



Occupational Safety and Health and HIV/AIDS Control in Selected East African Hotel and Chemical Manufacturing Companies: Situational Analysis and Recommendations for Industry-Specific Approaches

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Abbreviations

ABCT	AIDS Business Coalition Tanzania
ACPLRWA	Association Des Chauffeurs De Poids Lourds Au Rwanda
AEB	Association des Employeurs du Burundi
AIB	Association des Industriels du Burundi
ATE	Association of Tanzania Employers
CESTRAR	Centrale des Syndicats des Travailleurs du Rwanda
CNLS	Conseil National de Lutte contre le SIDA
COSYBU	Confédération des Syndicats du Burundi
COTU	Confederation of Trade Unions (Kenya)
CTI	Confederation of Tanzanian Industries
EABC	East African Business Council
EAC	East African Community
F&B	Food and beverages
FKE	Federation Kenya Employers
FUE	Federation Uganda Employers
GTZ	German Technical Cooperation
ILO	International Labour Organization
KHBC	Kenya HIV/AIDS Business Council
NACC	National AIDS Control Council
NOTU	National Organization of Trade Unions (Uganda)
OSH	Occupational Safety and Health
OSHA	Occupational Safety and Health Authority
PSF	Private Sector Federation (Rwanda)
SIDA	AIDS
SPAA	Support of the Private Sector in Africa to Fight AIDS
TACAIDS	Tanzanian Commission against AIDS
VIH	HIV
WHO	World Health organization
WPP	Work Place Program

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Executive summary

This report presents the key findings of an in-depth investigation conducted by way of case studies in two industrial sectors, namely the hotel industry and the chemical manufacturing industry, in the East African Community (EAC) countries of Burundi, Rwanda, Kenya, Tanzania and Uganda. The objective of the study was to uncover issues around and interconnections between AIDS control at the workplace and general occupational safety and health (OSH), in an effort to develop industry-specific approaches that promote workforce health in a comprehensive manner. The study identified activities for these three intervention levels:

Level 1: EABC and EAC regional activities

Level 2: National activities of industry associations, business coalitions and other relevant institutions

Level 3: Activities at company level

In terms of health problems, it was found that similarities exist between the sectors regarding common diseases, including respiratory infections and malaria. HIV was also not mentioned by any of the companies interviewed as their primary health concern. Despite these similarities, the study of these two sectors also revealed important disparities. Differences exist with respect to health and social issues, the focus of health activities and the needs relating to OSH and AIDS control.

Among the five hotels interviewed, OSH is implemented systematically, but restricted to catering and fire safety. All participating hotels reported regular official hygiene controls. Departments other than 'food and beverage' are only marginally involved in OSH. The EAC is currently in the process of introducing its own classification system for hotels and restaurants; trainers and assessors are being trained. The curricula still has room for more extensive elaboration of issues of occupational safety and health including HIV.

The hotel business especially in holiday resorts is highly influenced by seasonal peaks. Up to 30 percent of seasonal workers during peak season present an added challenge in providing health education and health care to their workforce. Hotels also face gender-related challenges, such as sexual harassment of female staff or commercial and occasional sex work. Empowerment of female staff and gender-sensitive health education are good practices that should be copied by other companies. Most hotels are also involuntarily involved in a sex supply chain; hotels could prove to be good points of entry for addressing high risk groups with preventive messages and services.

The hotel interview partners identified capacity needs ranging from very basic to sophisticated and targeted towards specific problems like conflict management or drug abuse. The hotels also expressed a need for support regarding an integrated approach that combines HIV and OSH activities, in order to save resources and reduce discrimination.

As potential activities, the findings of the study suggest for the hotel industry:

Level 1:

- Harmonization of OSH and AIDS control standards at regional and national levels, with special consideration of hotel industry requirements

- Strengthening OSH and AIDS control in the EAC hotel classification process
- Development of training and assessment capacity of national hotel associations and other support institutions
- Feasibility study for a Hotel Industry Health Fund

Level 2:

- Creation of assessment services for companies
- Provisions of training courses for companies
- Integration of OSH and HIV in professional college curricula
- Shared social worker and counsellor for health education

Level 3:

- Adapt hotel company OSH and HIV activities to needs
- Extend regular medical check-ups
- Introduce spokeswoman/female union representative for female staff

Among chemical manufacturing companies, OSH is very dominant. However, knowledge gaps do exist and, more specifically, external support in the form of advisory services or risk assessments is scarce. Companies are, therefore, not sufficiently capable to deal with issues of emergencies, production risks or product hazards. Support is needed for the development of risk assessments, response plans and a safe workplace environment. Protection of chronically ill workers such as people living with AIDS in a physically encumbering environment is an unresolved challenge. HIV interventions should be incorporated into the general OSH framework to become continuous and sustainable.

An industry-specific approach that combines health interventions, including HIV, with a gender-aware OSH perspective can help identify gaps and needs, thereby garnering support from managers. The following activities are suggested for the chemical manufacturing industry:

Level 1

- Harmonization of OSH and HIV at regional and national levels with special consideration of the needs of chronically ill workers
- Development of training and assessment capacity of national manufacturing associations and other advisory and assessment bodies
- Development of information materials
- Feasibility study for a Manufacturing Industry Health Fund

Level 2

- Provision of trainings to companies
- Creation of assessment services for companies

Level 3

- Improve workplace according to OSH standards
- Define and inform emergency medical support chain
- Introduce spokeswoman or female union representative
- Consider extra leave days for supporting female workers who take care of sick family members.

Currently, OSH exists independently from multi-sectoral AIDS control in the five EAC countries. In Kenya for example, OSH is a statutory requirement with an own directory. National frameworks for OSH and health at the workplace underutilize interconnections and synergies between the two. In terms of rules and regulations, OSH is set up in a more organized way with guidelines and official control instruments than AIDS control at the workplace. The synergetic alliance between OSH structures and workplace health promotion requires an industry-specific, gender-aware policy process at regional and national levels. All of the participating companies in the study acknowledged the value of integrating both. Some, however, still run separate activities for administrative or financial reasons.

Since the AIDS epidemic differs in the various EAC countries, the level of company experience with AIDS control also varies. Businesses in countries with a lower prevalence like Burundi and Rwanda are less familiar with workplace activities against HIV and AIDS. Lack of knowledge is a major issue for them. The private sector of Kenya, Tanzania and Uganda, in comparison, can benefit from years of engaging in HIV activities and learning from good practices of other companies. Nevertheless, businesses here face the challenge of keeping HIV activities dynamic and sustainable. The EAC provides an ideal platform for industry leaders to share experiences, learn from the various situations and forge new paths towards better health of the East African workforce.

Chapter 1: Introduction

Background of the study

HIV and AIDS remain a challenge for the private sector in all countries of the East African Community, where Kenya, Tanzania and Uganda have an HIV prevalence of around 7 percent and Rwanda and Burundi of around 2 percent. Despite the fact that many companies have started implementing HIV/AIDS workplace interventions, the private sector is not yet sufficiently involved in national AIDS control efforts. This is partly due to a lack of competency and capacities in addressing health issues. In addition, the health needs of companies exceed HIV prevention and AIDS treatment to include other diseases such as occupational hazards, malaria, diabetes and hypertension. Interest in HIV-only programmes is, therefore, difficult to initiate and maintain. A general trend in large multinational corporations has emerged to initiate broader occupational OSH programmes. In contrast, smaller, national entities remain rather inactive.

Health issues in companies touch on industrial production patterns and company specifics, as well as societal, cultural and environmental influences. OSH is a multidisciplinary field that is concerned with interrelations existing between work and profession on the one side and the human being and his or her health and diseases on the other side. According to the International Occupational Hygiene Association (IOHA), which holds a consultative status to both the International Labour Organization (ILO) and the World Health Organization (WHO), OSH is defined as “the discipline of anticipating, recognising, evaluating and controlling health hazards in the working environment with the objective of protecting worker health and well-being and safeguarding the community at large.”¹

Prevention of general health risks at the workplace compliments the OSH perspective. It takes into account that workers spend at least one third of their lives in the workplace experiencing many spill-over effects from their work to their homes and vice-versa. Since workers’ health also has an economic dimension translating into company productivity, it makes sense to combine OSH with general workplace prevention of ill health. This understanding is reflected in the ILO SOLVE component as part of the SafeWork Program,² as well as in the WHO “Healthy Workplace” framework³.

The perspective of health at the workplace as a combination of influences posed by the physical work environment, psychosocial factors, personal health resources and the community setting builds the bridge to HIV and other diseases. Factors that influence health programming in companies include the specific age structure and gender distribution of the workforce, the kind of workplace and occupational or social health risks involved, and the industry practices to occupational health and social support. Sector-specific approaches to HIV and AIDS provide an opportunity to give guidance for companies on how to meet their specific health needs. Since most industries are organized at the national level, capacity development can use existing association structures. Taking a regional approach to developing sectoral health programs in the private sector creates synergies from similar needs in different countries.

¹ Definition of OSH by the International Occupational Hygiene Association (IOHA): www.ioha.net

² ILO website <http://www.ilo.org/safework/about/lang--en/index.htm> (Accessed 5th Feb, 2010)

³ WHO website http://www.who.int/occupational_health/healthy_workplace_framework.pdf (Accessed 5th Feb, 2010)

This sector-specific and gender-sensitive approach was developed in close cooperation with the East African Business Council (EABC). Since diseases strongly involve medical and social factors, the investigation for the study presented here was conducted by a team consisting of a social scientist and a physician specialized in occupational medicine.

The sectors

Two industry sectors were selected for this investigation on activities and specific needs concerning HIV interventions and OSH structures in the respective EAC countries. This selection was based on a desk study⁴ which selected East African business sectors according to the following criteria:

- Companies belonging to the sectors should possibly be EABC members
- The sectors should have companies in all EAC countries
- The sectors should differ concerning business and workplace type
- The sectors should not yet be well documented on issues related to HIV and AIDS
- Females workers should be represented in the workforce

Based on these criteria, the first order preference was the chemical manufacturing industry and the second order preference was the hotel industry. Both sectors were selected in collaboration with EABC. The selection of the companies and hotels to be visited in the respective countries was undertaken by EABC in close collaboration with the focal points in the respective countries.

The chemical manufacturing industry

In the chemical manufacturing industry, different educational backgrounds and workplace environments (production/office) were represented, as well as various work processes such as manual and computerized. Although EABC membership was not a given in all five EAC countries, the exemplary character of the chemical industry for other manufacturing industries, as well as the complex occupational health and safety situation, justified this lack of criteria fulfilment. The manufacturing associations in all EAC countries, however, are all members of EABC either directly or via the local employers' associations.

The representative of the Rwandan ministry of labour challenged the selection of the chemical manufacturing sector as not being representative of the Rwandan industry situation. He felt that other sectors, such as the currently booming construction sector, would have been a more appropriate choice.

In fact, the chemical manufacturing industry is not currently a booming sector in all of the EAC countries; however, according to the Confederation of Tanzanian Industries it is growing at a significant pace in Tanzania. In Rwanda, it is a fairly strong sector, while in Burundi it is very small. Even in Tanzania, Uganda and Kenya there are not many pure chemical manufacturing companies. The selected companies all produce other goods, as well; only the company in Tanzania, which was also visited, is purely a chemical manufacturing company.

⁴ „Results of a desk study on economic sectors, available approaches for AIDS control and the EABC membership”, Ute Papkalla, September 2009

The hotel industry

The hotel, tourism and restaurant sector is a highly relevant area for all five EAC countries, as it is either well established (Kenya, Tanzania, and Uganda) or booming (Rwanda, Burundi). According to the Tourism Confederation Tanzania, tourism is the number one source of foreign currency in Tanzania and one of the biggest employment sectors.

This sector includes the target groups of employees, as well as guests, as both groups are exposed to risky sexual behaviour. The hotel industry employs a large number of female and seasonal workers and has a high turnover of staff. Although there are several case studies on the hotel industry available, the combination of OSH and HIV interventions has not yet been investigated. A distinction has to be made between small guest houses and big hotels. The small guest houses have to be treated like small and medium-sized enterprises. The field study only included big hotels or hotel chains, as they are EABC members and for reasons of reputation and competition highly interested in occupational health and safety.

The EABC membership of the participating hotels was also not a given in all participating hotels, but it was the case that all participants were members of their respective national associations.

Methodology

The focus of this study was to obtain a comprehensive understanding of occupational health practices and AIDS control activities in the chemical manufacturing and the hotel sectors in all five EAC countries. With this in mind, a consultant team, consisting of a social scientist specialized in HIV workplace programs and a doctor specialized in occupational health and safety, visited different key players in Rwanda, Uganda, Kenya, Burundi and Tanzania. The two researchers spent approximately one week in each country. The selection of the companies for the case studies and the interview partners on policy and technical level was lead by the EABC HIV unit, working in close collaboration with the focal point organisations in the respective countries.

The focal points accompanied the consultant team throughout their visits. In each country, a case study of one company per sector was conducted by using semi-structured interviews in the form of a questionnaire (Annex 1), which was sent to the respective companies in advance. Questions requiring special data could, therefore, be prepared in advance by the relevant interviewees. In the participating companies, the team requested discussions with:

- Top management
- Human resource management
- Person/department responsible for occupational health
- Person/department responsible for HIV interventions
- Focus groups with employee representatives
- Union representatives

It was not, however, possible to talk directly with all targeted groups or persons in every company. In some cases, only representatives of human resources departments were

available for discussions. Due to time constraints, it was also difficult for top management and for members of the workforce to participate in discussions.

On the policy/technical level in each of the respective countries, discussions were held with:

- Selected representatives of sector associations, and umbrella business associations
- National HIV and AIDS control commissions
- National occupational health and safety authorities
- Trade Unions
- ILO, UNAIDS and other relevant development partners in each country

Again, discussions were to be held with various stakeholders, but it was not possible for all of them to meet for interviews in all countries.

Chapter 2: Experiences, observations and recommendations deriving from five hotel companies excluding small and medium-sized guesthouses

General observations relevant to HIV and OSH in a hotel workplace setting

The majority of the workforce in the selected hotels was between ages 24 and 49; however, in Uganda a high ratio of 50% of staff younger than 24 years was reported. This also applied to Burundi to a lesser extent.

The hotel companies in all countries report strict hygiene controls of their food and beverage departments (F&B) by their respective public health systems and in some instances also by the local Bureau of Standards. Some companies have an additional in-company control system. Due to these controls all F&B employees wear clothes according to hygiene regulations and undergo regular medical check-ups. This does not apply to staff working in other departments. Controls of occupational safety and health (OSH) issues are done less vigorously but regularly. Basic security equipment such as fire extinguishers and first aid kits are in place.

In 2009, the East African Countries finalized its first set of common standards of classification for hotels and restaurants in the EAC. This enabled the community to establish common quality standards in the sector. Guidelines and classification criteria for 'star rated' and 'non star rated' accommodation establishments now exist, which also integrate occupational health issues. A training of trainers in the region has been conducted, but further capacity building, especially on health issues, is still outstanding. Raising awareness among hotel businesses on the new classification system is now the next task.

According to statements made by hotel associations in Rwanda and Kenya, commercial sex work is taking place in hotels of all sizes. This may involve external commercial sex workers coming to the hotels, as well as occasional sex work for salary topping up of in-house staff. This involves both heterosexual and homosexual sex. Observations indicate that there is a sex supply chain involving commercial sex workers, taxi drivers, security workers, porters, receptionists, bar managers, etc. It often involves bribery between the different

stakeholders. Since commercial sex work is forbidden or at least is taboo in most countries, the sex supply chain to and from hotels operates in a grey zone. It is not welcome by the hotel managements but has to be tolerated for the sake of guest satisfaction. Neither guests nor commercial sex workers are addressed in terms of risk reduction. The secretive nature of this system also reduces access to health education and preventive testing for those most at risk.

According to a hotel manager in Zanzibar, drug trafficking and abuse are a very common problem on the island which also affects the hotels. The Tourism Association of Tanzania pointed out the specific challenge posed by tourist groups coming from Europe and engaging deliberately in high-risk sexual and drug-abusive behaviour. The Kenyan Hotel Association reports a high incidence of alcohol abuse during night shifts of hotel bar workers due to easy access to alcohol. Drug and alcohol abuse are well-known risk factors for transmission of HIV and other infectious diseases, as well as chronic disease and impoverishment.

According to trade unionists and participants of focus group discussions, the low payment of many workers in the hotel industry is a contributing negative factor to employee health. They reported lack of resources for food and health care. In addition, one association linked occasional sex work of male and female staff to low payment.

Observations concerning health at the hotel workplace

In terms of ergonomic risks, back pain is reported from all departments that require long standing, walking, bending, and heavy lifting such as administration, reception office, repair and maintenance, laundry, and room service. Physical risks like burns, cuts and electric shocks are reported from workplaces in the kitchen, laundry, repair and maintenance, garden and swimming pool. Allergies resulting from chemical hazards involve laundry and swimming pool maintenance. Mosquito bites are the major biological hazard reported in all countries apart from bites from other poisonous insects, snake bites in lodges and general bacteria exposure during cleaning. Psychosocial risks are present where massage is offered as a hotel service. The Uganda hotel also reported robbery of staff on the way to or from work.

The hotels in four countries report upper respiratory chest infections as the major disease occurring. Malaria is named as the second most common health issue. Other diseases that were mentioned as being as significant to workplace health were HIV, diabetes, typhoid, diarrhoea and sexually transmitted infections. No information on the common disease spectrum could be retrieved from human resources personnel at the Uganda hotel.

Some hotels participate in national health campaigns by conducting educational health sessions and offering special medical check-ups (Kenya, Zanzibar, Rwanda). Some companies conduct their own talks on health issues; in Kenya special gender-separated discussions take place. These talks can include both OSH and HIV. Three of the hotels have specially-trained staff on health issues.

The seasonal character of hotel work with peak and off-seasonal periods determines the frequency and intensity of health activities. This applies especially to lodge and beach settings. Hotels in a town setting have year-round business due to business travellers. They can spread their activities over the whole year. Holiday resorts, on the other hand, depend on holiday periods. This leads to a smaller window of time for conducting health activities.

Seasonal workers can hardly benefit from health education because during the off-season they are not at the workplace and during the high season health education is reduced to a minimum. Seasonal workers with a lower educational profile are often recruited from the surrounding villages, while more educated workers migrate from cities to holiday resorts placing them at higher risk for HIV transmission, due to the absence from their homes and social networks. More educated workers are often graduates of hotel and tourism colleges.

The workplaces in hotels are very diverse in terms of educational background and work routine. Some departments work all day long, others have peaks during different times of the day. This makes it challenging to integrate health education in routines. Face-to-face counselling is a model applied successfully in response to the above mentioned challenge in a hotel in Kenya. This is done by the hotel's peer educators.

On the topic of maternity all hotels have to follow the legal requirements of their countries. Apart from this it is mentioned that expecting mothers are expensive to the company. Concerning a recent extension of maternity leave in Kenya, one association member suspected that women now have even more difficulties to find jobs.

A hotel in Kenya is integrating OSH activities with an HIV programme in the form of health talks, medical check ups, peer education and availability of information material. In Tanzania and Burundi, OSH and HIV are dealt with by separate departments despite some overlapping of topics. The deliberate separation of OSH and HIV are due to existing funding structures in these two sites. The Rwandan hotel conducts health education on different health topics including HIV but does not have other HIV programme components such as an HIV policy. The Federation of Ugandan Employers provided two trainings on HIV to the Ugandan hotel. Condoms in all hotels are provided to staff only and not to guests. The combination of OSH and HIV was met with a positive response in four hotels with one hotel expressing no opinion either way. The hotels in Burundi and Tanzania, however, remarked that combining OSH and HIV may complicate fundraising and finance management. On the other hand, it would reduce discrimination.

The hotels in Kenya, Uganda and Tanzania all have private health insurance coverage for their employees. In Kenya and Tanzania, family members of permanent staff are included in the coverage. The Rwandan hotel has its own clinic and refers staff members to other facilities based on a cost-sharing arrangement. The Burundian hotel has contracted public clinic services and offers in-house diabetes screening, as well as chronic disease follow-up.

Absenteeism is monitored in all hotels. Four hotels also reported regular monitoring of injuries and accidents. The hotel managers view high medical costs and management of sick employees as major challenges. Monitoring of sick staff is seen as very time-consuming; others mention non-use of the contracted clinic, absenteeism without excuse, chronic diseases and major surgery as issues. The Burundi hotel mentioned lack of health insurance as problematic. In Rwanda the lack of disability and accident insurance was criticized.

Observations concerning gender issues in hotels

The percentage of female workers in the five hotels at the time of the interviews was between 26% and 39%. They work primarily in room service and at the hotels' reception desks.

The union in Uganda receives anonymous reports of sexual harassment. This is not reported by the hotels but the hotel in Kenya provides a special training on conflict management for female staff. A need for such training was also expressed by staff members of the hotel in Zanzibar.

Females are reported by the Federation of Ugandan Employers to be less knowledgeable of their rights. This leads to lower payment of women, the increased incidence of sexual bribery, commercial or occasional sex work, and inter-generational sex. The Kenyan Union COTU also reports lower salaries for women in general. The Kenya Association of Hotel Keepers and Caterers has observed that bar maids in small hotels are often paid badly with the argument that they get top-ups by way of tips from clients. In addition, the competition for a job in the hotel sector is very high in Kenya. All this creates grey zones and leeway for risky behaviour and sexual exploitation of women.

Night shifts pose a recognized hazard to female staff in all hotels, due to the risk of being raped on the way home. In response to this heightened risk, hotels in Kenya, Uganda, and Burundi provide hotel transport when a night shift is required. The Tanzanian hotel tries to avoid night shifts for female staff, especially for married women.

Needs and gaps regarding OSH and HIV in the hotel workplace setting

The hotels in Rwanda, Burundi and Uganda expressed numerous capacity development needs concerning OSH, health and HIV topics. They need initial training as much as regular knowledge refreshment in all health fields.

The hotel in Kenya observed a lack of advanced OSH training capacities in the Kenyan market, especially with respect to management and control of occupational hazards. The managers see the hotel's OSH and health efforts already at fairly high level, but still see a gap compared to international standards. Having participated in elementary trainings on OSH and HIV, they now want more advanced and professional trainings for peer educators, management and health care professionals. Additionally, management requires support to sustainably integrate OSH aspects into the workflow.

Hotel management in Zanzibar expressed a need for a special training with respect to drug abuse and HIV transmission. Furthermore, community outreach is regarded as a necessary next step to enhance its activities.

The Rwandan hotel views disability and accident insurance coverage as desirable. The Ugandan hotel would like to have more protective equipment and education on its proper use.

Important gaps identified in the hotel industry

Insufficient capacity

Despite the fact that the hotels in all countries have knowledge of basic occupational safety and health, there is still room for further awareness creation and information on OSH issues and their solutions. It is not necessarily understood, for example, that a loose wire is not only a technical problem, but also a health risk which affects the productivity of the company. On the same note, a psychosocial hazard like sexual harassment at the workplace is also an occupational health issue. This connection is not always made. The knowledge on

the multitude of workplace influences on staff health and, thereby, on company prosperity can be further extended through internal trainings and external needs assessments.

The knowledge and awareness level seems to differ between countries. The Kenyan hotel, for example, expressed a need for more advanced training that would help the hotel branch to reach higher international standards. Due to differing AIDS epidemics and situations in EAC countries, this is even more the case with respect to HIV at the workplace. While Kenya, Uganda and Tanzania are more experienced in HIV interventions, Rwanda and Burundi are still starting to implement activities. Training needs exist here concerning all areas of HIV prevention, anti-retroviral treatment and impact mitigation.

Generally, all hotels would benefit from a greater understanding of the complexity of HIV transmission as it relates to hotel workplaces. Furthermore, more targeted approaches are needed that take into consideration the needs specific to adolescents and young adults, as compared to adults in family situations; women also have other information requirements than men.

Capacity building with respect to OSH, HIV and other health issues is also needed at regional level for the trainers who are currently imparting the knowledge, and assessment competency is needed for the East African standardization process of the hotel industry. This process is still in its initial phase, which makes this an appropriate time to integrate capacity development on OSH and health issues.

Division of responsibility for OSH and HIV

When HIV workplace programs were first introduced in East African countries, they were not included in existing OSH efforts. This was partly due in part to the fact that HIV was not seen as an occupational health issue and partly because of exclusive funding opportunities for AIDS. In all countries, separate institutions exist which deal with HIV at the workplace and OSH at the workplace. They lack the vision and means of cooperation, which is often fuelled by a lack of information of one about the other. Opportunities for cooperation have to be identified and enhanced by way of technical trainings that introduce the use of new instruments, such as checklists that include HIV and other relevant health issues.

According to one hotel in Kenya, combining OSH and HIV under one umbrella approach has been advantageous because it has helped to reduced both programme costs and employment-related discrimination against people living with HIV/AIDS. Other companies still have two separate programs, or are in the process of establishing HIV interventions apart from other occupational health efforts. Since the international health discussion is oriented towards a comprehensive health approach integrating HIV, this does not seem advisable anymore.

Seasonal, migrant workers unaddressed

As in the case of other business sectors, migrant workers are specifically vulnerable to HIV transmission. Unfortunately, they are also especially hard to integrate into workplace activities. Seasonal migrant workers in the hotel industry require targeted approaches either during their periods of employment or during their professional education phase outside of employment.

Insufficient response to sexual harassment

Sexual harassment is a phenomenon which is recognized by the hotel sector as a hazard to

women. Certain interventions like avoiding late night shifts and providing transport are important responses. These, however, are not sufficient. Women need to be educated about their rights and require a reference person for confidential support in the case of sexual harassment. Hotel managements also need to become aware of salary inequalities and unofficial structures like tip systems which might create dependences and pressures on female staff to engage in risky behaviour. Training in conflict management is a specific intervention that should be given to females working in the hotel sector to empower them to respond to sexual harassment.

Challenges posed by the sex supply chain

Commercial sex work is an unwelcome but real phenomenon of hotel businesses in all five EAC countries, since it is created by guest demand and commercial sex supply. Though it is illegal, hotels use their policies related to registration and room occupancy to manage it. Bribes are paid by commercial sex workers and their customers in order to access the hotel in search of business, or to access rooms. Various staff working during night shifts can be involved in this negotiation process. Taxi drivers often serve as resource persons and brokers to hotel guests looking for commercial sex workers.

Unregulated transactional sex is a dangerous source of sexually transmitted infections (STI), including HIV. Commercial sex workers require more access to information that will help them to understand the benefits of regular STI screening, and need easier access to condoms for protection. Ways must be identified to utilize this sex supply chain for health education and also for provision of protective devices to hotel guests. Since it cannot be wiped out, it has to be turned into a safe sex supply chain. Since commercial sex work is a challenge not unique to one hotel, but common to the whole industry, the solutions should involve joint action on the part of the hotel sector, generally. United action with other hotels may achieve a milestone in efficient STI control among a high risk group at lower costs.

Knowledge gap on drug abuse and disease transmission

Drug and alcohol abuse create physical and psychosocial risks for poor health. The hotels need more knowledge about dangerous behaviour like needle sharing, flash blood practices or the vicious circle of addiction and prostitution. Information materials and training are required to inform staff and drug consumers about the risks.

Suggestions for hotel industry-specific OSH and HIV interventions at three different levels of approach

Approach level 1: EABC regional activities

Activity A) Harmonization of OSH and AIDS control at regional and national level

EABC cooperates with the EAC OSH initiative and national OSH institutions to identify areas of cooperation and to achieve a better integration of HIV into national OSH plans concerning the hotel sector.

Sub-activities: Joint meetings, trainings on HIV for OSH specialists, development of instruments like checklists for assessment that cover HIV workplace, and inclusion of HIV specialists in Regional consultative meetings on standards and regulations.

Activity B) Strengthening OSH and AIDS control in the EAC hotel classification process

EABC strengthens the competencies and capacities relating to OSH and HIV of the national assessors and regional trainers, who promote and support the East African hotel standardization process.

Sub-activities: Review and development of best integration of HIV into classification system, standards, trainings on OSH and HIV for national trainers and consultants or accrediting institutions such as colleges,

Activity C) Development of training and assessment capacity of national hotel associations and other support institutions

EABC enhances the capacities of national hotel associations, training colleges and other relevant institutions on OSH and HIV programs, as well as good practices, such as trainings on conflict management for women.

Sub-activities: Various francophone and anglophone trainings, review of assessment and accreditation tools

Activity D) Feasibility study for a Hotel Industry Health Fund

EABC investigates the potential and feasibility of a health fund for the hotel industry for insurance purposes of HIV and other preventive and curative health issues.

Sub-activities: Contracting a consultancy

Approach level 2: National activities of industry associations and other relevant institutions in the EAC countries

Activity A) Creation of assessment services for companies

Hotel associations and other institutions offer in-house assessment of and advice on occupational hazards and health issues at the workplace.

Sub-activities: Company visits, assessment advice

Activity B) Provision of training courses for companies

Hotel associations and other institutions provide external training courses to hotel staff and management on identified training needs such as conflict management for female staff, prevention of back pain, assessment and better control of occupational hazards, use of protective equipment, hygiene issues and malaria prevention.

Sub-activities: Various target-group oriented trainings

Activity C) Integration of OSH and HIV in professional college curricula

Curricula modules on OSH and HIV for professional trainings for service staff are developed jointly with college managements, OSH specialist and other stakeholders.

Sub-activities: Development of curricula, training of teachers

Activity D) Shared social worker and counsellor for health education

Hotels jointly finance a shared social worker and counsellor for demand-driven external counselling of hotel staff. In addition, this professional provides health education, counselling and support to high risk groups, such as commercial sex workers.

Sub-activities: Development of terms of reference and a work plan, training

Approach level 3: Activities at company level

Activity A) Adapt hotel company OSH and HIV activities to needs

Companies review their existing workplace activities on OSH and HIV to integrate both and to add missing services such as age-group-oriented education, gender-separated health discussions, night transport, active disease prevention i.e. malaria prevention including mosquito spraying, and distribution of bed nets.

Sub-activities: Review of work plans, planning and budgeting of activities, development of monitoring

Activity B) Extend regular medical check-ups

Companies extend regular medical check-ups from F&B staff to all staff. In addition to hygiene issues other health topics should be included. Nutritional advice and education is needed to reduce the incidence of diabetes.

Sub-activities: Cost-analysis, arrangement of check-up services

Activity C) Introduce spokeswoman for female staff

Companies install a spokeswoman for female staff to record inequalities, complaints and problems arising from issues like sexual harassment.

Sub-activities: Sharing Experiences, development of a concept note

Chapter 3: Experiences, observations and recommendations deriving from five chemical manufacturing companies in the EAC

General observations relevant to HIV and OSH in a chemical manufacturing workplace

The age structure in the visited chemical manufacturing companies is diverse. The younger age group under 24 years makes up between 15% (Kenya, Rwanda) and 60% (Burundi) of the workforce. Most workers (except in Burundi) are between 25 and 49 years old.

The ratio of female workers is low in chemical companies. It ranges around three percent in the visited sites, except for the company in Kenya, where the ratio ranges at 30%. Gender issues include the accommodation of few women in a predominantly male workshop, i.e. the provision of separate change and wash rooms for women and men. Female staff is mostly employed in administration and, therefore, does not work night shifts. Female employees, however, have divergent health information and impact mitigation needs.

According to the Principal (Factories) safety inspector in the Occupational Safety & Health Department in the Ministry of Gender, Labour and Social Development in Uganda, female workers are not empowered and knowledgeable enough about labour laws and, thus, may be underpaid. Also, sexual favours may be expected from women for employment, promotion or other company internal interest.

The ILO representative in Uganda stated that the leave days for female workers needs to be reconsidered, as the “cultural role” of the woman is to take care of sick relatives. Companies could provide support to women in this regard.

Production needs and challenges may lead to extended working hours due to frequent power cuts. For example, in Burundi, during the day, the day shifts often extend into the night when power becomes available again. Also in Burundi, workers sometimes work overtime and long shifts of more than 12 hours due to power cuts during the day. Due to a shortage of workers, it also may occur that workers have to report to work even when they are on sick leave.. Work situations like these may compromise the ability to concentrate of people operating heavy and/or dangerous machinery or work processes.

The ratio of casual workers is reported from Uganda as being 40% and from Tanzania as being 17%. Those who are hired on a daily basis or receive lower salaries than permanent staff are difficult to motivate for after-work health education or to participate consistently in sessions. The CESTRAR Union Rwanda links underpaid work with malnutrition of workers and lack of health care.

OSH regulations exist on the national level and are currently being updated as part of an EAC-led initiative. Government auditors for OSH also exist in all countries, but partly face restrictions in terms of number of trained auditors (Burundi) or funds for transport (Tanzania) to sites, so that regular controls are not reported by all companies. In addition to national regulations, some companies also have their own regulations which translate into policies and manuals (Kenya and Uganda). Other companies have assembled less comprehensive material, such as posters and leaflets.

Observations concerning health at the chemical manufacturing workplace

First aid kits are in place in all companies. One company reports the availability of an ambulance for the factory. While all companies report availability of general protective equipment, non-adherence and non-usage occurs. Further, protective equipment may be insufficient in number for all employees. The Federation of Ugandan Employers noted that local companies often have to use second-hand and outdated protection equipment imported from Europe. They also underlined that lack of education and illiteracy undermines proper use of protective gear. The CESTRAR union in Rwanda criticized the lack of education and training provided by companies with respect to operation of complicated and dangerous machines. They also challenged the availability of sufficient protective gear against chemicals. Some companies provide milk as a means against toxification. The Burundi Manufacturing Association noted that only a few companies provide protective devices such as masks. This observation was supported during the focus group discussion with workers of a Burundian company. The standards of workplace activities on OSH and HIV differ between companies. The company in Kenya conducts a high standard OSH risk management program and an HIV workplace programme with support of the Kenyan HIV/AIDS Business Council. Other companies provide some education on OSH issues through internal or external trainings, as well as basic HIV preventive action like condom distribution. Peer educators are trained in the companies in Uganda, Tanzania, Burundi and Kenya. The implementation of peer education sessions varies from never implemented to actively implementing. Those companies that are in contact with their local business coalition against AIDS seem to have more effective per education. According to the Federation of Kenyan Employers, the companies experience high drop-out rates of staff, making it necessary to train new peer educators on a regular basis.

In the chemical companies' ergonomic risks due to heavy lifting and repetitive movements lead to back pain. Companies in Kenya and Uganda state that they offer employees the opportunity to work in other workplace settings when they experience back pain. Biological hazards are not reported for the chemical companies. As psychosocial risks, traffic accidents and insecure ways home are mentioned. The main risks in chemical companies are posed by mechanical and chemical hazards. Common injuries are caused by operating machines, resulting, for example, in lost limbs, contusions and burns. Noise and fumes, non-functioning fans, as well as allergic reactions are further threats. Allergies, eye and skin irritation, as well as toxification also plague these companies. Only one of the five companies provides clean water dispensers. Regular drinking of clean water dilutes the accidental intake of small amounts of chemicals. These hazards endanger healthy workers and even more so people with chronic diseases, especially those living with HIV, due to their suppressed immune system.

According to the EAC Principal Labour and Employment Officer, the professional and supportive capacity for risk assessment and response planning is insufficient in East African countries. To date, only two East African Universities offer courses in OSH. One company reports insufficient knowledge about proper handling of chemical agents and production accidents. The latter involves first aiders as well as fire fighters and the medical emergency chain alike. For a precise and efficient treatment, the character of the chemical agent has to be known as well as the proper antidote. Milk is recommended as the primary antidote for

any chemical poisoning, but there are no studies that demonstrate the benefits of this practice in people⁵.

Malaria, upper respiratory tract infections, as well as gastro-enteric infections caused by parasites and typhoid bacteria are major illnesses causing absenteeism in the industry. The company in Burundi responds to malaria with free mosquito nets. It also reported malnutrition as prevalent and distributes soap to promote better hygiene practices. The company in Rwanda established a canteen and free water provision in order to reduce cases of gastro-enteric diseases. In Tanzania, according to company officials, sexually transmitted infections have decreased thanks to education and better treatment.

The companies in Rwanda, Burundi, Uganda and Tanzania have their own company clinics which differ in terms of staffing and equipment. They range between health post level with only one nurse and a better equipped unit with clinical officer, nurse and medical technician. In addition, reimbursement and insurance schemes exist, some of which offer different coverage for permanent and temporary staff, as well as for different salary levels and with respect to inclusion of family members.

Four companies mentioned their struggles with the financing of health care. One company feared accidents most, due to their costs. Another company criticized that permanent workers often do not know the insurance scheme and exceed its limits. A third company intends to introduce a co-financing arrangement for the workforce. A fourth company complained that the workers do not care sufficiently for their health and only adhere to check-ups if they are mandatory. In the same company, workers mentioned that confidentiality gaps exist, a contributing factor to lower uptake of company-provided HIV testing.

All companies monitor absenteeism and injuries. Internal and external monitoring mainly refers to occupational safety and health and not to HIV-related activities.

Needs and gaps identified in chemical manufacturing companies

Needs identified by the companies

In terms of workplace interventions against HIV, some companies require basic knowledge on prevention, care, treatment and impact mitigation. Others with active programmes need support in terms of monitoring and new means to sustain the programme after the duration of external funding had ended. Support for people living with HIV and for orphans was explicitly mentioned. The companies in Kenya and Tanzania see possibilities for involving supply chain companies in activities, if funds were made available.

The Burundian company requested prevention teams from outside to educate on HIV, malaria and other health issues including hygiene. Since a big part of the workforce is illiterate, this education has to be targeted to their education level. The Rwandan company generally involve professional assistance and assessment in order to reach international standards on OSH. Company employees from Burundi, Kenya and Tanzania remarked that their staffs require better information and training on the chemical substances that they are working with, including a risk mapping on health and environmental hazards.

⁵ Canadian Centre for Occupational Health and Safety. Website: <http://www.ccohs.ca/oshanswers/chemicals/firstaid.html>

Regular and confidential check-ups, especially for chronic diseases, were requested by the workforce in Kenya. They also asked for removal from hazardous workplaces, as well as provision of light duties for people with chronic disabilities. The Burundian workforce called for more testing for HIV and tuberculosis.

Insufficient knowledge about OSH, HIV and labour laws

Despite the legal regulations and the additional efforts on the part of the industry, there still prevails a lack of knowledge about occupational hazards. Basic requirements are fulfilled, but the risk assessment respective to the handling of chemical substances, production methods, machines, etc., should be improved. Clear information about all aspects of the production line should be made available to every employee based on the principle “know your chemicals.”

Information and knowledge is also insufficient with respect to emergency situations. Training is needed for first aiders, as well as the shop floor management and the medical support chain from the emergency transport to the referral health facility. Regularly scheduled educational sessions are also required with respect to labour laws so that workers are empowered to resist production practices that may heighten their health risks at the workplace.

To increase company productivity, health education has to comprise all aspects relevant to workforce health. An analysis of common diseases is needed to define the information needs of the workers, i.e. with respect to HIV and hygiene. The companies require internal and external education to leverage the health understanding of the workforce. Existing health education often ignores the level of general education and literacy of employees. It is also more efficient to target information, e.g. between men and women. There is a lack of knowledge and empowerment for female workers to resist sexual harassment at the workplace.

Inadequate risk assessments and response plans

Companies with products and production lines involving hazardous ingredients and dangerous machines require competent risk assessments and response plans for each step of the production line. The capacities and competencies with respect to OSH have to be enhanced in the chemical sector in East Africa. This is necessary in order to provide companies with external support for developing tailored OSH plans for the various company settings.

A special situation exists with respect to people living with HIV. Their needs for special protection should be sufficiently recognized in the chemical manufacturing setting. Light duties and workplace alternatives should also be reliably available for people working in this sector who also have chronic disabilities. Innovative ways for impact mitigation of immune-system-weakening diseases like HIV/AIDS need to be found such as the creation of a ‘sick day bank’ to collect and share voluntarily donated employee sick days with colleagues in need.

HIV interventions are not optimized

Components of an HIV workplace program are often implemented but they still need to be

incorporated into the general OSH framework of the company to make them continuous and sustainable. This holds especially true for companies that receive temporary external support for HIV activities. Opportunities created by the type of workplace are insufficiently identified and used.

Insufficient safety equipment in the workplace setting

The means to creating a safe workplace setting need to be recognized and utilized. Sources of bad health such as lack of ventilation in the production hall, dirty water, etc., need to be acknowledged and eradicated. Short-term improvements to workplace health, such as providing employees with a canteen that offers healthy meals, providing water dispensers in the production hall, etc., could be undertaken. The OSH equipment is also not specific enough about the risks posed to workers by workplaces of individual companies.

Suggestions for chemical manufacturing-specific OSH and HIV interventions at three different levels of approach

Approach level 1: EABC and EAC regional activities

Activity A) Harmonization of OSH and HIV at regional and national level with special consideration of the needs of chronically ill workers

EABC cooperates with the EAC OSH initiative and national OSH institutions to identify areas of cooperation and to achieve a better integration of HIV into national OSH plans. Special consideration should be given to the harmful effect of occupational hazards on PLWHA and other chronic disease patients.

Sub-activities: Joint meetings, trainings on HIV for OSH specialists, development of instruments like checklists for assessment which cover HIV workplace programs

Activity B) Development of training and assessment capacity of national manufacturing associations and other advisory and assessment bodies

In cooperation with national manufacturing associations and OSH institutions, national support structures for assessments of occupational safety and health are identified. Trainings of national trainers and consultants on OSH and HIV in the manufacturing industry are provided. Special capacity is built with respect to handling of chemicals and assessment of risks arising from manufacturing.

Sub-activities: Various Francophone and Anglophone trainings, review of assessment and accreditation tools

Activity C) Development of information materials

Resource materials are developed which provide target-group oriented information on the risks and the protective means that come with chemical manufacturing. The content shall cover the danger of explosion, the reaction of different chemicals, danger of fire by chemicals, danger of toxic fumes etc.

Activity D) Feasibility study for a Manufacturing Industry Health Fund

EABC investigates the potential and feasibility of a health and social security fund for the chemical manufacturing industry for insurance purposes of preventive and curative health action as well as rehabilitative medicine.

Sub-activities: Contracting a consultancy

Approach level 2: National activities of industry associations and other relevant institutions

Activity A) Provision of trainings to companies

National manufacturing associations or other institutions relevant to the manufacturing industry provide training courses on OSH and other health issues to companies.

Sub-activities: In-house and external trainings

Activity B) Creation of assessment services for companies

Manufacturing associations and other institutions offer in-house assessment of and advice on occupational hazards and health issues at the manufacturing workplace.

Sub-activities: Company visits, assessment advice

Approach level 3: Activities at company level

Activity A) Improve workplace according to OSH standards

Companies improve their workplaces according to OSH standards and regulations. To enhance adherence companies introduce a closer monitoring and incentive system.

Companies especially assess risks for people living with chronic diseases like AIDS.

Sub-activities: Needs assessment, costing analysis, work plan development

Activity B) Define and inform emergency medical support chain

Companies plan for emergency medical support and evacuation and define special information needs along the support chain. Information is then provided to the staff members and service providers involved in the emergency chain.

Sub-activities: Assessment of emergency support chain, information materials, trainings

Activity C) Acknowledge female needs with respect to health and health care

In order to empower female employees, a spokeswoman or female union representative can be introduced. The collaboration with the Unions should be proactively undertaken, in order to protect the female employees against sexual harassment or forced unsafe sex. Companies could consider a solution such as a sick-leave sharing bank in order to support female staff members, who are taking care of sick family members.

Chapter 4: Conclusions

The visits and interviews with companies in the hotel industry and the chemical manufacturing industries revealed important sector disparities regarding OSH and AIDS control. The sectors differed in terms of health and social issues, the focus of health activities and the needs relating to health.

While hotels underscore regular hygiene and fire safety controls, they are less vigorous about general OSH controls. This is in contrast to chemical manufacturing companies, which have to deal with OSH in a very comprehensive manner. In terms of health problems, it was found that similarities exist between the sectors regarding common diseases, including respiratory infections and malaria. The stricter hygiene controls in hotel companies may be the reason why hotels reported lower incidence of gastro-enteric problems than did study participants in the chemical manufacturing industry. HIV was also not mentioned by any of the companies interviewed as their primary health concern. Capacity gaps prevail in the chemical manufacturing industry with respect to identification and awareness of hazards, risk assessment, response planning and proper safety equipment for workplaces. The potentially encumbering environment of a chemical manufacturing workplace poses special challenges to the support and protection of chronically ill workers, such as people living with AIDS. To a lesser extent, chemical manufacturing businesses face fewer challenges around social issues. Activities targeting the chemical manufacturing industry have to target the development of specific OSH capacities with integrated measures around HIV/AIDS control and protection of chronically ill employees. As family caretakers are primarily women, a special regulation concerning leave days for taking care of sick family members could be considered. For support and empowerment of women against sexual harassment, a female spokesperson or female union representative could be introduced.

Hotels employ far more women than do chemical manufacturing companies. This creates the need for gender-specific interventions, including conflict management and empowerment to resist sexual harassment. Hotels are also more influenced by seasonal work; a high number of seasonal employees make continuous health education difficult. Commercial and occasional sex work is a risk factor connected to a hotel setting due to customer demand and commercial sex supply. Although hotels are only indirectly involved in the sex supply chain, they provide a good entry point to address high-risk behaviour and to leverage health information and services. Activities targeting the hotel industry thus need to address to a greater extent gender and social issues. An extension of OSH activities beyond hygiene and fire safety will provide room for a better integration of HIV and other health issues.

Currently, national frameworks in EAC countries for OSH and AIDS control at the workplace overlook interconnections and synergies between the two that could create better support and monitor mechanisms, save resources and enhance sustainability. The synergetic alliance between OSH structures and workplace health promotion requires a policy process at regional and national level. Parallel processes such as the development of an East African hotel and restaurant classification system or the review of all EAC national plans for occupational safety and health provide ample opportunity to integrate workplace health promotion and AIDS control into OSH practices.

Finally, while this study set out to discover the major challenges associated with linking AIDS control and OSH at the workplace, there are numerous critical issues that this study did not address, but that should be taken up by future investigations in order to better link the two.

More specifically, what this study does not address is the interlinking of OSH with industry, the state and insurance; the identification of specific work-related health issues; an analysis of the costs associated with and access to work-related accident and health insurance; (road) accidents on the way to and from work; and the preparation of a database of hazardous materials and health hazards. Also, specific to OSH issues for working youth and mothers, the study does not address regulations that set maximum limits on weekly working hours and prescribed rest breaks during working hours.

ANNEXES

Question guideline for the development of sector-specific approaches to occupational health and HIV

The East African Business Council (EABC), in cooperation with German Development Cooperation (GTZ), wants to contribute to an improved employee health management of its members. Over the past two decades HIV/AIDS has become a special threat to businesses operating in Africa. HIV/AIDS workplace programmes have been developed in response. Apart from the challenges posed by HIV/AIDS, companies in Africa also face a considerable number of general health problems within their workforces, as well as specific occupational health risks. EABC and GTZ have, therefore, commissioned a consultancy mission to establish exemplarily the comprehensive health management situation and needs of companies in two selected business sectors. The results of this situational analysis and needs assessment shall guide the way to a better integration of HIV/AIDS prevention, general disease management and occupational health and safety.

The following questionnaire is meant to provide you with an impression of the questions which will be asked by the consultants. It is not intended to be filled in by a company representative, but shall rather serve as a guideline for discussions with different company representatives: a member of top management, the human resource department, the occupational health service, and selected workforce representatives. Parts of the questions might be difficult to answer because they do not fit precisely the company's structures. Others may require preceding preparation.

EABC and GTZ would highly appreciate your company's sincere attention to and support of this study. Following compilation of the study's results, a meeting of all participating stakeholders will be held in the beginning of the coming year in order to bring theory down to practice. Our objective is to create a profound basis for industry-specific approaches that provide a basis for addressing all major health-related concerns within a business sector.

This question guideline includes:

- Questions for the general management
- Questions for the HR department
- Questions to the person responsible for occupational health (HR manager, company doctor or nurse)
- Questions for representatives of the workforce

Kind regards,

Charles Mbogori, EABC

Dr. Birgit Lampe, GTZ

Questions for the general manager

1. General information on the company	
1.1. Name of the company	
1.2. Governance structure (Board governance, family business, etc.)	
1.3. Hierarchy levels (managers, shop stewards, workers, etc.)	
1.4. Where is the principal office of the company located? Where do additional production or branch sites exist?	
1.5. Do you see employee health as a factor in your company productivity? Yes/ no	
1.6. Which diseases would you see as the major challenge to your employees' health?	
1.7. Is HIV/AIDS a problem in your company? Yes/ no	
1.8. What is your company's responsibility for employee health?	
1.9. Do you have a policy with respect to health y/n and, specifically, to HIV/AIDS? y/n	
1.10. Who is responsible in the company management for employees' health? Which department? How is the communication and networking with the top management organized?	
1.11. What do you expect from the individual employee with respect to health and healthy behaviour?	
1.12. What are the needs of your company regarding occupational health and safety and HIV and AIDS programmes?	

Questions for the HR department

2. Employees	
2.1. What is the total number of employees?	
2.2. What is the percentage of women working in the company?	
2.3. Which percentage of your workforce is permanent, which percentage is casual?	
2.4. Which percentage of the work is skilled work, requiring professional training?	
2.5. What does the age structure of your workforce look like? Percentage of 15 – 24 y, 25 to 49 y, above 50 y?	
2.6. Where do the employees mainly live?	

3. Workplaces	
3.1. Types of workplaces admin Cleaning, room cleaning, kitchen, serving, reception, driver, security, ... Production, sales, storekeeping, security, admin, transport, packing, cleaning, kitchen, laboratory, etc.	
3.2. Do some workplaces require shift work? y/n, which	
3.3. What are the main female workplaces? Is shift work involved in some? y/n	
3.4. What are the main male workplaces? Shift work?	
3.5. In which department are the most employers? How many?	

4. Health financing and coverage	
4.1. Is health a cost factor in your annual expenditure budget? y/n	
4.2. Do you monitor absenteeism? y/n	
4.3. Do you encounter absenteeism due to the need to care for sick relatives? y/n	

<p>4.4. Does the company provide a private health insurance for employees? Public health insurance? Health provider contracts? Reimbursement of medical expenses? No medical support?</p>	
<p>4.5. Is it a full finance or co-finance arrangement (employee has to co-pay)?</p>	
<p>4.6. Who is covered by your medical support arrangement? Only employees? Employees and family? How many children?</p>	
<p>4.7. How does the company manage employees with chronic disease?</p>	
<p>4.8. How does the company deal with unfitnes for work?</p>	
<p>4.9. Does a person on sick leave continue to receive payment/salary?</p>	
<p>4.10. Which challenges do you face with respect to health care for employees?</p>	
<p>4.11. Which are the most expensive health problems for your company? Does the company pay for accidents at workplace?</p>	
<p>4.12. Which employee behaviour do you regard as risky to their health?</p>	
<p>4.13. In which areas of health care do you see support needs of your company?</p>	

**Questions to the person responsible for occupational health
(HR manager, company doctor or nurse)**

5. Occupational health structure	
5.1. Is there a company clinic, health post or on-site medical support? y/n	
5.2. If yes, does the company employ a medical doctor or a nurse? Y/n	
5.3. Does the company conduct medical examinations as part of the recruitment process? Y/n	
5.4. Are there regular medical check-ups? Y/N	
5.5. Has the company developed occupational health guidelines? Y/N Are these guidelines adhered to? Y/N Are they regularly reviewed? Y/N	
5.6. Is anything available for medical emergencies like first-aid equipment or transport? Y/N , what	
5.7. Do you have health champions or people in charge of health and emergencies on the shop floor? Y/N	
5.8. Do you conduct occupational health education? If yes, how often, which contents. How are the branches involved in this health education?	
5.9. Is protective equipment needed and available? To which percentage is it used? How do you control the proper use of this equipment?	
5.10. Is there an injury monitoring system? Y/N	
5.11. Is there an external control of the occupational health situation? Y/N if yes what	
5.12. Which health risks are associated with the workplaces? groups	
5.12.1. Biological hazards (i.e. exposure to microorganisms, viruses, medical waste, etc)	

5.12.2.	Psychosocial hazards (i.e. violence, mobbing, insecure ways home, rape, robbery, alcohol abuse, etc)	
5.12.3.	Ergonomic hazards (i.e. repetitive movements, heavy weight lifting, etc)	
5.12.4.	Mechanical / physical hazards (i.e. fire, explosion, chemical reactivity, machine operations, temperature, noise)	
5.12.5.	Chemical hazards (i.e. hazardous chemical materials and toxins? Which ones?)	

6. Health problems		
6.1.	Which health problems do appear in the company (i.e. via own clinic or sick-certificate)? Which are the most frequent diseases?	
6.2.	How often do you see sexually transmitted infections (STI) among the diseases?	
6.3.	Do you have the impression that some of the diseases are opportunistic infections due to AIDS?	
6.4.	Are there differences between male and female employees with respect to diseases?	
6.5.	Which are the most expensive health problems?	
6.6.	What preventive strategy do you have to deal with these problems?	
6.7.	Do you involve family members of employees in prevention and treatment? If yes, how?	
6.8.	Are there areas of improvement with respect to the occupational health care of your company?	

7. HIV/AIDS workplace activities		
7.1.	Is HIV/AIDS an issue in the company? Y/n	
7.2.	Is HIV dealt with separately, or as part of the overall health concern?	
7.3.	Who is dealing with HIV issues in the company?	
7.4.	Does the company conduct HIV prevention activities? Which activities?	

7.5. Do you conduct voluntary counselling and testing (VCT) activities? How successful are they?	
7.6. Do you provide anti-retroviral treatment (ART) to employees with AIDS? How is this organized?	
7.7. Has the company developed an HIV policy?	
7.8. Does the company use educational means such as peer education?	
7.9. If an HIV programme exists, how active is the programme?	
7.10. Is funding allocated in the budget to support the HIV/AIDS programme? Y/N	
7.11. Does the company partner with other institutions in this respect?	
7.12. Does the company reach out to surrounding communities?	
7.13. Does the company extend its programme to companies within its supply chain?	
7.14. How could HIV best be integrated into the general occupational health care?	
7.15. What are your support needs in this respect?	

Discussion questions for representatives of the workforce

Discussion input	
1. What do you do when you are sick?	
1.1. Who is paying for medical treatment for you, your wife, your children?	
1.2. How does the company deal with employees who are sick or unfit for work?	
1.3. Do you inform the person responsible for sick leave on the reason for your absence from work?	
2. What are major health concerns of you, your family and your colleagues?	
2.1. Do you think many people are sick due to AIDS?	
2.2. What are the main causes of sickness which lead to absence from work among the colleagues?	
2.3. Which diseases do you see as preventable (i.e. through healthy behaviour, better protection)?	
3. Which health risks are associated with your workplaces (i.e. biological, chemical, psychosocial, and physical)?	
3.1. What do you think about health education in your company?	
3.2. What does your company do against AIDS?	
4. What are your needs with respect to disease and, specifically, HIV prevention?	
4.1. How could HIV best be integrated into the company's approach to health at the workplace?	

EABC Regional Working Group Focal Point Organisations

EABC Regional Working Group, Focal Point Organisations				
Country	Organisation	Representative	Position	Website/E-Mail
Rwanda	PSF	Clemence Murekatete	HIV and AIDS coordinator	clemencem@psf.org.rw
	Private Sector Federation			
	Rwanda			
	P.o.box 319 Kigali-Rwanda			
Kenya	Kenya HIV/AIDS Private Sector Business Council	Dr. Hellen Magutu	Programme Manager	hmaguto@gmail.com hmaguto@kabcnetwork.org www.khbcnetwork.org
Uganda	Federation of Uganda employers	George Tamale	Director Employment Relations	fue@infocom.co.ug
	P.O. Box 3820 Kampala, Uganda		Training Counsltancy&HIV/AIDS	www.employers.co.ug
Burundi	A.E.B	Gaspard Nzasabira	Secretaire General	assoae64@yahoo.fr
	Association des Employeurs du Burndi			
	A.I.B			
	Association des Industriels du Burundi			
	B.P1 41 Bujumbura-Burundi			
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