Editorial

Opportunities for Making Every Contact Count approaches in workplaces

In 2007, the National Institute for Health and Clinical Excellence (NICE) published public health guidance on promoting health-related behaviour change, called 'Making Every Contact Count (MECC)’ [1]. Based on daily interactions that individuals and organizations have with other people, the MECC approach aims to help make positive changes to people’s mental and physical health and well-being. MECC enables the opportunistic dissemination of consistent and concise evidence about healthy living and empowers individuals to engage in conversations about their health across populations and organizations. Drawing on evidence for behaviour change, MECC maximizes the opportunity for brief or very brief discussion on health or well-being factors as part of routine health and wellness interactions. There is now evidence that widespread adoption of the MECC approach by people and organizations in the health and care sector can have a significant impact on their health [2,3]. However, the implementation of the MECC approach elsewhere, such as in the workplace, might raise questions.

Indeed, the workplace is an interesting arena for community-based prevention since people spend a significant part of their lives at work. Health and prevention are not unknown to workers and employers, whether through occupational health professionals’ interventions or Health, Safety, Quality and Environmental (HSQE) policies. For instance, there are numerous interventions based on the promotion of healthy lifestyles, especially related to cardiovascular risk factors and prevention of out-of-hospital cardiac arrest, like balanced diets or physical activity [4,5]. First-aid measures and cardiac massage are also frequently tackled themes. However, there are several important reasons explaining why MECC approaches are scarcely applied there. First, healthcare providers are absent from most occupational settings and their interventions are infrequent. Second, these approaches often promote lifestyle behaviour changes, while many occupational risk factors are related to collective exposures, for which workers have little control. Thus, providing behavioural interventions to workers with limited control over their environmental exposures might be stressful and even counterproductive. Lastly, there is often a barrier between the workplace and home where prevention of occupational exposures should be dealt with at work and prevention of individual risk factors should be of concern at home.

However, although possibly suffering from major limitations in occupational settings, MECC might be of interest in some specific cases. Some specific workplaces might represent an opportune area for MECC deployment and implementation. Some of them are peculiar because caregivers are present, whether nurses, physicians but also other health and social care employees or local authority staff. For instance, the healthcare sector includes caregivers who could implement MECC for their patients, their colleagues and themselves. Indeed, MECC first steps are supposed to take a few minutes, without adding to the workload, allowing brief intervention for patients, whichever the reason for seeking healthcare, from a global health perspective [6]. These short interventions could also happen between colleagues at work to promote healthy behaviours without stigmatization.

Furthermore, in some countries and/or in large companies, occupation health services are located onsite [7]. Such practitioners are trained to evaluate and prevent work-related risk factors and could be pivotal for providing brief interventions at the worksite. Indeed, even if public health and occupational health are usually separated, there are relevant opportunities for combining the prevention of individual and professional risk factors, as public health and occupational issues are often related even when they are somewhat distinct. For instance, working long hours account for about one-third of the total estimated work-related burden of disease and constitutes the largest burden of occupational diseases [8]. This risk factor is explained by the direct effects of work stress, but also indirect effects through preventable cardiovascular risk factors related to unhealthy behaviours, from addiction to sedentary lifestyles that can be related to such working conditions [8,9]. Raising awareness on the intertwined relations between occupational risk factor and individual risk factor is a good opportunity to have access to multiple levels of prevention. Thus, this example illustrates the possibility of combining prevention of personal and occupational risk factors through MECC approaches carried out by prevention ambassadors.

However, is it possible to go further, beyond the strict medical framework? Prevention ambassadors, who can be local nonmedical staff trained to occupational and safety regulations, but also to health promoting communication and techniques.
As stated previously, prevention is not a foreign concept to the workplace and integrating health promotion (e.g. sleep and stress management, physical activity, hydration, balanced nutrition, etc.) to existing ergonomic/occupational prevention frameworks could foster healthy lifestyles, well-being and productivity at lower cost. For example, simple but fundamental messages systematically delivered through brief or very brief interventions might be imagined: integrating psychosocial factors prevention with sleep and stress management; or physical activity, hydration messages, when implementing ergonomic prevention; or working together in cardiopulmonary resuscitation and first-aid training … The main benefits of this approach would be interventions that may be closer to the workers that could be intimidated by a medical setting, and more adaptive to the specifics of each company.

Implementing MECC in the workplace through prevention ambassadors, whether occupational or safety professionals, or health practitioners, and systematic and structured messages/tools constitutes an opportunity to combine individual and professional prevention towards millions of employees [10]. However, evaluations are warranted for these community-based prevention initiatives to be considered effective, as well as cost-effective. These evaluations are also challenging because prevention policies are multifactorial, complex and often require long-term intervention, requiring them to assess multiple outcomes of different nature and levels (individual, organizational … ). Furthermore, long-term engagement from local stakeholders must be ensured beforehand through bottom-up implementation involving top and middle management, workers, and health providers. Construction of interventions in the workplace that do not involve all these actors would be seen as top-down directives and wane adherence. Likely such prevention ambassadors would have to focus mainly on umbrella messages to simplify the transmission of information, with an emphasis on integrating health promotion to existing practices and raising awareness. This type of locally implemented MECC could improve the approach as well by creating a common prevention culture in private companies and improving health literacy in the workplace.

In conclusion, MECC approaches could be considered, organized, and evaluated in some workplaces, outside of the usual settings. They could offer better adhesion to prevention actions, by relying on short, low-cost interventions, and involving both healthcare and nonmedical workers in a common prevention culture that is not divided between the workplace and other settings.

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COMPETING INTERESTS

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REFERENCES


