknowledges a body of research which suggests that the promotion of behavioural change through education and persuasion of the individual is likely to be less cost-effective than changes in the environment, such as the application of safety standards.

2.4 Alcohol and drug abuse

Abuse is the repeated or episodic self-administration of alcohol or drugs to the extent of experiencing harm from their effects or from the social or economic consequences of their use.

2.5 Alcohol and drug dependence

As a general term, dependence is the state of needing or depending on something or someone for support or to function or survive. As applied to alcohol and drugs, it means the need for repeated doses of the drug to feel good or to avoid feeling bad.

2.6 Alcohol- and drug-related problems

The term “alcohol- and drug-related problems” can be applied to any of the adverse accompaniments of drinking or drug-taking. “Related” does not necessarily imply causality. The term can be used either of an individual drinker or at the level of society as a whole. It may be taken to include both dependence and abuse, but it also covers other problems and is therefore the term most commonly used in this report.

2.7 Alcohol- and drug-related initiatives in the workplace

Programmes to reduce or prevent alcohol- and drug-related problems that focus on the workplace or occupational group often involve several different levels of intervention. Thus, for example, employee assistance programmes¹ (which can include constructive confrontation of employees

¹ Programmes designed to assist employees with drug abuse or other problems by means of counselling, treatment or referral.

whose performance is impaired by drinking or drug-taking), random screening of employees, educational materials aimed at all employees, and the restructuring of the work environment to provide more exercise or reduce stress are all discussed in this report as part of the range of health promotion initiatives relevant to alcohol- and drug-related problems. Such initiatives should take into account not only the health of the working population but also the health of the public with whom workers come into contact.

2.8 National programmes

A comprehensive national programme on alcohol and/or drug abuse will include the components of prevention, treatment and rehabilitation, law enforcement, research and policy. A coherent response to the problems resulting from alcohol and drug abuse requires the involvement of numerous individual groups and sectors of government, particularly those concerned with health education, labour and industry. It should be emphasized that, if the national programme is to be successful, it must operate at different levels in the local community as well as nationally and will often work through existing social institutions, such as the workplace. The national context in which workplace initiatives occur will influence the effectiveness of such initiatives.

There are two main approaches to the prevention of alcohol- and drug-related problems: reducing availability and reducing demand. Commonly used strategies include: taxation, which affects the price of alcohol; licensing and law enforcement, which affect the availability of alcohol and drugs; and education (4-7).

2.9 International programmes

The support of recognized international agencies such as WHO and the International Labour Organisation (ILO), as well as nongovernmental organizations, is important for the development of national programmes. This is particularly true of countries where such programmes are still at an early stage. International programmes on alcohol and drug abuse provide expertise and guidance for national programmes and facilitate intercountry and interregional cooperation and the sharing of knowledge and experience. These programmes assess the global situation, trends and needs, and identify issues on which international action or consultation is necessary. They bring together experts in different disciplines for the study of problems related to alcohol and drug abuse. They can also provide training facilities for those who will have responsibilities in national and local programmes. In African countries, for example, training has been provided in recent years for people who will take responsibility for developing health promotion activities in their own districts. The organization of scientific meetings and the promotion of research are also significant elements in international programmes.

3. **Alcohol and drug problems in the workplace**

3.1 **Nature and extent of the problems**

The nature and extent of alcohol and drug problems in the workplace are likely to reflect those in the general community among the same age group. Alcohol or drug consumption may affect the ability to carry out precision work, thus endangering the workers themselves as well as productivity. The range of alcohol- and drug-related problems seen in the workplace has been described in the report of the WHO Expert Committee on Health Promotion in the Work Setting (1).

Managers have been convinced of the need for intervention (counselling and treatment) by their awareness that absenteeism, occupational morbidity, inefficiency on the job and safety hazards are often due to alcohol and drug use. In the United Kingdom, for example, alcohol is implicated in 20% of industrial accidents (8).

In some countries, drugs are regarded as stimulants that increase work performance. In East Africa, especially in Ethiopia, Kenya, Somalia and the United Republic of Tanzania, khat is used and is still widely believed to improve performance in a wide variety of occupations that require sustained alertness, vigilance or wakefulness, such as long-distance driving and guard duties. From time to time, episodes of drug use by individual groups of workers are reported in the United Nations *Bulletin on narcotics* (9, 10), but surveys such as the one on the pattern of psychotropic drug use among civil servants in Ibadan, Nigeria (11) have rarely been conducted.

It is relevant to note two aspects of the “risk” of alcohol- and drug-related problems associated with employment:

- Employees may be at personal risk because of the nature or structure of their work or their access to alcohol and drugs (maritime workers, retailers of alcoholic beverages, pharmaceutical workers and people under high pressure with low levels of supervision are often cited).
- Others in society may be at risk from the activities of workers in, for example, public transport, nuclear industries, petrochemical industries, the armed forces, hospitals and all kinds of occupations that involve decision-making.

3.2 **Contributing factors**

A wide range of biological, personal, social and environmental factors, including problems related to the individual’s employment, may contribute to alcohol and drug problems in the workplace.

As noted earlier, the empirical evidence linking adverse psychosocial conditions of work to the emergence of alcohol- and drug-related problems has become stronger in recent years, although the debate still continues over the exact nature of the relationship (1, 12).

With regard to employees’ personal risk, it has been suggested that a study of job characteristics that facilitate or inhibit problem drinking, rather

than general job stress, would better explain drinking behaviour (13). For example, the maritime population, which includes merchant marine, fishery, naval and oil-rig workers, is a high-risk group. Such factors as long absence from home and family, loneliness and a harsh climate, as well as accepted drinking practices and traditions, may play a significant role in the development of alcohol and drug abuse.

The employer's policy on tolerating or banning alcohol and drugs in the workplace will also contribute to the extent of alcohol- or drug-related problems by influencing availability. Availability is also an issue in employment settings where it is possible to obtain alcoholic beverages at extremely low cost, as in certain diplomatic and parliamentary circles and international organizations. Those working in the retail alcoholic-beverage industry and the pharmaceutical industry are also at risk, given their ease of access to these substances, as are medical professionals such as anaesthetists and family doctors (14, 15). In Malaysia, a large number of young adult drug-dependent patients were found to be workers in coffee shops known as major sources of illicit drugs (16).

4. **Health promotion initiatives relevant to alcohol- and drug-related problems in the workplace**

4.1 **Historical and cross-cultural review**

Until the end of the Second World War, action and experience in Western Europe and North America were mainly confined to alcohol consumption and its effects. It was not until the 1960s, when the so-called "explosion" of drug use took place and spread to many countries, that the impact of drug abuse in the workplace began to receive serious attention.

The alcohol problem among workers was a subject of concern even before the turn of the century (17, 18). At first, it was considered to be due to unhealthy working and living conditions. Recognition of these influences on alcohol consumption was accompanied by concern about accidents at work resulting from the drinking habits of employees. This led to the application of various control measures, often including regulations forbidding alcohol consumption at work and even, in many cases, extending the prohibition of consumption to work canteens.

During the First World War, the fact that alcohol consumption might lead to the weakening of the national war effort led to the adoption of stringent regulatory measures in some of the countries at war. For example, in some cases the government intervened to protect vital industries threatened by the excessive drinking habits of employees.

A new dimension in the approach to alcohol consumption which was to have repercussions in the workplace appeared in the late 1930s. At that time, the concept of "alcoholism" as a disease and of the "alcoholic" as a sick person was first enunciated. Later, this concept was applied to drug

dependence and the drug-dependent person. Industrial programmes began to appear, whose aim was to identify, counsel and rehabilitate employees who were perceived to have a substance-abuse problem.

Programmes for drug-dependent persons were rather slow to appear, owing to unfamiliarity with the problems of drug consumption in industrialized countries and with the attitudes of many drug users, which often differed dramatically from those of the traditional alcohol-dependent person, and because of the legal implications of illicit drug use. Gradually, however, the use of psychotropic drugs increased and medicament abuse began to pose serious problems in developed and developing countries alike. As a result, the trend towards substance-abuse programmes covering all dependence-producing substances gained momentum.

The earliest structured programmes to deal with alcohol abuse, and later drug abuse, in the employment setting were established in the United States of America in the post-Prohibition period (i.e. since 1933). They were generally based on the principles of rehabilitation espoused by Alcoholics Anonymous and Narcotics Anonymous, and became the standard model for alcohol- and drug-dependence programmes in North America (19). Such programmes, often located in the employee assistance departments of enterprises and under the direction of employees previously dependent on alcohol or drugs, have claimed much success in the sociocultural setting in which they have been employed. From North America, programmes of this type have spread to other continents, but on the whole they have been restricted to English-speaking countries or to subsidiaries or branches of North American industries operating elsewhere.

In Europe, a different approach has been taken to alcohol and drug problems in industry. While it has been accepted that such problems belong to the health sector, the illness concept has frequently been modified.

In France, for example, many programmes on the problems of alcohol consumption were set up in French industries in the 1950s. These took account of the fact that, while some of those consuming excessive amounts of alcohol had psychiatric problems, others had serious organic impairment such as cirrhosis of the liver. Major French companies took part in long-term discussions on the subject, and in 1960 they convened the first international meeting on alcohol in the workplace, entitled "The enterprise of today – health, safety, sobriety" (20).

In some Nordic countries, programmes in industry started with the objective of preventing and reducing the problems of substance abuse, resulting in a combination of primary, secondary and tertiary prevention (21).

In the former Soviet Union and certain Eastern and Central European countries, alcohol and drug dependence has been seen as a health problem, but this has been coupled with emphasis on the individual's

responsibility for his or her problem and the fact that the dependent individual is letting down the workforce and jeopardizing the achievement of its productivity targets. In the former Soviet Union, widespread educational and health services for workers have been developed, using specially trained health staff stationed in the workplace in liaison with advisory specialists in addiction (22).

More recently, as for example in Australia and the United Kingdom, attention has been focused on the “spectrum” or “continuum” model, which acknowledges that a wide group of alcohol and drug users may have problems. In the case of alcohol, for example, users are considered to range from occasional and social drinkers to those who have become dependent on alcohol. In this model, the dependence syndrome may be seen as including traditional “alcoholism”, viewed as an illness, but it is recognized that individuals can be at different levels of dependence and move in either direction along the continuum (23). Programmes based on this concept take a flexible approach and accept not only that those who are actually dependent on alcohol or drugs need advice, but that help should be made available to any employees who may have more minor drinking or drug-taking problems (22). In this situation, consultation services within or outside the workplace are increasingly employed.

In some countries, more attention has been given to certain categories of worker. In Spain, the Marine Social Institute (*Instituto Social de la Marina*) attempts to deal with alcohol- and drug-related problems in its centres. An example is the programme of assistance and rehabilitation for alcohol- and drug-dependent seafarers in Vigo (24). This is not only for seafarers, but also offers help and advice to their families. The centre at Vigo has studied some of the socio-psychopathological phenomena observed in seafarers and the situations of strain and living conditions aboard ships. Counselling and rehabilitation of those with alcohol and drug problems are carried out with educational and information services for both clients and their families. Indirectly, this service may have an impact on consumption habits, and it certainly helps to alleviate some of the stress of the seafarer’s life. It exemplifies the possibilities of combining assistance services for those with alcohol- and drug-related problems and their families with a preventive programme that attempts to counteract strongly entrenched occupational customs.

In another section of the maritime population, namely dockers, it was found in a French port that those who drank in excess were regarded not as sick, but as not complying with the rules of solidarity within their own community, which in turn excluded them (25). In one instance, dockers created their own anti-alcohol committee consisting only of themselves, without professionals, believing that rehabilitation by re-establishing social ties with one’s peers was the most effective approach.

Workers in the alcoholic-beverage trade have easy access to alcohol. In Queensland, Australia, an innovative way of approaching the problem has been to obtain the cooperation of alcoholic-beverage retailers, particularly

bar staff, in reducing drunken behaviour (26). In this way, employees are involved in preventive action by being given responsibilities towards their customers and, at the same time, they are themselves the target of a preventive programme.

In developing countries, alcohol and drug programmes can often be found in multinational firms, following the model of the parent firm. Often, these have tended to serve only the expatriate executive and technical employees. When they have attempted to serve the local workforce, they have had to be adapted to make them conform with cultural and traditional attitudes to alcohol and drug-taking. Thus, if the parent company supplies a blueprint for an employee assistance or medical programme to deal with alcohol and drug dependence, it should serve as a generator of ideas rather than being adopted in its entirety; this could apply to both prevention and treatment.

In many Asian countries, alcohol and drug use have long been part of social life and culture and, although they were often deprecated, they were not seen as a serious threat to productivity. Since the Second World War, however, some Asian countries, in particular those in the western part of the continent, have introduced severe repressive measures to curb illicit drug use in pursuance of their obligations under the Single Convention on Narcotic Drugs, 1961 and the Convention on Psychotropic Substances, 1971. This has meant that national prevention campaigns have directed the attention of citizens in all occupations to the dangers and penalties of drug use. In these campaigns, every social institution, including the workplace, is a medium of prevention.

In Japan until the mid-1950s, many workers used stimulant drugs as a matter of course to counter drowsiness and make themselves more energetic. In 1954, the Japanese Government introduced a law controlling the selling, possession and use of stimulant drugs, and this law has been strictly enforced, with severe penalties for infringement. Since then, the number of stimulant-drug users has dramatically decreased.

In countries where a strong religious practice means that drinking is not encouraged, social habit can nevertheless overcome religious dictates. In Thailand, despite a strong Buddhist tradition, alcoholic beverages are not new to the national culture. A community survey done in a north-eastern province of Thailand, well known for a tradition of heavy drinking, reported that 50% of the men and women who drank on four or more days per week in the urbanized area were actually drinking alone. The percentage of people who drank rose considerably with age. The study covered students, the unemployed, heads of household, government officials, business owners, farm workers and nongovernmental employees; the alcoholic beverages they consumed were traditional fermented beverages (65.8%-74.5%) and imported spirits and beers (38.2%-52.3%) (V. Poshyachinda, unpublished observations, 1991).

The ILO has a project in Asia to develop programmes for the prevention of drug and alcohol problems in a number of enterprises in India, the

Philippines, Sri Lanka and Thailand. In carrying out these activities, the ILO collaborates closely with ministries of labour and employers' and workers' organizations.

In Africa, the ILO has been helping a number of countries in recent years to establish resource centres for the development of prevention and rehabilitation programmes for drug- and alcohol-related problems. As part of this work, workplace prevention programmes have already been launched in a number of enterprises in Mauritius, Zambia and Zimbabwe, and were due to commence in Botswana, Malawi and the United Republic of Tanzania in 1992.

In most parts of Africa, the use of alcohol in the workplace has been largely regulated by tradition and enforced by the village chief or elders. For instance, drinking has always been prohibited during important communal work such as harvesting or when elders meet to discuss important matters or to settle disputes. Drinking has generally been allowed, however, in the evening or after work. Drinking by children and young women has traditionally been severely restricted or totally prohibited. In East Africa and parts of the Arabian Peninsula, the stimulant khat has traditionally been widely used during working hours, but has been restricted or banned at various times, specifically since the Second World War.

One promising field for information dissemination and education has been the pre-employment period or apprenticeship. Trade schools and professional institutes may usefully include health information in their curricula and draw attention to the hazards of alcohol consumption and drug-taking. In Brazil, the national services of industrial and commercial teaching provide in their curricula information regarding the hazards of alcohol consumption. The Swiss apprenticeship regulations state that enterprises must give apprentices the training and knowledge required to exercise their profession and must exert an educational and humane influence on apprentices with a view to favouring their intellectual development and personality; this includes promoting understanding of, and appropriate attitudes to, alcohol- and drug-related problems (27).

4.2 Nature of health promotion initiatives

This review of the diversity of programmes and strategies across cultures and over time demonstrates the enormous scope of activities encompassed by the term "health promotion". The application of the Ottawa Charter for Health Promotion to these widely differing approaches creates a new benchmark. The Charter calls for strategies that build upon the strengths of individual employees and foster the development of group support and policies for running the workplace that will involve employees in the formulation of solutions to alcohol and drug problems.

A health promotion approach will favour initiatives that influence the whole population. The available research on alcohol-related problems demonstrates the importance of a broad focus. As a recent WHO report states: "Heavy drinkers are more likely than moderate drinkers to

experience severe alcohol-related problems, but those experienced by moderate drinkers are the more numerous, because there are very many more moderate than heavy drinkers. Therefore, to reduce alcohol-related problems, both heavy and moderate drinkers should be targeted” (28). A workplace programme must, therefore, pay attention to the habits of all its employees, and any educational programme must reach all workers.

The content and perspective of workplace initiatives will often vary depending on the cultural setting and the occupational group. Where alcohol- or drug-induced intoxication is likely to lead to a harmful outcome, such as injury, a total ban on alcohol or drug consumption at work is more likely to be enforced. In lower-risk occupations, the emphasis may be placed on health promotion initiatives that encourage workers to abstain or to moderate their alcohol and drug use. Cultural approaches vary greatly. For example, in some cultures the message will be that, if drinking takes place, it should be sensible drinking with due regard to time, place and quantity. In other cultures, total abstinence would be the norm.

In industrialized countries, an important area of discussion is whether management and unions would prefer a subprogramme on alcohol and drug abuse, as part of a general health promotion programme for employees, or a specific alcohol and drug programme. If the former is more acceptable, then there must be safeguards to ensure that the alcohol/drug component of the overall health promotion programme receives its due share of resources. The relationship between the prevention programme and the treatment and rehabilitation services must be clearly established when considering the professional requirements of the programme.

The importance of paying due attention to the contractual terms of employment should not be underestimated in alcohol- and drug-related programmes in the workplace (29). For example, the question may arise whether it is fair or reasonable to dismiss an employee for lying about medical tests on recruitment, or for drug or drink offences outside working hours which damage the firm’s reputation. Actions such as withdrawing a company car following a drug or drink offence, without adequate compensation for taxi services, and the dismissal of an employee who did not use drugs but was aware that cannabis was growing in his garden have been the subject of litigation. The legal responsibility of employers in relation to illicit drug use by their employees (whether or not this takes place on work premises) needs to be clarified.

4.3 Development and implementation

Before consideration is given to setting up preventive or therapeutic programmes, some assessment is required of the type, amount, frequency and context of alcohol and drug use among the workforce at different levels (30). Such an assessment might well be initiated in collaboration with workers of all levels in a workplace, perhaps following some educational efforts and discussion in small groups.

Decisions about dealing with alcohol and drug use in the workplace are best not taken unilaterally by management. The problem is a labour/management one and the attitudes of trade unions are of the utmost importance. Union recognition of the problem is increasing. Industrial alcohol and drug programmes are generally no longer seen as an employer's tool which conflicts with the worker's right to autonomy in his or her personal life. However, the question of drug abuse complicates this situation because of the law-enforcement issues involved. A 1987 resolution of the International Labour Conference (31) has fostered understanding among unions that alcohol and drug programmes in industry benefit the health of the workers and their families, besides being valuable to employers because of their effects on efficiency of production. In establishing a preventive programme in industry, the cooperation of the relevant trade unions should always be sought and the objectives and operation of the programme discussed with the responsible trade union officials.

In Germany, the Federation of German Trade Unions (DGB) has called for the appointment of an "addiction delegate" (*Suchtbeauftragte(r)*) in all factories and administrations with more than 50 employees. The delegate's position is of a social/political character and, in the larger enterprises, is a full-time job.

A careful review and assessment of approaches is required in order to ensure that as many workers as possible are reached, both unionized and non-unionized and in the formal and informal sectors. A large percentage of workers are, in fact, not unionized and are self-employed in the informal sector. Special strategies should be formulated to utilize available channels such as the family, nongovernmental organizations and religious organizations in order to reach such workers (32). Community-based services should also be developed to provide assistance to small businesses. One successful approach has been the development of programmes by a consortium of businesses for the benefit of enterprises as well as the community as a whole.

It might be suggested that the prevention programme for alcohol- and drug-related problems in the workplace should be located in the medical department or the employee assistance programme, since these have traditionally been associated with identifying and helping the "sick" employee. There might, however, be advantages in handling a prevention and information service for the whole workforce in another way.

One option is to utilize a model similar to that commonly used in the area of safety. In some firms, one staff member is selected as a "safety officer" and given the responsibility of keeping other employees informed of current safety-related issues. A newsletter may be used for this purpose. Safety officers have their own jobs alongside other workers and may be listened to more than outside officials. Such safety officers are in contact with, and supported by, the health and safety departments, which supply them with relevant information. This approach could be extended from

safety information to alcohol and drug information, which would naturally involve some training of the person bearing this responsibility.

In villages, small towns and rural areas, where workplaces are small, other procedures could be envisaged. For example, a “reference person” with knowledge of addiction problems could be designated to give help and guidance, as in Costa Rica and Trinidad and Tobago in smaller towns and villages. A mobile travelling information unit may also provide a viable information and promotion programme.

Another option, which has been introduced in France, is to designate certain employees as “prevention agents” (33). Training is provided to ensure that such agents have:

- a general knowledge of alcohol- and drug-related problems;
- basic information on psychology and psychosociology;
- the ability to deal with a person who has a substance-abuse problem; and
- the ability to determine the most favourable method for an effective preventive strategy.

This last objective in the training of prevention agents should lead to a dynamic approach to influencing attitudes to alcohol and drug problems. The methodology for implementing an effective strategy would include specialist lectures, group discussion, use of audiovisual aids and continuous evaluation by the prevention agents, who should have sufficient authority or status to develop the programme. This system could also be introduced on a community level for small enterprises or rural workers.

One problem that needs to be faced is that those who provide education on drug and alcohol matters experience difficulty in obtaining access to up-to-date information, and time is needed to process that information. National and local community resources might be mobilized to meet these needs. An approach with great potential has been adopted in the Netherlands, where the Government proposed a combined effort by the existing prevention organizations, the alcohol industry, employers and employees, the Ministry of Social Affairs and Employment and the Ministry of Welfare, Public Health and Cultural Affairs (34).

An important starting point was the offer of a prevention package (education, early detection and treatment, in which education took the highest priority) to organizations with more than 50 employees. A national agency was founded with the goal of “prevention of addiction problems in business, industry and non-profit organizations”. It proposes to achieve its goals by providing advice in problem situations and on appropriate organizational changes to prevent problems of dependence, as well as through the development, organization and implementation of courses, the promotion of expertise in the field of dependence, especially through education, and the coordination of all relevant activities.

A further option is the setting up of a working group on alcohol and drug

problems in the enterprise (35). Such a group would consist of employees who had a certain interest in or responsibility for alcohol and drug issues in the workplace, including those involved in the social, medical and personnel departments, members of the work council and section leaders, as well as individual employees. The group might come together for informal consultations and could develop projects for the prevention of substance abuse in the workplace. With the support of management and unions, the group might eventually be entrusted with responsibility for implementing these projects to prevent substance-abuse problems as they affect employees and the firm.

There are many other ways of achieving the same effect. For instance, the concept of the workplace health promotion group (*betriebliche Gesundheitszirkel*), developed in Germany at the Berlin Technical University, could also be applied to drug- and alcohol-related problems in the workplace (36).

Whichever option is followed, those responsible for prevention or information activities should not be confined to a specific profession or discipline. Comprehensive training for the persons designated for this role is of great importance; a specialized agency may be able to undertake this task. In some countries, such as Australia, Brazil and Costa Rica, a number of firms, rather than setting up their own programme on alcohol and drug abuse, have preferred to contract out the operation of the programme to an outside specialized body. While this has mainly been for the purposes of treatment and rehabilitation, it can also apply to prevention.

Professional groups, including lawyers, clergy, engineers, teachers and university staff, journalists, doctors and dentists, can often be reached as targets for preventive activities through their professional societies, though some of these groups have been labelled as “hard-to-reach” (37).

In initiating programmes for preventing drug and alcohol abuse, particular attention must be paid to the mobilization and utilization of existing resources, infrastructure and programmes, both in the workplace and in the community. These include programmes on occupational safety and health, workers’ education and workers’ family welfare. The role of trade unions has been seen as important in formulating and implementing joint labour/management policy. Additionally, union initiatives on the prevention of drug and alcohol problems within the community are considered necessary and highly desirable.

4.4 **The regulatory context**

The concept of regulation is a very broad one. Society-wide regulation may include various forms of public policy – laws, regulations and administrative acts. Each society will have a unique approach with specific regulatory measures, some of which affect health promotion activities (38). In Chile, for example, national legislation prohibits alcohol in all workplaces. Furthermore, any injury at work is deemed an occupational

accident, even if the employee is intoxicated, which provides an incentive for the employer to monitor drinking by employees.

Regulation also applies to enterprise-level activities, and regulation of alcohol or drug use in a firm may be an important arm of prevention. Employees need to understand the reasons behind any rules, and it is one of the functions of a preventive service to make sure that they do so. Regulation of alcohol and drug use may concern:

- arriving at work under the influence of alcohol or drugs;
- possession or consumption on the job;
- consumption in the firm's restaurant and cafeteria;
- abstinence for a determined time period before working, when driving, sailing or flying is involved;
- limiting the amount of alcohol to be served at any receptions or official functions on the firm's premises (39).

An example of the complementary roles of regulation and education comes from the aviation sector, where the synergistic effects of alcohol, drugs and hypoxia have long been recognized (40). International standards, complemented by educational and prevention programmes, have therefore existed for a long time. Aeromedical authorities consider that prevention, education and rehabilitation programmes in aviation medicine in general have contributed to the excellent safety record of international civil aviation.

4.5 Drug screening and testing

The concept of health promotion used in this report is difficult, if not impossible, to reconcile with the strategy of drug screening and testing in the workplace (41). Drug screening and testing are, by definition, a regulatory process, for the most part imposed by employers on employees in a definitive expression of management rights and obligations. However, the philosophy of health promotion embodied in the Ottawa Charter does yield certain criteria useful in evaluating, *a priori*, the ethical nature of drug screening and testing options. Since health promotion interventions, by definition, seek to serve the needs of employees in attempting to gain, regain or maintain control over their own health, it follows that any regulatory policy accompanying these interventions should involve only such invasions of individual privacy and dignity as are absolutely necessary in order to achieve public health and safety objectives. For certain occupational groups (transport workers, heavy machinery operators, surgeons, etc.), whose activities can affect public safety, drug screening and testing programmes may be considered more appropriate.

An important issue with regard to the impact of alcohol and drug use on public safety is that, although the technology exists, and has been accepted in the legislation of many countries, to estimate levels of alcohol intoxication by testing blood-alcohol levels, the most widely used methods of screening for other drugs can only demonstrate that the drug has been

consumed at some time in the recent past. Such techniques have not yet been shown to yield results that relate clearly to drug-induced impairment (42).

At present, various immunoassay methods are used for initial drug screening. However, these tests are no more than screening methods; they are not always reliable and frequently give false-positive results. They should be followed by more specific confirmatory tests (gas chromatography and mass spectrometry).

With regard to drug screening, a report issued in the USA by the National Institute of Drug Abuse in 1990 indicated that forensic scientists had long been concerned about the chain of custody for urine samples, security, use of validated methods, quality control/assurance, purity of reference standards, qualified personnel, record-keeping and other factors beyond the analytical method itself (43).

A recent study of the predictive value of pre-employment drug screening has shown that users of marijuana and cocaine present higher relative risks for termination of employment, accidents, injuries and disciplinary action than non-users, though the levels of risk are lower than previously claimed (44).

Holders of civil aviation licences – an occupational group whose optimum performance is of paramount importance for public safety – have been the subject of a comprehensive study by the International Civil Aviation Organization (ICAO). In addition to the primary objective of assessing the nature and extent of substance abuse by aviation personnel, the study permitted an evaluation of the cost-benefit considerations and the usefulness or otherwise of mandatory screening. Responses to a questionnaire addressed to ICAO Contracting States indicated that, within the administrations that have instituted mandatory screening programmes, there have been no significant problems related to substance abuse by aviation personnel (45).

Some legal practitioners consider drug testing to be beneficial as a law-enforcement measure, because of its potential deterrent effect (46).

However, given the very vague relationship between safety in the workplace and the use of drug screening, such screening is likely to remain controversial, at least until the technology is developed to allow the more relevant issue of drug-induced impairment to be measured. It is a matter of concern that, in some countries, drug testing programmes have become very fashionable and have generated a large industry, which may increase the likelihood of screening.

In view of the controversial nature of drug screening and the opposition it causes, the Committee considered it preferable to develop drug-related health promotion initiatives that do not make use of it. Testing for alcohol-induced impairment in certain occupational settings with implications for public safety may be less controversial, but it is also best placed in an appropriate health promotion context.

An alternative to screening and testing is performance appraisal, carried out by simulating tasks using computer/video technology. Performance appraisal is more consistent with accepted industrial relations practice and is inherently preferable to drug screening and testing because it emphasizes “fitness for work” rather than putative drug abuse.

5. **Evaluation**

As the WHO Expert Committee on Health Promotion in the Work Setting pointed out in its report (1): “One of the important needs for any workplace health promotion programme is a careful evaluation of the programme’s progress and outcome. Evaluation should be a periodic activity.”

Evaluation should be seen as an integral part of the introduction of an alcohol and drug policy in the workplace (46). It does not need to be complicated or time-consuming, although careful consideration needs to be given to the resources required. When evaluation is planned, the needs of decision-makers within the workplace must be taken into account (47), consideration being given to the type of information to be obtained, its purpose and its potential users.

There is a tendency to focus mainly on outcome indicators when conducting evaluations, but such indicators may be difficult to set because of inadequate baseline data. Sometimes the targets are unrealistic or the models inappropriate. Changes in outcome indicators may also be due to external factors rather than to the programme itself. In addition, it is often not feasible to use a strict experimental design to test the effectiveness of the different components of a prevention programme.

The evaluation process should not be restricted to outcome indicators that reflect the long-term goal of the initiative. The number and quality of outputs, as well as their timing and sequence, are also part of it. For example, among the potential evaluation criteria is the employees’ subjective belief that they are capable of handling difficult situations in which alcohol or drug use is involved; job satisfaction is another such criterion.

Process evaluation gives information relevant to the assessment of prevention programmes for alcohol and drug abuse. Careful documentation of every intervention is useful in order to provide feedback to decision-makers and employees that the initiative has progressed as planned; it also helps in the interpretation of outcome evaluation measures.

“Formative” evaluation is also an essential part of good practice, and some would argue that it is in this area that evaluation resources should be concentrated, at least at first. Formative evaluation includes a review of available data on the nature and extent of the problems to be addressed or the behaviour to be encouraged, the methods available and the setting of

relevant and realistic objectives and measurable targets. Evaluation data may then be collected to refine the implementation of the initiative.

Learning from evaluation is a prerequisite for success in future programme planning. As the WHO Expert Committee on Health Promotion in the Work Setting pointed out (1): "There are ... many indicators of positive economic effects of health promotion programmes in the workplace. As more results emerge, more studies are conducted, and interest in employees' health promotion grows. A 1983 survey of managers and union leaders found that 60% felt that workplace health promotion could improve employees' health and reduce long-term costs."

6. **Multicultural situations**

6.1 **Multinational operations**

The growth of multinational firms in the last 25 years, with nationals of many countries working abroad, has posed new challenges for programmes on alcohol- and drug-related problems. These international operations involve three broad categories of employee: (1) expatriate employees from the parent company; (2) local employees; and (3) employees of a third country.

Any of these employees or their dependants may have alcohol- or drug-related problems.

Many companies have difficulty in maintaining an alcohol or drug programme in all their overseas operations. There is a growing practice of giving overseas employees information before their departure about the culture and social background of the country to which they are going. This includes some reference to local attitudes to alcohol and drug consumption, legislation on the subject and facilities for help if problems arise.

Some firms attempt to evaluate the drinking or drug-taking habits of employees, and sometimes of their families, before sending them overseas, in an attempt to ensure that the conduct of the whole family does not run contrary to the accepted social norm in their new country. This places a heavy responsibility on the medical or personnel officer who has to decide whether the employee is suitable for overseas service. The provision of guidelines for such decisions may well be one of the functions of the preventive programme.

6.2 **Migrant and seasonal workers**

Workforce mobility is a widespread phenomenon today. Much needs to be done to familiarize migrant workers with occupational hazards, work organization and the habits, traditions and customs of the country in which they are guest-workers. The governments of both the home and the employing country should take considerable responsibility for this. Precautions should also be taken to safeguard workers who may be

cheated by private employment agencies and travel agencies, who have often exploited workers in various ways. The financial and security aspects are of particular concern here. Employers should be involved in this area in order to ensure that employment contracts are equitable. More attention should be paid to financial arrangements, as well as to housing and welfare facilities for the workers.

Guidance for workers from other areas or countries should be one of the targets of health promotion programmes. Social and psychological support for the workers and their families is especially important since alienation, homesickness, lack of contact with local people, language difficulties and work difficulties may all play a role in the development of unhealthy drinking or drug-taking habits. Some national and local authorities in both home and employing countries issue brochures and provide information for migrant and seasonal workers. Cooperation among the authorities concerned may lead to better understanding and more effective support, which will make the workers and their families feel more settled. This mutual support may actually increase labour productivity.

Authorities and employers must ensure that migrant and seasonal workers understand the occupational hazards of their work. Although this may be spelled out in information leaflets, the language difficulty must not be overlooked. Some firms in Germany have spent time teaching immigrant workers about safety, and obviously alcohol and drug issues should figure in such briefings (48, 49).

Quite often expatriate and migrant workers form associations and clubs for their nationals. Such groups may be used for preventive education against substance abuse in parallel with workplace programmes.

7. **Problems of developing countries**

As indicated above, the workplace is not always a large industrial enterprise, even though employees' problems may be more obvious to the outside world in such settings than in smaller working units or in agricultural and home-based industries.

In developing countries, many different types of workplace must be considered. In those countries, urbanization and industrialization are advancing side by side with age-old and traditional working systems. The relatively rapid change from village life to employment in large industrial centres can influence drinking and drug-taking behaviour for many reasons. In these situations, health promotion is of vital importance but, because of limited resources, it has to compete with other priorities. Moreover, some developing countries are faced with massive unemployment; the many contributing factors cause additional stress and can lead to increased alcohol consumption and drug abuse among unemployed people and their dependants.

The second United Nations Conference on the Least Developed Countries in September 1990 drew up a programme of action for the

1990s. It was concerned, among many other issues, with what it called the strengthening of the “human capital” in these countries. In this respect, three areas play a role: population policies, health services and education and training (50).

Health promotion should obviously figure prominently in the programme of action, but it is not easy to define the role of a workplace alcohol and drug programme. In the situation in which most of the developing countries find themselves, it is hardly realistic to expect the establishment of specialized programmes for the prevention of alcohol and drug abuse, except in multinational companies or in the largest indigenous enterprises. For employees in the formal sector, public or private, the same principles or mechanisms for health promotion could be applied as in the developed countries. However, these will need to be adapted to the actual situation in the country and in the individual workplace, depending on the resources and infrastructure available.

For most workplaces in the community and in rural areas, health promotion programmes aimed at alcohol- and drug-related problems should be integrated into the primary health care systems which developing countries have adopted. Health promotion would then be one of the functions of staff responsible for primary health care or community development (51). In this way, the programmes would stand a better chance of reaching both the smallest working units within the community and its individuals and families, thus providing more than one channel through which workers might be reached. As with other primary health care activities, health promotion should be introduced with the full involvement and participation of the community.

Prerequisites for effective health promotion action in developing countries in this respect are:

- Development of national drug and alcohol policies in countries where they do not yet exist.
- Collection of baseline data, which are either very scarce or non-existent in most developing countries – these may help in the subsequent evaluation of the programmes.
- Training of personnel, particularly those already involved in primary health care or community development, to enable them to incorporate the additional health promotion activities related to alcohol and drug problems into their routine work.

8. **Gaps in knowledge and experience**

There is a need for research on effective and culturally appropriate ways of collecting basic data on alcohol- and drug-related needs and risks in a variety of workplace settings, in particular for action and evaluation purposes. If such data-gathering exercises are to comply with the framework for health promotion described above (see section 2.2), workers need to be involved in the design and implementation of the

research at workplace level. In so doing, workers (in collaboration with invited external consultants) may develop “local theories” about alcohol and drug use which place it in its social, economic and political context (52–54).

Currently, there are few efforts being made to accumulate knowledge about the approaches used in different countries to assess the needs and risks of workers in relation to alcohol and drugs, or the ways in which countries are dealing with these issues. A survey was undertaken by the ILO in 1987, which could form the basis of international research in this area (22).

Improved coordination and extension of efforts could be promoted if countries pooled information on:

- the ministry or ministries that take major responsibility for health promotion programmes in the various workplaces;
- the other public or private bodies involved at central, regional and community levels;
- the coordinating mechanism, if any;
- the extent of coverage of the programmes – the entire working population, or only specific groups (e.g. enterprises above a certain size, groups at high risk of having or causing alcohol- and drug-related problems);
- the range of health promotion programmes available;
- the content of these programmes, including activities related to alcohol and drug issues;
- the people involved in establishing and running the programmes (e.g. trained education, health or other personnel, workers themselves);
- the training and supervision available to these people;
- any research envisaged, or already carried out, to assess the outcome of the programmes;
- the effect of preventive programmes in the workplace on particular groups of the working population;
- whether experiences gained in one country can be extrapolated to other countries or to other cultural settings.

Publication and dissemination of such information might prove of value to countries intending to develop services for health promotion in the workplace, and could help to improve the allocation of responsibilities for, and the content and coordination of, such services.

There is little information available about different experiences of alcohol- and drug-related problems among subgroups within specific occupations. Such research has a practical perspective, in that studies of variations in alcohol/drug problems within occupations may identify contributory factors in the organization and design of work which could be changed. Although studies covering a number of occupations also have this potential, they are less likely to realize it because there is little that can be done to equate, for example, bakers with nurses or seafarers with miners.

Further data are also needed on the correlation between specific working conditions and occupational groups, such as migrant workers and members of the armed forces, and the occurrence of alcohol- and drug-related problems. Shift workers, night workers and those working many hours of overtime, for example, may use stimulants to remain alert.

There are some gaps in knowledge about the abuse of legally prescribed drugs that have dependence potential. Some of these drugs, such as diazepam, a benzodiazepine tranquillizer and one of the most widely used drugs in the world, will directly influence safety at the workplace. Other drugs, such as the freely available painkillers, may not impair work performance, but they are known to have long-term adverse effects on health. More information is also required on the influence of exposure to chemicals, especially solvents, and to mixtures of chemicals in the workplace as a cause of, or aggravating factor in, alcohol- and drug-related problems.

Research is needed on the cost-effectiveness of workplace programmes, in comparison with other preventive programmes. It has been suggested that alcohol- and drug-related problems in the workplace may be adequately controlled by national policies, which may be more cost-effective than local policies (A. Maynard, unpublished observations, 1991). This suggestion needs to be properly investigated.

In the field of prevention of problems related to the use of illicit drugs, the relationship between workplace prevention activities and law-enforcement activities is still not clear. Protecting the individual who needs help while obeying the law poses very real problems.

9. **Conclusions and recommendations**

1. The Committee recommended that comprehensive health promotion policies and programmes should be designed for the workplace, using the Ottawa Charter for Health Promotion as the frame of reference. In this context, health promotion in the workplace should be understood to cover any organizational initiative whose object is to increase workers' control over their own health and to prevent the emergence of alcohol- and drug-related problems. The goal of such policies and programmes should be the maximum possible development of the psychological, social and physical factors that promote workers' well-being and prevent substance abuse. The programmes should include:
 - (a) a way of determining workers' needs for information regarding alcohol and drug use and of ascertaining the risk of abuse, preferably by means of joint labour/management cooperation;
 - (b) a commitment by employers' organizations and – where relevant – workers' organizations to respond appropriately to these needs and risks;

- (c) programmes to increase workers' knowledge and, if necessary, change their attitudes towards alcohol and drugs (these may be special programmes or may be included in more general health promotion activities);
 - (d) programmes to help workers to develop skills relevant to the prevention or self-management of alcohol- and drug-related problems, such as stress management, coping skills and assertiveness;
 - (e) employee assistance programmes;
 - (f) a commitment by managers to examine and remedy problems in the organization and design of work that may contribute to undue stress and/or to working conditions that favour the development of alcohol- and drug-related problems.
2. The Committee noted considerable gaps in knowledge and experience concerning the use of alcohol and drugs (licit and illicit) and related problems among the working population, especially in groups such as women, migrant workers and children. There is also a lack of information about how countries are currently dealing with these problems. WHO should facilitate studies to provide information on these topics, which could assist in the planning of action programmes and further research, especially in developing countries.
 3. WHO should promote research, using established methodology, to assist the development of culturally appropriate, well designed health promotion programmes concerned with alcohol- and drug-related problems in the workplace. Such research should involve all levels of the workforce, in consultation with employers' and workers' organizations. Initially, projects could be expected to deal with a particular type of workplace and involve a small number of countries whose governments have agreed to collaborate in the work and support the implementation of the findings. Later, they could be extended to a wider range of workplaces and countries.
 4. WHO should encourage the use of appropriate methods for evaluating health promotion initiatives concerned with alcohol- and drug-related problems so that, in both developing and industrialized countries, emphasis is placed on the continued development of culturally appropriate, well designed programmes with relevant and realistic objectives. Outcome evaluation should include, where possible, a comparison of the initiatives' cost-effectiveness with that of other approaches.
 5. In view of widespread concern about drug screening and testing, and the fact that screening programmes would not be applicable in all situations, WHO should promote studies to determine the usefulness, reliability and effectiveness of drug screening and testing programmes. The Expert Committee was of the opinion that, even if such programmes proved cost-effective, they should be introduced only as part of more comprehensive health protection and promotion

- programmes, which should emphasize education about and prevention of alcohol- and drug-related problems. Drug screening that limits the right of individual employees to privacy and dignity should be performed only if it serves clearly established public health objectives.
6. Small-scale employers and family businesses who have difficulty in developing their own health promotion activities should foster links with the community so as to facilitate the integration of health promotion activities on alcohol- and drug-related problems for their workers into existing community services.
 7. Migrant and seasonal workers need special attention and proper information and instructions regarding safety and the drinking or drug-taking habits of their host communities. Special consideration should be given to these vulnerable groups by international organizations such as WHO and the ILO.
 8. Vocational training programmes in health promotion in the workplace as it relates to alcohol- and drug-related problems should be organized for prevention officers and community health workers. Training programmes in health promotion in the workplace (covering prevention, identification and treatment of alcohol- and drug-related problems, as well as rehabilitation and social reintegration of affected workers) should also be organized for professionals in occupational health and safety and personnel management and for representatives of employers' and workers' organizations. All staff dealing with workers' health should accept their responsibility for health promotion.
 9. Governments should endeavour to incorporate health promotion concepts and objectives into national programmes, to be implemented both by health agencies and by those not exclusively concerned with health.

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Annex

Ottawa Charter for Health Promotion¹

The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond.

This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma-Ata, the World Health Organization's Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.

Health promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource of everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Prerequisites for health

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through *advocacy* for health.

Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring

¹ The Ottawa Charter was developed and adopted in November 1986 by an international conference organized jointly by the World Health Organization, Health and Welfare Canada and the Canadian Public Health Association. The text of the Charter was published in *Health promotion*, 1986, 1(4): iii-v, and is reproduced here by permission of Oxford University Press.

equal opportunities and resources to *enable* all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making health choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organizations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to *mediate* between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health promotion action means:

Build healthy public policy

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

Create supportive environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitute the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance – to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization – is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

Strengthen community action

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

Develop personal skills

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient health services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in the health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should

support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.

Moving into the future

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Commitment to health promotion

The participants in this conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and most importantly with people themselves;
- to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for international action

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, non-governmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the Year 2000 will become a reality.