# Summary

## Commission on Women’s Occupational Health - summary

The Commission on Women’s Occupational Health (‘the Commission’) was appointed on 8 March 2024 for the purpose of formulating a comprehensive knowledge base for women’s occupational health, proposing measures designed to contribute to better occupational health, including reduced workforce absence and exit rates for women. This knowledge base emerges in Part II of the study and is regarded as a primary deliverable from the Commission.

Participation in the labour force is high amongst women in Norway. 75 per cent of women are employed, although one-third of them work part-time. Norwegian working life is described as gendered, due to the fact that women and men are not equally represented in various industries, sectors, occupations and positions.

In female-dominated industries, the work often involves direct interaction with patients, users, students, customers and clients. Women in these industries and occupations have a higher incidence of psychosocial workload issues, such as emotional demands, role conflicts, low self-determination, violence and harassment or threats, as compared with the average employee in the workforce. This often occurs in combination with mechanical exposure factors such as heavy physical work and strenuous working positions.

In situations where employees are exposed to multiple working environment factors simultaneously, this can reinforce the effects of the respective factors on health. A significant share of women are exposed to a combination of psychosocial and mechanical/ ergonomic stressors in the working environment. High exposure to psychosocial and mechanical working environment factors particularly increases the risk of mental/emotional disorders, musculoskeletal ailments and absence due to illness (sick leave). There is a need for more knowledge about the health effects of such combined exposure, which can be used in preventive working environment work. Working environment factors can also contribute to social differences in health. In some female-dominated occupations with the most challenging working environments, we find a high percentage of women without higher education and, in some occupations, a high percentage of women with an immigrant background.

Different organisational and psychosocial working environment factors can have a protective or health-promoting effect, reduce the risk of negative health outcomes and contribute to forming a greater attachment to working life. Such factors can include self-determination, social support and good cooperation with colleagues, recognition of work done, opportunities to use knowledge and skills, as well as the possibility of developing new knowledge. Factors at the organisation level, such as good leadership and manageable organisational structures, good training of employees along with colleague support and mentor arrangements, can also have a positive impact on women’s occupational health.

We find the highest sick leave rates in Norway among women in typical female-dominated industries and occupations. Women also report more work-related absence than men, and absence for pregnant women is around four times as high as for women who are not pregnant. Musculoskeletal and mental health diagnoses are clearly the most prevalent diagnoses in women’s sick leave. Exit rates from working life with disability pension are also higher than the average in multiple female-dominated industries.

Shift work and part-time positions characterise the working conditions in many of the female-dominated industries and occupations. Work outside of normal daytime hours can also entail

an increased risk of health ailments, illnesses and sick leave. Small part-time positions are often linked with poorer professional development and a reduced learning environment. Shift rotation schemes based on full-time positions and a full-time culture are associated with a practice that promotes a good working environment, good competence, predictable working hours and wages, work continuity and better services. *The Commission* therefore presumes that measures aimed at increasing the number of women who work full-time may have an effect on women's working environment and health. At the same time, more knowledge is needed about how working hours are organised and the link with occupational health, sick leave and work attachment.

Differences in the scope of work-related health ailments, illness, sick leave and occupational injuries in various industries and occupational groups can be the result of different workloads or risk. Targeted, knowledge-based, preventive and health-promoting working environment efforts in industries where sick leave and dropping out of working life is high, and where there is a large percentage of women, can contribute to increasing women's participation in and attachment to working life.

Most adult women assess their own health as being good. At the same time, many live with various health ailments, such as migraines, headaches, body pain and mental/emotional ailments such as depression and anxiety. Little research is available as regards how chronic illnesses and conditions impact women's occupational health and work attachment. There is a general need for more knowledge that can shed light on connections between women's health challenges that are not caused by work-related factors. This can relate to women's health in different phases or situations in life, as well as illnesses that particularly affect women.

There are several ways to approach an understanding of the life-phase issue. Hormonal changes affect the lives of women throughout different phases, such as pregnancy and menopause, while these same life phases are also marked by responsibilities and tasks linked to family relationships and the work-family balance. The working environment and follow-up and facilitation at the workplace may have significance for women's participation in the workforce throughout various phases and situations in life. *The Commission* is proposing measures that help promote work attachment through various life phases, based on existing research, while also highlighting areas where additional knowledge is needed. Employees that are or have been subjected to violence may need follow-up and facilitation on the job. *The Commission* believes it is important to give employers and enterprises access to relevant knowledge and guidance about potential policy instruments in this area. Attempts have been made to explain the high rate of sick leave among women through various different hypotheses: "the working environment hypothesis" explains women's relatively high level of health ailments and absence with the fact that many women work in occupations with heavy workloads that increase the risk of health ailments or worsening of ailments, and/or can make it challenging to remain in jobs with their existing health ailments. "The biological hypothesis" explains women's health ailments and illnesses using biological factors that boost the risk of health ailments, including consequences associated with menstruation issues, pregnancy and menopause. The "double burden hypothesis" explains women's higher level of health ailments by the fact that women, to a greater extent than men, combine occupational activity with greater responsibilities and time spent linked to care or social welfare tasks in the home. The "socio-cultural hypothesis" explains gender differences on the basis of differing illness behaviour between women and men. In sum, the research shows that when the various hypotheses are tested, we are still left with unexplained differences in sick leave. That's why a further need for research and knowledge development is highlighted.

Vista Analyse estimates socioeconomic costs due to reduced women's occupational health and exit from the workforce at NOK 59 billion each and every year. It's difficult to assess an

"achievable" potential gain, which is why these numbers carry substantial uncertainty. Nevertheless, *the Commission* assumes that there could be potential socioeconomic benefits in the order of several billions of kroner associated with implementing successful measures to improve women's working environment, occupational health and work attachment, and which can reduce absence and exits from the workforce.

The knowledge at hand shows that effective working environment efforts must take a point of departure in the challenges at the respective workplaces. At the same time, a number of industry-specific factors and challenges will be shared, which also entails that industry-specific tools and sector collaboration could be very significant.

The statutory framework for Norwegian working life lays a foundation so that employers and employees in the workplace can and shall cooperate on preventive working environment efforts. At the same time, the knowledge base reveals an improvement potential in the work on risk assessments and targeted preventive working environment efforts, both in the enterprises in general and in female-dominated occupations in particular. Established knowledge and targeted means, measures and tools are not being deployed to a sufficient extent. Employers and employees at the enterprise level are calling for better knowledge and expertise to address systematic and targeted preventive working environment efforts.

Therefore, the effort to promote women's occupational health will require the involvement of all responsible parties; the authorities, employers and employees, specialist communities and local enterprises, in a commitment to women's occupational health – both in cooperation and within their respective areas of responsibility. The new knowledge base on women's working environment, occupational health and work attachment must form the foundation for this commitment, and *the Commission* believes that communicating the knowledge base is a key action in itself. The next step *the Commission* highlights is the necessity of developing new and up-to-date knowledge about women's occupational health. The consensus is that the greatest potential for improvement lies in reinforcing systematic working environment efforts for women in the enterprises, mainly within prevailing requirements and frameworks, supported by national knowledge banks, sector programmes and guidance material, etc., and with employers and employees as active promoters.

The proposed measures and actions target all parties in this chain and entail assessment and follow-up of regulations, guidelines, authority follow-up, knowledge development, cooperation among the parties, collective wage agreements, training, organised cooperation and framework conditions at the workplaces.

## Structure and content of the study

The Commission on Women's Occupational Health's (the Commission's) study consists of three parts.

*Part I: Background* (chapter 2) describes the Commission's composition, mandate and work.

*Part II: Knowledge base* (chapters 3–8) comprises a comprehensive knowledge base on women's participation in the workforce, women's working environment and occupational health, other factors of significance for women's participation in the workforce, framework conditions and follow-up measures, as well as socioeconomic impacts and the potential for prevention.

*Part III: The Commission's assessments and proposals* (chapters 9–11) comprise the Commission's assessment of the knowledge base on women's occupational health, and the

Commission's proposed measures that can contribute to better occupational health, reduced absence and exit from the workforce. These measures are divided into seven action areas:

1. Systematic and health-promoting working environment efforts in the enterprises
2. Work organisation and management structures that promote good occupational health for women in the enterprises
3. Tripartite cooperation that promotes women's occupational health
4. National measures and tools that promote women's occupational health
5. A working life adapted to women's life phases
6. Violence and assault outside work is followed up inside the enterprises
7. Research commitment and bolstered data and documentation base on women's working environment, occupational health and life phases

A brief statement on the content of the study is presented in the following, as well as the knowledge base on women's occupational health. This is followed by a description of the Commission's assessment of the knowledge base, and an overview of all measures proposed by the Commission.

## About Part I Background

Chapter 2 describes the *Commission's composition, mandate and work,* as well as the Commission's interpretation of the mandate. An account is also given of the knowledge and the contributions the Commission has obtained through studies, meetings with experts and written submissions, such as on the Commission's website. The Commission on Women's Occupational Health shall prepare a comprehensive knowledge base on women's occupational health. With a background in this knowledge base, the Commission will propose measures that can contribute to better occupational health for women, including reduced absence and exit from the workforce. Topics addressed by the Commission on Women's Occupational Health include the significance of both the working environment and the employment relationship for women's health (occupational health) and work attachment, as well as how framework conditions and follow-up measures in working life can help women facing health-related challenges due to various factors remain in the workforce longer. The Commission's work is limited to follow-up and measures at a broader community level.

It is well-documented that different working environment factors have an impact on occupational health, absence and exit from the workforce. A number of individual factors, such as health challenges linked to genetics, life phase and life situation, lifestyle or illness that are not linked to the work are also significant for women's sick leave and participation in working life. Framework conditions in working life and follow-up and facilitation at the workplace are of significance for whether or not women with various health issues are placed on sick leave or can remain in the workforce longer.

"Occupational health" means health factors that are caused, in whole or in part, by performing the work and influences from the working environment. "Working environment" relates to the specific work to be performed, and is linked to how one organises, plans and executes the work. How the working environment affects women's health and participation in the workforce, in both positive and negative directions, is a key topic for the Commission. The Commission acknowledges that all workplaces are different and have different working environment challenges.

In addition to assessments linked to working environment and occupational health, the Commission's assignment encompasses evaluating how working life can be facilitated so that women who have health issues not immediately related to their job, can still work. This

framework entails that the point of departure for the Commission's discussions is factors that touch on both work and health, and how these factors are interconnected. Issues and measures that do not relate to the relationship with and between work and health, are not generally considered relevant for the work of this Commission.

## About Part II Knowledge base

In line with the mandate, the Commission has developed a comprehensive knowledge base related to women's occupational health, cf. Part II of the study. The knowledge base is a key deliverable from the Commission. The knowledge base builds on data and documentation of recognised professional quality. This indicates that it can be used as a basis for knowledge-based measures and for developing further knowledge. Several areas reference knowledge gaps and a need to develop additional knowledge on women's occupational health.

*Chapter 3 Women's participation in the workforce – status and development* gives a general picture of women's work attachment by presenting statistics showing the scope of women's participation in the workforce, in which sectors and occupations they work, and how and to what extent they are attached to working life. The chapter also illuminates some of the differences in workforce participation between women and men, as well as characteristics associated with work participation in the immigrant population. Norwegian women exhibit a high rate of participation in the workforce and a high percentage of part-time work, in a gendered workforce.

Chapter 3 also discusses sick leave statistics for women, and data on women's exit and withdrawal from the workforce. This lends a backdrop for subsequent descriptions of women's working environment and occupational health, and causes of health impacts and withdrawal. The section also includes a discussion of the share of female employees who are organised in trade unions and who are covered by collective wage agreements in the Norwegian workforce.

*Chapter 4 General information on women's working environment and occupational health* is mainly based on research that studies women, or includes analyses that differentiate between women and men, or studies conducted in female-dominated industries where the majority of the studied group is made up of women. In this chapter, the Commission provides an account of the scope of work-related health ailments, illnesses, sick leave and occupational injuries among women, as well as some general differences between various occupations and industries.

A thorough account is given of knowledge relating to various categories of working environment factors, including organisational, psychosocial, physical, chemical, biological and mechanical (ergonomical) working environment factors, and how they can be linked to various health effects, and to sick leave and withdrawal from the workforce among women. Particular reference is made to the fact that a large share of women are exposed to a combination of negative psychosocial and mechanical (ergonomical) working environment factors, in addition to working outside of normal working hours. In situations where employees are exposed to multiple working environment factors at the same time, combinations of various factors may reinforce each other's negative or positive impact on health. Different organisational and psychosocial working environment factors can also have a protective and health-promoting effect, reduce the risk of negative health outcomes and contribute to enhanced work attachment. Chapter 4 also includes a detailed review of the knowledge about health effects from working hours and working hours schemes. Furthermore, it provides a description of the significance of a "full-time culture" which entails more than simply a high rate of full-time employment. A full-time culture is also associated

with a practice involving good working environment, good expertise, continuity in operations and better service quality. In this context, there is also a description of characteristics associated with so-called “sustainable working environments”, where employees manage to continue working full-time until retirement age, and “the good shift” as a foundation for achieving a sustainable working environment in the health care sector’s shift work.

Chapter 4 also notes that working life is constantly evolving, and that introducing new technology can have both positive, but also negative impacts on the health and well-being of employees. For example, artificial intelligence can be used to plan shifts and rotation schemes in the public health service; however, as a ‘precautionary’ strategy, more knowledge is needed regarding how the use of artificial intelligence affects occupational health and safety. The chapter also has a particular focus on working environment and occupational health for immigrant women and social differences in health linked to working environment. The chapter also points to the need for more knowledge about the effect of working environment on women’s occupational health and workforce participation, as well as the need to reinforce the basis of data and documentation in this context.

*Chapter 5 Women’s working environment and occupational health in selected occupations and industries in Norway* describes working environment factors that women are exposed to as well as women’s occupational health, sick leave and withdrawal from the workforce in different occupations and industries, with emphasis on women’s own assessments of work-related health ailments and their absence due to illness as sanctioned by physicians. This includes a more detailed assessment of working environment and occupational health in relevant female-dominated occupations and industries, in addition to women’s working environment and occupational health in selected occupations and industries with varying percentages of women. These occupations and industries represent certain different challenges as compared with the female-dominated occupations and industries.

Female-dominated industries and occupations described include the health and social work sector, teaching, hairdressers and cleaning staff. The review of women’s working environment in occupations and industries that are not female-dominated comprises the petroleum industry, the food industry and retail. Working environment factors that are relevant for office jobs are also described.

One of the topics highlighted in the Commission’s mandate is that the consequences of work-related ailments and illnesses affect women who work in the health and care sector to a significant extent. The knowledge base illustrates a high level of sick leave and lost workdays in this sector. Therefore, working environment factors in the health and care sector is a key topic in the Commission’s work. Health effects in the form of musculoskeletal ailments and minor emotional/mental health problems, both separately and in combination, are particularly relevant in this context.

In *Chapter 6 Other significant factors for women’s participation in the workforce,* the *Commission* refers to knowledge that can shed light on links between women’s health challenges that are not caused by influences from their work/the working environment (occupational health) and participation in the workforce. This can relate to women’s health in different life phases or situations, and illnesses that particularly affect women. There are several angles of approach to achieve an understanding of the life phase issue. Hormonal changes affect women’s lives through different phases, while at the same time, these same life phases are characterised by responsibilities and tasks related to family relationships (work-family balance). Among the life phases affected by hormonal changes, and how these changes can affect participation in the workforce, a specific and more detailed description is given as regards the significance of menstrual issues, pregnancy and menopause. Some of the other life

situations that are significant for women’s participation in the workforce are laid out in a review of the status of knowledge about violence and sexual assault and ailments and illnesses that largely affect women, but which cannot be characterised as “women’s health conditions”.

Such “other factors” were thoroughly addressed in the Women’s Health Commission study (NOU 2023: 5), which discusses how biological differences can have an impact on women’s participation in the workforce.

*The Commission on Women’s Occupational Health* points to areas where more research is necessary, and proposes measures that can promote women’s attachment to work in different phases of life based on the existing knowledge. *The Commission* emphasises that society must not pathologise normal conditions that follow from women’s biological life phases with hormonal impact. At the same time, *the Commission* is concerned with ensuring that relevant issues that affect many women must be elevated from an individual to a structural level.

*Chapter 7 Framework conditions and follow-up measures* provides an account of development, follow-up and the status of statutes, regulations and what the public authorities are doing, which are particularly relevant for women’s working environment, occupational health and rights. This includes a description of international frameworks and guides for health, safety and the environment that entail international law obligations for Norway. Furthermore, the chapter reviews frameworks and follow-up that occurs under the auspices of dual and tripartite cooperation. This includes e.g. arenas to facilitate cooperation and the collective wage agreement system. Reference is made to the added value of this tripartite cooperation, including through the work on the IA (inclusive working life) agreement and knowledge-based guidance on and tools to facilitate targeted preventive working environment efforts that have been developed in this context. The parties have agreed to bolster preventive and working environment efforts in the current IA agreement (2025–2028). In this context, the importance of good training in working environment efforts is highlighted, including that the efforts undertaken at the respective workplace are key.

*Chapter 8 Socioeconomic impacts and potential for prevention* includes a review of Vista Analyse’s general socioeconomic calculation of the effects of diminished women’s occupational health and women’s absence and withdrawal from the workforce. A corresponding assessment of the potential associated with preventive and facilitating measures is also included.

An assessment and quantification of the socioeconomic costs that follow from work-related health ailments may contribute to raise awareness concerning the importance of creating a good working environment, to reduce risk factors and especially also contribute to working environments that promote health. At the same time, knowledge about costs helps facilitate informed decisions about needs and the commitment of resources that is warranted in this area. Costs associated with work-related health ailments also provides some indication of how much can be gained from potential measures.

Vista Analyse’s best estimate of socioeconomic costs associated with diminished women’s occupational health and women’s absence and withdrawal from the work force is NOK 59 billion per year. These costs are considerably higher than the results from other comparable estimates made earlier. This difference is primarily due to the number of workdays lost as a result of sick leave, work assessment or disability. Despite the fact that this study only looks at women, the number of work-related absence days as a consequence of diminished health is greater than previously assumed, for both genders as a whole.

The realisable potential gain is defined as the increased benefit that can be achieved by implementing all realisable preventive and facilitating measures to promote good

occupational health and work attachment among women. Vista Analyse describes various approaches and multiple scenarios to highlight the potential gains that may be realised by means of various preventive and adaptive measures.

*The Commission* notes that the estimated socioeconomic costs associated with loss of productivity, death and treatment expenses resulting from issues surrounding women's occupational health and work-related absence for women amount to extremely significant sums. It is difficult to assess what exactly constitutes a "realisable" potential gain, which means these figures are characterised by considerable uncertainty.

## About Part III The Commission's assessments and proposals

*The Commission's* assessments and proposed measures to bolster women's occupational health and work attachment are based on an analysis of the knowledge base, cf. Part II of the study.

*Chapter 9 The Commission's assessment of the knowledge base* takes its point of departure in Part II of the study. This chapter gives an account of how the knowledge base is used as a platform for a joint understanding of the problem – a "scarlet thread" from the interpretation of the Commission's assignment and mandate to promote understanding of documented knowledge and frameworks for potential measures and targeted follow-up when it comes to women's occupational health and work attachment.

Another point made is the expectation of a significant increase in the scarcity of competent labour in the time ahead, viewed in light of an aging population and presumably a greater need for public health and care services. Estimates may indicate that the greatest potential for increasing employment and the number of full-time equivalents can be achieved by implementing measures that reduce the number of people who drop out of the workforce and transition to disability pension. Therefore, it is important to commit to improving working capacity at the earliest possible stage. Reduction in sick leave, particularly long-term sick leave, could reduce withdrawal from working life and transition to work assessment allowance, and subsequently to disability pension.

*The Commission* agrees that the knowledge base represents the best professionally documented knowledge we have today. At the same time, reference is made to knowledge gaps in several areas and the need for further knowledge development on women's occupational health.

*The Commission* notes that the scope of work-related health ailments, illnesses, sick leave and occupational injuries in different industries and occupational groups may be due to differences in workloads or working conditions that entail risk.

*The Commission* notes that Vista Analyse estimates socioeconomic costs associated with diminished women's health and women's absence and withdrawal from the workforce at NOK 59 billion per year, related to loss of production, loss of productivity, death and treatment costs. *The Commission* notes that there could be a potential socioeconomic gain in the order of several billions of kroner if we succeed in taking actions that improve women's working environment, occupational health and work attachment, and which reduce absence and withdrawal from the workforce.

The greatest potential is presumably found in measures within female-dominated industries and occupations, which include many women and where the work is characterised by emotional and relational demands and mechanical stresses. These are working environment factors that have been proven to have an effect on the dominant work-related causes of sick

leave and exit from working life; less serious mental/emotional ailments and musculoskeletal ailments.

A characteristic of many female-dominated occupations and industries is a combination of high workload linked to both psychosocial and mechanical working environment factors. Various organisational and psychosocial working environment factors can also have a protective and health-promoting effect, can reduce the risk of negative health outcomes and contribute to greater work attachment. *The Commission* is therefore of the opinion that targeted, knowledge-based, preventive and health-promoting working environment efforts in industries where sick leave and withdrawal from working life are high, and where the percentage of women is high, have a potential for influencing women's participation in the workforce and work attachment overall.

*The Commission* also refers to the need for more knowledge about the health effects of combined exposure to both psychosocial and mechanical working environment factors. This knowledge must be utilised in the preventive working environment efforts.

The Commission believes that it may be possible to reduce sick leave among pregnant employees who work in challenging occupations through better facilitation for those who experience pregnancy-related ailments.

*The Commission* also refers to the need for additional knowledge that can shed light on the links between women's health challenges that are not a result of impacts from the work /working environment and participation in the workforce. This could relate to women's health in various life phases or life situations, and illnesses that to a significant degree impact women.

In addition, *the Commission* notes that formal structures and a scope for action and latitude have been established through regulations, cooperation between the involved parties and other formal framework conditions for following up occupational health, both as regards the requirements for what is needed to create good working environments and the arenas for joint cooperation.

Legislation and agreements in Norwegian working life lay the groundwork for employers and employees in the workplace to cooperate on preventive working environment efforts. Both knowledge and knowledge-based tools and instruments designed for enterprises have been developed for use in the enterprises' HSE work.

Nevertheless, the knowledge base reveals a potential for improvement when it comes to work on risk assessments and targeted preventive working environment efforts in the enterprises. Established knowledge and targeted policy instruments and tools are not sufficiently being deployed in the enterprises. Employers and employees at the enterprise level are calling for better knowledge and expertise about systematic and targeted work within preventive working environment efforts. There is a call for sector-specific information for use in HSE training.

*The Commission* points out that there is a potential for using the established latitude in working life to ensure that enterprises obtain sufficient knowledge and expertise about statutes and policy instruments to allow them to work in a targeted and effective manner to address prevention and facilitation work. The knowledge we have shows that effective work on the working environment must take a point of departure in the challenges at the individual workplace. This is an important starting point for the work on risk assessments and action plans in the enterprises. At the same time, *the Commission* notes that a number of sector-specific factors and challenges will be shared, so that sector-specific tools and sector cooperation may be very significant.

Therefore, it is necessary that all responsible parties, authorities, employers and employees, expert communities and local enterprises must be engaged in the effort to promote women's working environment and work attachment, joining in a commitment to women's occupational health – in cooperation and within their respective spheres of responsibility. The new knowledge base on women's working environment, occupational health and work attachment must form the basis for these efforts, and *the Commission* believes that communicating the knowledge base is a primary action in and of itself. Further, *the Commission* notes the necessity of developing new and up-to-date knowledge about women's occupational health. The consensus is that the greatest potential for improvements lies in bolstering the systematic working environment efforts for women in the enterprises, primarily under the umbrella of applicable requirements and frameworks, supported by national knowledge banks, sector programmes and guidance material, etc., and with employers and employees as active driving forces.

The measures target all parties in this chain and entail assessments and continuing to monitor regulations, guidelines, follow-up by the authorities, knowledge development, cooperation between involved parties, collective wage agreements, training, organised cooperation and framework conditions at the workplaces. The new knowledge base on women's working environment, occupational health and work attachment must be used as a point of departure for this commitment, and *the Commission* believes that communicating the knowledge base is a primary action. Further, *the Commission* notes the necessity of developing new and up-to-date knowledge about women's occupational health. The consensus is that the greatest potential for improvement lies in bolstering the systematic working environment efforts for women in the enterprises, primarily under the umbrella of applicable requirements and frameworks, supported by national knowledge banks, sector programmes and guidance material, etc., and with employers and employees as active driving forces.

*Chapter 10 Measures that can contribute to better occupational health and reduced absence and withdrawal from working life for women* presents the Commission's proposed measures, a total of 47 suggestions on which the Commission reached agreement.

*The Commission* has presumed that the proposed measures shall:

- Respond to the Commission's mandate
- Build on the knowledge base
- Have significance for women's occupational health and health-related absence and withdrawal from working life

*The Commission on Women's Occupational Health* proposes a commitment to women's occupational health, under the direction of the enterprises, employers and employees and the authorities, and a commitment to developing new and up-to-date knowledge about women's working environment and occupational health. This commitment can be incorporated into a new national working environment strategy, if such a strategy is established.

*The Commission's* proposals relate to following up women's working environment and occupational health in general, both in female-dominated occupations and industries, and in occupations and industries with varying representation of women. The greatest potential is believed to lie in measures that strengthen systematic workplace environment efforts for women, particularly in female-dominated industries and professions. These sectors involve many female employees, and the work is characterised by psychosocial and mechanical (ergonomical) negative working environment factors. The proposed measures

also address women's life phases, violence and assault outside work and health factors that are not by definition caused by the working environment, but which nevertheless have an impact on women's work attachment and participation in the workforce.

*The Commission* proposes a commitment to research on women's occupational health, including developing and updating professional and documented knowledge about women's working environment, and the importance of the working environment for health, withdrawal and work attachment. The proposals also include knowledge-promoting measures relating to immigrant women's occupational health, and research on links between women's life situation, health and participation in the workforce. In an effort to obtain better knowledge about work factors that affect the incidence of work-related illness, work-related sick leave and disability among women in Norway, *the Commission* also proposes measures that can bolster the scope, quality and access to the database on working environment and health factors for analysis and research communities.

These proposed measures will contribute to empowering employers and employees at the respective workplaces to work in a targeted, preventive and health-promoting manner on factors in working life, and to help ensure that the work is facilitated so that employees with health challenges and employees on sick leave can remain at work. The proposed measures will facilitate effective follow-up by the authorities and a well-functioning tripartite cooperation on targeted, preventive and health-promoting working environment and facilitation efforts. The workplaces and the parties involved in the dual and tripartite cooperation will be held accountable when it comes to preventive efforts for the working environment. Moreover, the proposed measures will contribute toward developing necessary knowledge and expertise, as well as the follow-up and facilitation so that women with health challenges are taken into consideration in the enterprises, regardless of whether or not their health challenges are linked to their work.

In summary, *the Commission* recommends that a commitment to women's occupational health and work attachment encompass the following priority areas:

1. Systematic preventive and health-promoting working environment efforts in the enterprises
2. Work organisation and management structures that promote good women's occupational health in the enterprises
3. Cooperation between employers, employees and other parties to promote women's occupational health
4. National measures and tools to promote women's occupational health
5. Working life adapted to women's life phases
6. Violence and assault outside work must be followed up in the enterprises
7. Research commitment and reinforced data and documentation basis on women's working environment, occupational health and life phases
8. Vista Analyse has assisted the Commission with estimating the consequences of the proposed measures.

*The Commission on Women's Occupational Health* proposes the following measures to follow up women's occupational health and work attachment:

*Systematic preventive and health-promoting working environment efforts in the enterprises*

1. Bolster systematic HSE work in the enterprises, with emphasis on women's occupational health.
2. Use the company/occupational health service to promote women's occupational health
3. Sound working environment for female employees with an immigrant background

*Work organisation and management structures that promote good women's occupational health in the enterprises*

4. Organisation and management that facilitates good follow-up
5. Organisational measures that promote working environment, occupational health and work attachment
6. Working hours schemes that promote health and full-time positions
7. Policy instruments to deal with emotional stressors
8. Greater development and use of digital and technological aids

*Cooperation between employers, employees and other actors to promote women's occupational health*

9. Implementing knowledge about women's occupational health in the IA sector programmes
10. Consider new IA sector programmes in female-dominated sectors
11. Employer and employee organisations promote measures for women's occupational health
12. Employers and employees contribute to HSE training that includes women's occupational health
13. Employers and employees contribute to use of the company/occupational health service
14. Organised working life as a means of including immigrant women in the workforce
15. Employers and employees contribute so more women can remain in their jobs longer

*National measures and tools to promote women's occupational health*

16. National working environment strategy, with women's occupational health as one of the commitment areas
17. Update and communicate national tools and knowledge banks relating to working environment
18. Management support relating to preventive working environment efforts and following up sick leave
19. Update the framework for HSE training in the enterprises
20. Develop tools for evaluating organisational changes and new work methods and tools in the enterprises
21. Develop training assistance on women's occupational health for issuers of medical certificates
22. Digital interaction forum for simpler and better information-sharing in following up sick leave
23. Intensify and target sick leave follow-up
24. Update national senior management programme for municipalities and the specialist health service with knowledge about women's occupational health, and continue this effort
25. Increased supervision to ensure that protective gear is adapted for women
26. Preventing and dealing with violence, threats and harassment in working life
27. National guidance material on the balance between citizens' statutory rights and employees' rights to a responsible working environment
28. Provide for training regarding transfers, emotional and relational requirements, violence and threats, in female-dominated fields of education

29. New national strategy for immigrant health, with particular focus on women's occupational health
30. Targeted HSE work in relation to women with an immigrant background

*Working life adapted to women's life phases*

31. Facilitate taking women's life phases into account in the enterprises
32. National guidance material on facilitation for pregnant women in working life, including with regard to fertility treatment
33. National guidance material on maternity allowance
34. National guidance material on leave of absence for nursing mothers
35. National guidance material on menopause in the workplace
36. National awareness regarding measures that can help ensure that more women can continue to work longer
37. Spread knowledge about the activity and reporting obligation (ARP), as a tool for strengthening women's working environment

*Violence and assault outside work must be followed up in the enterprises*

38. Establish expert assistance for working life as regards domestic violence
39. Include topics related to the workplace and employers' follow-up in the guidelines for municipal action plans to combat domestic violence

*Research commitment and reinforced data and documentation basis on women's working environment, occupational health and life phases*

40. Establish a unified and coordinated research commitment on matters of significance for women's occupational health and health-related work attachment
41. Implement measures aimed at enhancing knowledge concerning immigrant women's occupational health
42. Develop research-based knowledge on how life phases impact women's occupational health
43. Develop register-based information on work-related sick leave
44. Streamline and digitalise the physicians' reporting system on work-related illness to the Norwegian Labour Inspection Authority
45. Include issues related to working environment, occupational health and work-related illness in the regional and national systematic health surveys
46. Facilitate linking of data from the Living Conditions Survey on working environment with Norwegian health registries
47. Improve access to working hours data from the public sector by updating regulations