

**ADHERENCE TO OCCUPATIONAL SAFETY AND HEALTH
MEASURES BY EMPLOYEES IN SELECTED RESTAURANTS
IN KAMPALA DISTRICT**

BY

ZIPPORAH AJAMBO

2010-BSCPH-FT-038

An Undergraduate Research Report Submitted to the Institute of Health
Policy and Management in Partial Fulfillment of the Requirements for the
Award of a Bachelor's Degree in Public health of International Health
Sciences University.

SEPTEMBER, 2013

DECLARATION

I declare that ***ADHERENCE TO OCCUPATION SAFETY AND HEALTH MEASURES BY THE EMPLOYEES IN SELECTED RESTAURANTS IN KAMPALA DISTRICT*** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. This work or any part thereof has not previously been submitted in any form to the University or to any other body whether for the purpose of assessment, publication or any other purpose.

SIGNATURE

AJAMBO ZIPPORAH

DATE

SUPERVISOR: DR. PETER KIRABIRA

Signature _____

Date _____

DEDICATION

This Dissertation is dedicated to my dear father MR. WUMAH JAMES and mother MRS. MORO VIOLET who have both supported me in diverse ways to make this work and studies in general a success.

ACKNOWLEDGEMENTS

First and foremost, I want to thank my heavenly father JEHOVAH who has given me the strength to go through all the difficult and trying times. I also wish to thank all the study participants who have been interviewed for having the patience to endure such a time-consuming interview. I also wish to thank the restaurant managers and the food service supervisors who made it possible for me to have uninterrupted interviews with the restaurant workers.

I am also grateful to my mother, Mrs. Moro Violet for her continued support throughout my research

To my supervisor; Dr. Peter Kirabira, I extend my sincere appreciation to him. His experience and constructive criticism in the respect of supervision assisted me in completing my research.

Lastly, I also wish to express my special thanks and appreciation to Mr. Robert Afayo and Mr. Pardon Akugizibwe for their support, encouragement and advice.

TABLE OF CONTENTS

DECLARATION.....	i
DEDICATION.....	ii
ACKNOWLEDGEMENTS	iii
TABLE OF CONTENTS	iv
LIST OF TABLES	viii
LIST OF FIGURES	ix
ABBREVIATIONS.....	x
ABSTRACT.....	xi
CHAPTER ONE	1
INTRODUCTION.....	1
1.0 Introduction.....	1
1.1 Background to the study.....	1
1.2 Background to study area.....	4
1.3 Problem statement.....	5
1.4 Research objectives.....	6
1.4.1 Main objective.....	6
1.4.2 Specific objective.....	6
1.5 Research questions.....	6
1.5.1 Main question.....	6
1.5.2 Specific questions.....	7
1.6 Significance of the study.....	7
1.7 Justification of the study.....	7
1.7 Conceptual Framework.....	8
CHAPTER TWO	10

LITERATURE REVIEW	10
2.0 Introduction	10
2.1 Level of adherence to OSH measures	10
2.2 The socio-demographic factors affecting the adherence to OSH measures of the employees in restaurants	11
2.2.1 Age.....	11
2.2.2 Gender	11
2.2.3 Work experience/length of service.....	12
2.2.4 Level of education	12
2.2.5 Monthly income.....	13
2.3 Knowledge of employees in restaurants about occupational safety and health measures. .	13
2.3.1 Aware of the risks associated with work	13
2.3.2 Aware of the precautionary measures against risks.....	14
2.3.3 Aware of the importance of the PPE	14
2.3.3 Aware of the rights to safety.....	15
2.4 The institutional factors affecting the adherence to OSH measures of the employees in restaurants.....	15
2.4.1 Distance to work.....	15
2.4.2 Trainings on safety at work	16
2.4.3 Working environment.....	16
2.4.4 Systems of work	17
2.4.5 Supervision at work	17
2.4.6 Protective Equipment	18
CHAPTER THREE	19
METHODOLOGY	19
3.0 Introduction	19

3.1 Study design	19
3.2 Sources of data	19
3.3 Study population	19
3.4 Sample size determination	19
3.5 Sampling procedures	19
3.6 Inclusion and Exclusion criteria	20
3.6.1 Inclusion criteria	20
3.6.2 Exclusion criteria	20
3.7 Study variables	20
3.7.1 Dependent variable	20
3.7.2 Independent variables	20
3.8 Data collection tools and data collection techniques	21
3.8.1 Questionnaire	21
3.8.2 Key Informant Interview (KII) guides	21
3.9 Data analysis	21
3.10 Quality control	21
3.12 Plan for dissemination	22
3.13 Ethical issues	22
3.14 Limitations to the study	22
CHAPTER FOUR.....	23
DATA PRESENTATION, ANALYSIS AND INTERPRETATION	23
4.0 Introduction	23
4.1 Level of Adherence to OSH measures among restaurant workers.....	25
4.2 Socio-demographic factors influencing the level of adherence to OSH measures.	27
4.3 Knowledge factors influencing the level of adherence to OSH measures.	29

4.4 Institutional factors influencing the level of adherence to OSH measures.	31
CHAPTER FIVE	35
DISCUSSION	35
5.0 Introduction.....	35
5.1 Level of Adherence to OSH measures among restaurant workers.....	35
5.2 The socio-demographic factors affecting the adherence to OSH measures of the employees in restaurants	36
5.3 Knowledge of employees in restaurants about occupational safety and health measures. .	38
5.4 The institutional factors affecting the adherence to OSH measures of the employees in restaurants.....	41
CHAPTER SIX	47
CONCLUSIONS AND RECOMMENDATIONS.....	47
REFERENCES.....	49
APPENDIX A1: CONSENT FORM FOR THE RESEARCH QUESTIONNAIRE	55
APPENDIX A2: CONSENT FORM FOR KEY INFORMANT INTERVIEW GUIDE	56
APPENDIX B: THE RESEARCH QUESTIONNAIRE	57
APPENDIX C: KEY INFORMANT INTERVIEW GUIDE	59
APPENDIX D: STUDY BUDGET	60
APPENDIX E: WORK PLAN.....	61
APPENDIX F: LETTER OF INTRODUCTION	62
APPENDIX G: MAP OF KAMPALA SHOWING THE DIVISIONS OF THE CITY.....	63

LIST OF TABLES

Table 4.1: Distribution of the restaurants in Kampala and the number of workers.....	24
Table 4.2: Distribution of restaurant workers to the level of adherence to OSH measures. (n=230)	25
Table 4.3: Socio-demographic factors of restaurant workers	27
Table 4.4: Bivariate analysis of Socio-demographic factors influencing the level of adherence to OSH measures.	28
Table 4.5: Knowledge factors influencing the level of adherence to OSH measures.....	29
Table 4.6: Bivariate analysis of Knowledge factors influencing the level of adherence to OSH measures.	30
Table 4.7: Institutional factors influencing the level of adherence to OSH measures.....	31
Table 4.8: Bivariate analysis of Institutional factors influencing the level of adherence to OSH measures.	32
Table 4.9: Multivariate analysis of factors associated with the level of adherence to OSH measures.....	34

LIST OF FIGURES

Figure 4.1: The distribution of the respondents (%) in the different Divisions.....	24
Figure 4.2: The response rate of all the restaurant workers.....	25
Figure 4.3: The level of adherence to OSH measures among restaurant workers.	26

ABBREVIATIONS

BLS	Bureau of Labor Statistics
CCOHS	Canadian Centre for Occupational Health and Safety
CDC	Center for Disease Control
CI	95% Confidence Interval
Et al	and others
ILO	International Labor Organization
ISO	International Organization for Standardization
KCCA	Kampala Capital City Authority
KII	Key Informant Interview
LWDC	Lost Work Day Case
MOH	Ministry of Health
OR	Odds Ratio
OSH	Occupational Safety and Health
PPE	Personal Protective Equipment
SOPs	Standard Operation Procedures
STF	Slips Trips and falls
SPSS	Statistical Package for Social Sciences
UDHS	Uganda Demographic Health Survey
UNBS	Uganda National Bureau of Standards
US	United States
USA	United States of America
WCB	Workers Compensation Board
WHO	World Health Organization

ABSTRACT

Background

The study was carried out to identify the reasons for low levels of adherence to occupational safety and health measures among the restaurant workers. The study was done because despite the availability of effective interventions to prevent occupational hazards and to protect and promote health at work place, there are still noticeable accidents among employees in restaurants due to gaps in adherence to OSH measures.

Objective

The main objective under study was to assess the factors influencing the adherence to occupational safety and health measures by employees in selected restaurants in Kampala District.

Methodology

The study followed quantitative and qualitative research methods using a cross-sectional survey design. The target population comprised of restaurant kitchen workers including; chefs, waiters, waitresses, managers and cleaners in the selected restaurants and 230 workers were interviewed. Purposive sampling procedure was employed to provide the data relevant to the study. Research administered questionnaires and key informant interviews were used to collect data. With the quantitative tools, the analysis was done using the statistical package for social sciences (SPSS 16.0) programme, Microsoft excel, absolute figures, tables, percentages and statistical tools such as graphs, charts were used. Whereas for qualitative, analysis of feedback from interviews was done manually.

Results

The major findings in this study were as follows; Out of the 230 interviewed respondents, 54.40% of them adhered to OSH measures and the use of gloves was least adhered to with only 12 (5.2%) adherence. The study revealed that the restaurant population is also dominated by males with 124(53.9%) than females 106 (46.1%). At the bivariate analysis, under the socio-demographic factors, gender (p-value <0.001) and monthly income (p-value <0.001) were found to have a significant influence on the restaurant worker's adherence to OSH measures.

Awareness of precautionary measures against risks (p-value 0.035) and awareness of the importance of personal protective gears (p-value 0.023) were found to have some statistically significant influence on the restaurant worker's adherence to OSH measures. Distance to work (p-value<0.048), cleaning schedule prepared (p-value<0.001) and company providing personal protective equipment (p-value <0.001) under the institutional factors were found to have a significant influence on the workers adherence to OSH measures. At multivariate analysis, under gender the males were 2.4 times more likely to adhere to OSH measures than the female workers (OR=2.4, 95% C.I 1.1-5.3, P-value=0.029). The restaurant workers who said were aware of the precautionary measures were 17 times more likely to adhere to safety measures than workers who were not aware (OR=16.9, 95% C.I.6.7-42.7, P-value= <0.001). The workers who said that the management provided safety equipments were 3 times more likely to adhere to safety measures than those who claimed that management did not provide anything (OR=3.2, 95% C.I 1.5-6.8, P-value= 0.003).

Conclusion and Recommendations

In conclusion, the restaurant worker's gender, knowledge of precautionary measures and their acknowledgement of management providing safety equipment significantly influenced their adherence to OSH measures at work. The study recommends emphasis be put on the female restaurant workers to adhere to safety measures, workers focusing on precautionary measures against risks at work and management of restaurants insisting on the availability of safety equipments.

KEY OPERATIONAL DEFINITIONS

Adherence: are core safety activities that need to be carried out by employees to maintain workplace safety. Activities include; wearing closed shoes, gloves to prevent cuts and burns, use of the preferred lifting and handling methods to prevent strains and sprains, use of safety signs, aprons to protect the arms and legs, cleaning schedules, rubber-soled shoes to prevent slipping and electric shocks, use of cool clothes to avoid heat stress, and use of waste bins to prevent illness from biological waste and cuts from sharps.

A healthy work place: is a place where everyone works together to achieve an agreed vision for the health and well-being of workers and the surrounding community (Joan Burton, WHO Regional Office for Western Pacific, 2010).

An occupational accident: is an occurrence arising out of or in the course of work and resulting in a fatal or non-fatal occupational injury

Lost Work Day Case (LWDC): is a work related injury, resulting from a single identifiable event that renders the injured person unable to perform their normal work activities for more than one work day (Bae System, 2009).

Occupational Health: Is defined as the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations (WHO, 2013).

Occupational injury: is any injury, such as a cut, fracture, sprain, amputation and so forth, which results from a work accident or from exposure involving a single incident in the work environment (U.S Department of Labor, 1981).

Occupational illness: is any abnormal condition or disorder caused by exposure to environmental factors associated with employment (U.S Department of Labor, 1981).

Safety and health measures according to this study: are workplace health and safety rules put in place to prevent injuries and illnesses at work. Injuries include burns, back injuries, electrical shocks, chemical irritations, falls and cuts.

Workplace health promotion: are combined efforts of employers, employees and society to improve the health and well being of people at work (WHO, 2013).

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter explains more about; the background to the study and the study area, problem statement, the research objectives, research questions, research hypothesis, justification of the study and a conceptual framework.

Occupational accidents and diseases are on a rise and are due to failure of businesses to appreciate their negative influence on employee's productivity levels and that adhering to good safety and health practices is good for productivity (The Herald, 2012). So the study included variables like institutional, knowledge and social factors.

1.1 Background to the study

The right to decent, safe and healthy working conditions and environment has been a central issue for the ILO since its creation in 1944. The past years there has been development of a significant body of laws and regulations at the national level, covering many areas relevant to OSH. Progress has been achieved in numerous countries and working conditions have also improved in many parts of the world (ILO, 2010).

Over the past decades significant advances have been made in occupational safety and health (OSH) as many more countries have realized its importance and the need to give higher priority to preventing accidents and ill-health at work. However, many workers globally still face unhealthy and unsafe working conditions. Others face greater psychosocial risks at work due to intensification of work and fear to lose their jobs (ILO, 2011).

It was therefore very timely that the Seoul Declaration on Safety and Health at work was adopted in June 2008 during the XVIII World Congress, committing its signatories to "taking a lead in promoting a preventative safety and health culture and placing occupational safety and health high on national agendas". The declaration states that the right to a safe and health working environment should be recognized as a fundamental human right and that promoting high levels of safety and health at work is the responsibility of society as a whole (ILO, 2011).

Therefore, further improvement of the health of workers requires a holistic approach, combining occupational health and safety with disease prevention, health promotion and tackling social determinants of health and reaching out to workers families and communities (Joan Burton, WHO, 2010).

Many problems persist, however, and there is a general agreement that further sustained and coordinated action is needed at international and national levels to strengthen mechanisms for continued improvement of national OSH systems (ILO, 2010).

The Bureau of Labour Statistics (BLS) data indicates that slips trips and falls(STFs includes same-level falls, falls from and elevation, and slips and trips without a fall) account for the greatest percentage of total lost workday injuries in Food Services and Drinking Places, with an average incidence rate of 29.9 per 10,000 workers (CDC, 2012).

WHO estimates that 160 million new cases of work-related illnesses occur every year, and stipulates that workplace conditions account for over a third of back pain, 16% of hearing loss, nearly 10% of lung cancer; and that 8% of the burden of depression can be attributed to workplace risk (Joan Burton, WHO, 2010).

According to the CDC report on OSH risks among workers, it was found out that out of the 351,000 fatal occupational injuries globally, established market economics had 5%, Former socialist economics 5%, India 11%, China 26%, Other Asia and Islands 22%, Sub-Saharan Africa 15%, Latin America and the Caribbean 11%, and Middle-Eastern Crescent with 5%. It was also found out that 270 million workers suffered serious non-fatal injuries and 160 million suffered work-related diseases (CDC, 2011)

Inadequate occupational safety and health standards and environmental hazards are evident in the informal economy, and it is clear that informal workers do not have the necessary awareness and resources to implement health and safety measures. It was noted that informal employees often work in appalling, often dangerous and unhealthy conditions, without even basic sanitary facilities (Jantjie Xaba, 2002).

The constitution of Republic of Uganda recognizes the importance of good working environment of all workers and their rights. Article 39 gives workers a right to a clean and healthy

environment while article 40(1) empowers Parliament to enact laws to provide for the rights of persons to work under satisfactory, safe and healthy conditions. As a result in 2005 a bill on Occupational Safety and Health was brought to Parliament ending into the enactment of Occupational and Health Act, 9, 2006 with the overall purpose of safe guarding safety and health of all workers in all work places in Uganda. Despite a number of achievements in Uganda's economy, the achievements have not matched with the necessary safety and health standards, which standards are meant to guarantee good working conditions (Kiconco, 2008).

In Uganda the following labor laws are used like the Workers Compensation Act Cap 225, to compensate for workers who are injured out of and in the course of their work; The Employment Act Cap 219 and Employment Regulations of 1977, it covers the hours of work, rest and holidays, care of employees and others. And the Public Health Act is said to be used by Kampala Capital City Authority for inspecting the restaurants to make sure they adhere with standards (Occupational Safety and Health Profile for Uganda, 2004).

International Labor Organization (ILO) adopted nearly 40 standards dealing specifically with OSH. The most important standards that relate to OSH directly are;

1. Occupational safety and Health Convention, 1981 (No. 155) and its Protocol of 2002. It requires each ratifying member country to formulate, implement and periodically review a coherent national policy to prevent accidents and injury to the workers' health by minimizing workplace hazards. It also requires the governments to take some measures at the national and enterprise level which involves providing guidance to workers and employer (training on usage of different machinery and how to avoid hazards) and maintain an adequate and appropriate system of inspection to make sure that different labor regulations, especially those related to workplace safety, are complied with.
2. Occupational Health Services Convention, 1985 (No. 161). It requires establishment of occupational health services at the enterprise level with preventive functions and responsible for advising employer, workers and their representatives in the enterprise on: requirements for establishing and maintaining a safe and healthy work environment and adaptation of work to the physical and mental capabilities of workers.

3. Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187). It requires states to develop a national policy on OSH (as required under Convention 155) and promote a preventive safety and health culture where the right to safe and healthy working environment is respected by all; where all the tripartite actors fully participate in securing a safe and healthy working environment and where principle of prevention prevails. (ILO, 2013)

Uganda through UNBS adopted a number of ISO management system standards which include one directly related to OSH; Occupational Health and Safety Management System as per ISO 18001 (UNBS, 2012). The standard, though not adopted by ISO (International Organization for Standardization), is designed to be compatible with other management systems' standards already adopted by the Company, such as ISO 9001 (Quality System) and ISO 14001 (Environmental System), in order to facilitate the integration of all these systems in a synergetic and efficient way. It requires companies to develop and maintain a management system that continually improves and ensures the best possible conditions for workers, and decreases the risk of accidents, occupational hazards, and diseases (Sai Global, 2013).

In the restaurants, training and supervision are important to educate the employees on the importance and relevance of safety at work. Other measures that should be taken into considerations by the employees are; wear closed shoes, gloves to prevent cuts and burns, use the preferred lifting and handling methods to prevent strains and sprains, use safety signs, aprons to protect the arms and legs, cleaning schedules, rubber-soled shoes to prevent slipping and electric shocks, use cool clothes to avoid heat stress, and use waste bins to prevent illness from biological waste and cuts from sharps. (Remy K. et al, 2005).

1.2 Background to study area

The study was carried out in three divisions in Kampala district namely; Nakawa division, Kampala central division and Makindye division. The background of each of the divisions is given below.

Nakawa division is located in the eastern part of Kampala district with the population at 135,519 people. It lies 1133.8 meters above sea level; it covers a total area of 47,450 square kilometers with a land area of 39.4 square kilometers. It is located on about 22 hills of altitudes of 1120m

above sea level with flat summits, steeper upper slopes, merging into undulating slopes ending into broad valleys dissected by perennial streams. It has good climate characterized with breezes from Lake Victoria, rainfall distributed throughout the year with 1750-2000mm and dry seasons in June-July and December-January with relative humidity ranges between 53%-89%.

Kampala central division is Uganda's capital and largest city located on Nakasero hill. Nakasero is bordered by Mulago to the north, Makerere to the north-west, old Kampala to the west, Namirembe and Mengo to the south-west, Nsambya to the south, Kibuli to the south-east and Kololo to the east. The coordinates of Nakasero hill are: Latitude: 0.3244; Longitude: 32.5788. The city accommodates most of the ordinary business and commercial activities which include; taxi parks, train stations, shopping arcades, banks and restaurants. According to the Uganda Demographic and Health Survey, majority of people who reside in Kampala are job seekers with a high dependency ratio of 31%.

Makindye division is located in the South-Eastern part of Kampala district. It is bordered by Central and Rubaga divisions in the North-West, Mpigi district in the west, lake Victoria and Mukono in the south. Nakawa division is found in the North-East of Makindye division. It covers a total area of 40.7 hectares. Makindye is divided into 12 parishes. Poverty is one of the major problems people are facing in Makindye especially the youth and women who end up in small-scale businesses or industries like restaurant even without experience. People engage in other businesses like communications, sale of alcoholic and non-alcoholic beverages, commercial cycling, taxi driving and special hire, road side vending and among others.

1.3 Problem statement

Globally, 6,300 people die every day as a result of occupational accidents or work-related diseases. More than 2.3 million deaths per year and 317 million accidents occur on the job annually which too results in extended absences from work (ILO, 2013).

Despite the availability of effective interventions to prevent occupational hazards and to protect and promote health at work place, there are still noticeable accidents among employees in restaurants due to lack of adherence to OSH measures. The reasons for the lack of adherence to occupational safety measures are still not well understood. This has led to occupational injuries and illnesses that contribute to absenteeism, light duty assignments or other work restrictions,

and higher workers' compensation costs. Injuries include muscle strains, sprains and tears from slips, trips and falls; overexertion in lifting; repetitive motions; reaching and twisting; Cuts and lacerations from knives; food and beverage processing machinery such as slicers, grinders and mixers; and broken glass; Burns and scalds from hot liquids; hot oils and grease; heating and cooking equipment such as ovens and grills; hot pots and trays; and steam (WCB, 2001); and Respiratory diseases and disorders like asthma (CDC, 2012).

The possible reasons to the problem could be due to socio-demographic factors like Age, gender, salary level; institutional factors like supervision, provision of PPE; and Knowledge factors like aware of the importance of PPE, aware of the rights at work. Therefore, identifying the gaps will help to focus on utmost weak factors, selecting the needed and designing possible interventions which will help to improve on the health of the employees in restaurants in Kampala District (Dembe A E et al, 2005).

1.4 Research objectives

1.4.1 Main objective

To assess the factors influencing the adherence to occupational safety and health measures by employees in selected restaurants in Kampala District

1.4.2 Specific objective

1. To determine the level of adherence to safety and health measures of the employees in selected restaurants in Kampala District.
2. To identify socio-demographic factors affecting the adherence to occupational safety and health measures of the employees in selected restaurants in Kampala District.
3. To determine the knowledge of employees about occupational safety and health measures in selected restaurants in Kampala District.
4. To identify the institutional factors affecting the adherence to occupational safety and health measures of the employees in selected restaurants in Kampala District.

1.5 Research questions

1.5.1 Main question

What are the factors influencing the adherence to occupational safety and health measures by employees in selected restaurants in Kampala District?

1.5.2 Specific questions

1. What is the level of adherence to safety and health measures of the employees in selected restaurants in Kampala District?
2. What are the socio-demographic factors affecting the adherence to occupational safety and health measures of the employees in selected restaurants in Kampala District?
3. What is the knowledge of employees about occupational safety and health measures in selected restaurants in Kampala District?
4. What are the institutional factors affecting the adherence to occupational safety and health measures of the employees in selected restaurants in Kampala District?

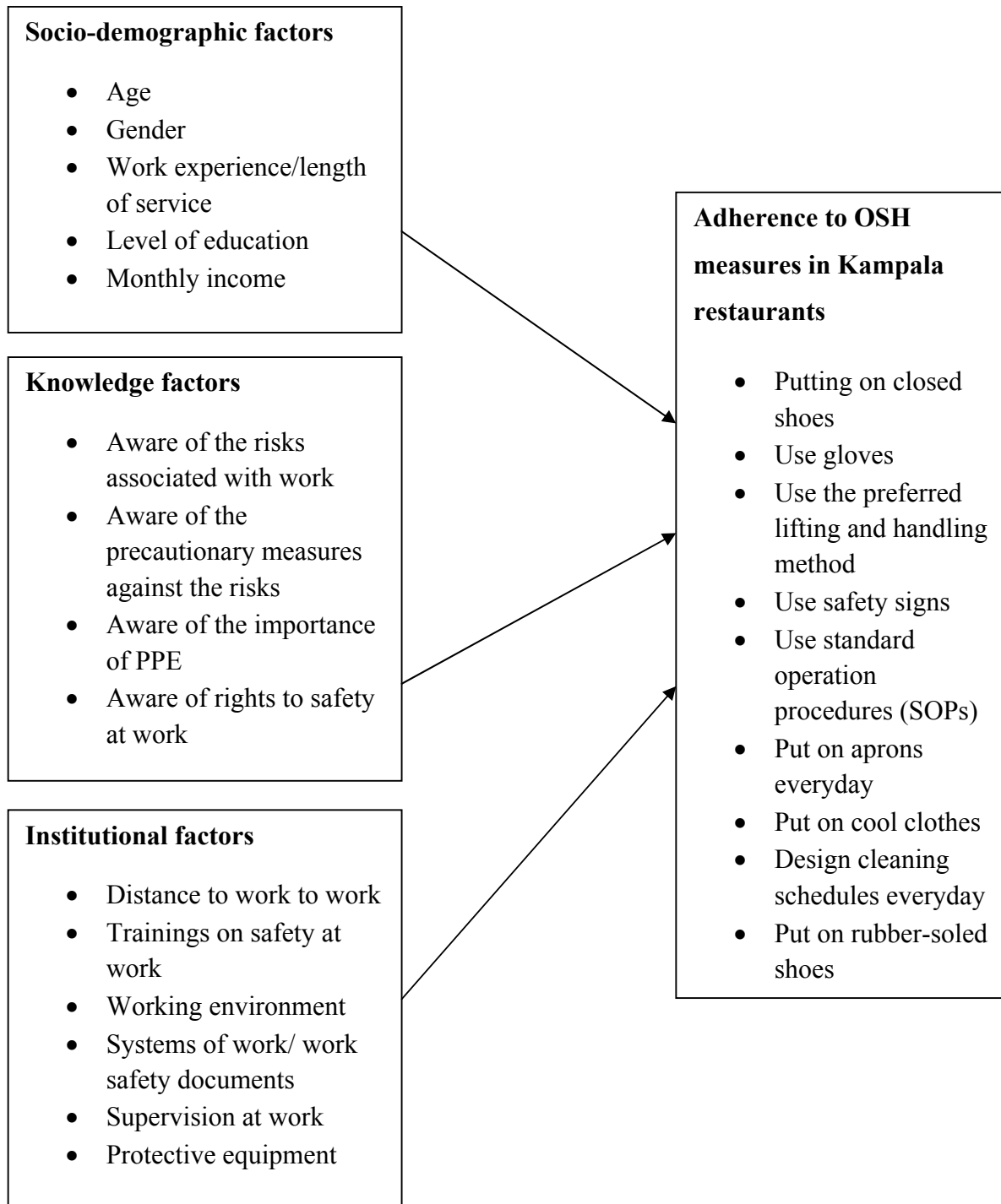
1.6 Significance of the study

Each day many workers go to work healthy and safe and expect to go back the same way. The workplace environment, nonetheless, has an influence on the workers level of adherence to safety measures and this in return exposes them to different kinds of injuries and diseases. Research and interventions are needed to reduce the tremendous burden and costs associated with the workers adherence to safety measures.

1.7 Justification of the study

Our study will help in developing an understanding of the factors associated with the workers adherence to OSH measures and to explore the appropriate methods for increasing the level of adherence to OSH measures in restaurants of Kampala District and those in other Districts. It will also elicit recommendation for the KCCA to take on increasing the level of adherence of restaurants to the recommended OSH measures in Kampala District.

1.7 Conceptual Framework



The conceptual framework represents the factors to consider when studying the occupational safety and health of the employees. Each component is conceived as making an independent contribution to a good occupational safety and health status. Socio-demographic factors like age, gender, level of education, salary/income level, and work experience/length of service all have a

way of affecting the workers adherence to OSH measures. Factors like trainings on safety at work, working environment, systems of work/ work safety documents, information provision, supervision at work, protective equipments, communication at work, working hours, assigned tasks at work, and work load are institutional based factors that increase the risks of accidents and injuries at work when the preventive measures are ignored. And the knowledge factors which are basically on an individual basis also determine the level of exposure to accidents and illnesses. Factors include aware of importance of occupational safety, orientation at work, knowledge of safety measures at work, and aware of rights at work.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Chapter two explains more about the objectives that were under study with highlights of data from other researchers. These included; the level of awareness about mitigating hazards, the safety measures put in place to prevent injuries and illnesses, and the institutional factors influencing the health and safety of the employees.

2.1 Level of adherence to OSH measures

Adhering with workplace rules and regulations is a vital key to safety in the workplace. A safe working condition is determined by the level of adherence with the safety rules. A study at Sasol about the level of adherence among workers revealed a high level of adherence at 75%, followed with a partial adherence at 20% and low adherence at 5% (Kwayiba, 2009).

In Melanie's study on occupational Safety of Large scale Food Service Units in South Africa (2006), it was shown that human factors (unsafe actions) have greater effect than non human-related sources. The unsafe actions of workers cause 80% of the accidents. The unsafe actions range from the negligence by the employers to negligence by the workers themselves by not wearing protective wear made available to them. The protective wear includes safety shoes, gloves, aprons, protective clothing and others.

Out of the 223 observations made in Melanie's study (2006), it was discovered that 6 workers chose not to wear protective gears yet they were available and due to their negligence they were all affected by chemicals. 9 workers claimed that the protective wear was available but not quickly accessed hence that exposed them to chemicals. 11 workers claimed that the protective wear was not available, 41 workers said the protective wear was insufficient and 25 claimed that the protective wear could cause discomfort or allergies hence neglect to use them.

According to Kelly's article on addressing the challenges of PPE non-adherence, she noted that non-adherence is cited as a top workplace safety issue by most of the workers (Kelly M. Pyrek, 2011).

2.2 The socio-demographic factors affecting the adherence to OSH measures of the employees in restaurants

2.2.1 Age

An introductory report on global trends and challenges on OSH among restaurant workers showed that young workers, for example, may be at greater risks of accidents because of a lack of training on adherence to safety rules and regulations or supervision, while older workers may be at greater risk of accidents than their younger colleagues because of a decline in physical, sensory or cognitive abilities like poor hearing and visual acuity that lead to non adherence to safety measures (ILO, 2011).

Young workers are known to take extra risks, perhaps trying to prove themselves in front of their fellow workers, or to perform tasks for which they have not yet been trained thus not conforming to the safety measures. This could be due to their lack of experience and knowledge of safe working procedures, but also lack the physical and psychological maturity to be able to see dangers ahead of not conforming to the safety measures (ILO, 2011).

Megan's study on OSH of workers in restaurants in United Kingdom and Canada found out that young workers need extra guidance to perform work safely, and are less able to judge their capability to safely perform certain tasks or apply the OSH measures (Megan, 2009).

2.2.2 Gender

Megan's study on OSH of workers in restaurants in United Kingdom and Canada found out. Males are more likely to take risks than females by not adhering with the safety measures which puts them at great risk of occupational injury than females. It was indicated that male workers have about twice the risk of injury compared to young females (Megan, 2009).

According to the ILO report on providing safe and healthy workplace for both women and men, it was found out that men tend to adopt less preventive and protective measures of carrying out work than women which exposes them to occupational hazards than women (ILO, 2008). According to the CDC report on teen workers in restaurants in USA, male employees were more likely to suffer burns, lacerations, and other injuries while performing tasks compared to females because they are less careful (CDC, 2012).

2.2.3 Work experience/length of service

In Megan's study (2009) on OSH of workers in restaurants in United Kingdom and Canada, experience was identified as a contributing factor to non adherence to OSH measures. Employees with 1 or 2 years of experience tend not to know or do much about safety. They do not have the knowledge and tend to do a lot of stupid things that do not adhere to the safety rules and regulations.

Abigail's report (2001) on workplace injuries and work force trends in United Kingdom discovered that individuals who have experienced a workplace accident in their current job and have been in their current job for less than 12 months consequently know the value in adhering with safety rules or measures and have a shorter time for which they are at risk of suffering a workplace injury. He also discovered that the risk of workplace injury declines with work experience along with the very high risks in the first few months of employment.

According to Melanie's study on occupational Safety of Large scale Food Service Units in South Africa (2006), no training had been acquired on the subject of occupational safety or safe working procedures or measures, so the workers that had little or no knowledge and those who had some knowledge acquired it through long service and common sense. In this case the workers did what they felt was acceptable to them, safe or not safe.

2.2.4 Level of education

According to Kwayiba's study on perceptions of workers towards OSH administration measures in South Africa, it was noted that education provides appropriate skills needed to make healthy lifestyle choices. Those with less education tend to run greater risks compared to those with higher education because they choose to adhere with the safety measures at work than those with less education (Kwayiba, 2009).

Not only does education shape health outcomes, it also influences health behaviors. A study in North Carolina on socioeconomic determinants of health showed that individuals with more education lead healthier lives and engage in fewer risky behaviors thus adhere to safety rules more compared to those with less education (North Carolina institute of Medicine, 2009).

In a study done by Lominsuk (2009) in Uganda on health hazards and practices of workers in a sugar factory, it was found out that education level of the workers had an influence on the

occurrence of occupational hazards. On the respondents interviewed, 53% had not studied beyond post secondary implying they had less skills to make the right choices as regards their safety at work.

According to the SafeWork 2012 handbook on workplace health and safety in South Australia, it was noted that a person's educational level has an influence on the adherence to safety measures. This is so because such persons lack concepts and details of the structure of workplace health and safety. Therefore, managers are encouraged to provide accurate information about workplace health and safety in order to increase the level of adherence.

2.2.5 Monthly income

According to the U.S. Bureau of Labor, half of all New York City restaurant workers actually earn less. Workers earning low wages are more likely not to adhere to health and safety measures because are not provided with health and safety training (Remy K. et al, 2005).

According to Kwayiba's study (2009) on perceptions of workers towards OSH administration measures in South Africa, it was noted that most workers tend to prioritize access to wages over labor conditions. This places them in an ambiguous position resulting in them compromising their lives as victims and risking their lives at work by not adhering with the safety measures.

According to the 2009 report by North Carolina institute of Medicine on socioeconomic determinants of health, monthly income was associated with the person's health behaviors. Persons with low income levels are more likely not to adhere to safety measures because they engage in risky health behaviors and experience greater levels of stress than those earning higher incomes.

2.3 Knowledge of employees in restaurants about occupational safety and health measures.

2.3.1 Aware of the risks associated with work

According to an accident and illness program in Slippery Rock University U.S, to ensure adherence every new employee should receive accident and illness prevention orientation as appropriate such as their responsibilities when they are at risk of injury, codes of practice, use of PPE and first aid to reduce risks (Slippery Rock University, 2013). Such training should be done before assigning any hazardous or risky work duties to the new employees so that they can be

aware of the hazards or risks on the job, control them and know how their non adherence can affect other workers (Worksafe NB, 2011).

A publication on guidelines on OSH in the service sector stated that the current knowledge and awareness about OSH within the service sector is very limited or sometimes even none existent and this leads to gaps in the workers knowledge and skills which limit how effective they can be in reducing risks at work. The employees do not adhere with the safety rules or measures because they do not have sufficient knowledge concerning; risks entailed by unsuitable work posture, improper use of technical equipment, unsuitable manual handling and overloading of joints and muscles. (Abu Bakar, 2004).

2.3.2 Aware of the precautionary measures against risks

According to Kwayiba's study (2009) about OSH administration measures in South Africa, it was argued that lack of knowledge renders one incompetent in applying and adhering with any given rule. The workers need to know and be familiar with what the rules are all about in order to see their value and adhere. Out of the 61 interviewed restaurant respondents, 35(57%) revealed a high level of awareness of the OSH measures of the restaurant, 15 (25%) disclosed a partial awareness of the OSH measures of the restaurant, and 11(11%) exposed a low awareness. Some of these could not interpret the signs, others had no idea of a defective tool and yet others had no idea of non-flammable cleaning material.

In Kwayiba's study (2009) when the workers were asked if they could tell the difference between a safe working condition and an unsafe one, some said the workplace had already been made safe for working hence caring less about the safety measures, others said that their workplace is as good as their gravesite, others that there are no safe working conditions since every workplace has its risks and this moves the workers to adhere to the safety measures o avoid injuries. Many said that a place with good housekeeping is a safe place but where good housekeeping is not followed it is a risky working condition.

2.3.3 Aware of the importance of the PPE

According to Kwayiba's study (2009) about OSH administration measures in South Africa, it was noted that some workers would only use the PPE simply to keep to the rules and not to land into trouble in case of an emergency otherwise the workers would work without the PPE because they do not know the importance of wearing protective equipments.

According to Kelly's article on addressing the challenges of PPE non-adherence she noted that despite the fact that workers are required to use personal protective equipments to reduce their exposure to hazards, the vast majority do not wear PPE due to their ignorance about the importance of using PPE (Kelly M. Pyrek, 2011).

2.3.3 Aware of the rights to safety

The South African Labor Guide report on "what every worker and employer should know about" stated that workers also have the right to be informed. The employer must see to it that every worker is informed and clearly understands the health and safety hazards of any work being done, anything being produced, processed, used, stored, handled or transported, and any equipment or machinery being used. The employer must then provide information about precautionary measures against these hazards (The South African Labor Guide, 2013).

According to Nicholas's study on unsafe working conditions among employees, it was noted that some employees do not know that they have a right to a safe and health workplace. It is because of this that when they are threatened to lose their jobs for failing to work in unsafe work conditions they decide not to adhere with the safety rules in order to keep their jobs (Nicholas A, et al, 1977).

2.4 The institutional factors affecting the adherence to OSH measures of the employees in restaurants

2.4.1 Distance to work

According to the report on managing fatigue of workers in Queensland, it was found out that excessive hours an employee spends travelling to work may reduce the time available for sleep and recovery between shifts. This increases the levels of fatigue influencing workers' behavior and attention to using safety measures during work because they never think clearly (Queensland Department, 2013).

According to Richard's article (2007) on '6 Main Causes of Stress' it was also found out that employees who commute to work daily are often exposed to slow traffic and long hours which makes them tired and become an easier target to stress. So by the time they reach work, they will be irritated and not in their right state of mind to perform their tasks in a safe way.

2.4.2 Trainings on safety at work

Alexander's study on OSH training in Columbia Stated that all workers including those in the food service industry are required to be trained because before one can adhere with any rule one has to show understanding of the rule; to render first aid in the event that workers are injured and in need of treatment to maintain life, reduce suffering, or prevent the condition from becoming worse until more expert help arrives. Training deficits leads to non adherence which then contributes to workers injuries, health complaints, and workplace fatalities (Alexander C., et al, 1998).

Alfred's study on restaurant hazards in U.S stated that integrating safety training into operational training provides two solutions at work; it ensures that the worker has safety training specific to his or her job duties, and it increases the management commitment to safety. When a cook is shown how to operate a fry station, training should include instruction and demonstration of working safely with and around hot grease they are more likely to adhere (Alfred J., et al, 2003). According to Kwayiba's study (2009) on perceptions of workers towards OSH administration measures in South Africa, it was revealed that when workers are made fully aware of the OSH measures they are more likely to conform to the workplace regulations.

According to the Department of Human Services, it was found out that when new workers are recruited or given new responsibilities they need further training so that they are appropriately equipped to carry out their new roles in a way that conforms to the safety rules. There is also a need to have refresh trainings because workers forget the lessons learnt and can fall into unsafe work habits (Victorian Government Department of Human Services, 2003).

2.4.3 Working environment

A study on OSH in the fast food industry in Australia also discovered that working in hot conditions, such as kitchen and restaurants, can lead to heat stress, especially if there is a low level of air movement or poor ventilation. Kitchen workers who put on head covers, gloves can decide not to use them due to the heat (Government of Western Australia Department of Commerce, 2012).

A report on workplace housekeeping in Canada, it was noted that poor maintenance of some equipments and machinery affect the work practices of the employees. In case of a broken or damaged item the workers may decide to carry out their tasks in ways that do not adhere with the

safety rules and regulations (CCOHS, 2011). There are many visual tasks in restaurant like reading the written working procedures. These should be placed in positions with good lighting where the worker will be able to read them to avoid non adherence (Abu Bakar, 2004).

Inadequate waste bins and irregular collection of waste contributes to poor housekeeping. This forces the workers to decide to dispose the waste anywhere on the floor like broken glasses which later cause accidents (CCOHS, 2011).

According to a report on workplace housekeeping in Canada, it was argued that since the restaurants are always busy places, there are areas that cannot be cleaned continuously such as entrance ways. Anti-slip materials can be placed in such areas to prevent slips and falls (CCOHS, 2011).

2.4.4 Systems of work

A focus report on preventing injuries to hotel and restaurant workers in Columbia stated that the Workplace Hazardous Materials Information System (WHMIS) can be used to provide employers with the necessary information about these hazardous products to ensure they are handled, used, and stored properly. And if workers, supervisors, and managers deliberately ignore safety rules and regulatory requirements, a system of progressive discipline should be developed (WCB, 2001).

A focus report on preventing injuries to hotel and restaurant workers in Columbia also stated that standard operation procedures (SOPs) that include rules and safe work procedures are developed to guide the employees on how their work is expected to be carried out safely. Procedures for changing oil in fryer and cleaning equipments can be provided to ensure adherence to safety rules and legislation (WCB, 2001).

2.4.5 Supervision at work

A focus report on preventing injuries to hotel and restaurant workers in Columbia stated that the supervisor' s first responsibility is to ensure that workers have been properly instructed and directed in the safe performance of their duties and to ensure that trained workers adhere with the directions provided (WCB, 2001).

An accident and illness program in Slippery Rock University U.S stated that supervision should be done to ensure that all employees adhere with the safety procedures and rules, are provided

with and use appropriate safety devices, safeguards, and personal protective equipment. This is so because many workers are provided with PPE but they do not use them since no one is watching them. Supervisors are to make sure employees are knowledgeable of the accidents and illness prevention measures applicable to their work so that they can apply them and prevent accidents or injuries (Slippery Rock University, 2013).

2.4.6 Protective Equipment

Melanie's study on occupational Safety of Large scale Food Service Units in South Africa discovered that protective wear is largely available but most likely insufficient or causing great discomfort since individual needs for specific protective wear are not catered for, so some workers choose not to follow the safety procedures or measures (Melanie, 2006). In a study done by Lominsuk (2009) in Uganda on health hazards and practices of workers in a sugar factory, it was discovered that the employees were not adhering with the safety rules and regulations because most of occupational health practices for example PPE, first aid kits, keeping records of accidents and illness among others were not being followed adequately.

In Jenny's study on "kitchen safety is no accident" in U.S, it was discovered that Companies like Friendly's are adopting innovative preventive measures that include helping employees buy slip-resistant safety shoes, employees working in the kitchen to wear back supports, and cut-resistant gloves when using the knife thus motivating the employees to conform with the safety measures (National Restaurant Association, 2012).

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter describes the methodology that was used in the study. It includes the research design, study area and population, sample size, sampling procedure, the methods used for collecting data and analysis.

3.1 Study design

The study was following quantitative and qualitative research methods using a cross-sectional study design. The study was designed to get immediate information on status of the employee's occupational health and safety. The quantitative research methods were to obtain results for statistical analysis and the qualitative research methods were to obtain feedbacks of the interviews for analysis in accordance to the study.

3.2 Sources of data

Data was obtained from the restaurant workers of the selected restaurants. Qualitative data was obtained from the restaurant managers and quantitative data from all the restaurant workers.

3.3 Study population

The study population comprised restaurant kitchen workers including; chefs, waiters, waitresses, managers and cleaners in the selected restaurants. Our study unit was the restaurant employees

3.4 Sample size determination

Sample size determination establishes the number of people who participate in the study. The sample size was determined depending on the restaurants preferred by KCCA and the customers in the given Divisions. All the workers in the preferred restaurants were included in the study and the total was 230. Chicken tonight with 170 workers, Mateos with 24 workers, Legends with 30, and Terracota with 6 workers. Therefore, we had no need to calculate the sample size, since all the restaurant workers were included in the study.

3.5 Sampling procedures

The above restaurants were all purposively included in the study. As the first step, Nakawa, Kampala Central and Makindye Divisions were purposively chosen by the responsible leaders in KCCA according to their need in safety and health. At the second step, the most preferred

restaurants by the customers and KCCA in the different Divisions were included in the study. Lastly, all employees in the selected restaurants were interviewed because they were few in number.

3.6 Inclusion and Exclusion criteria

3.6.1 Inclusion criteria

All the restaurant kitchen workers who were present at work and in a good health condition to be interviewed were included in the study.

3.6.2 Exclusion criteria

All restaurant kitchen workers who were on a work leave, sick, disabled to talk were not included in the study.

3.7 Study variables

These included one dependent variable and three independent variables.

3.7.1 Dependent variable

The dependent variable that was under study was adherence to Occupational Safety and Health measures.

3.7.2 Independent variables

These variables included socio-demographic factors, institutional factors and knowledge factors as shown below.

3.7.2.1 Socio-demographic factors

The socio-demographic factors were comprised of age, gender, level of education, salary/income level,

3.7.2.2 Institutional factors

The institutional factors were comprised of trainings on safety at work, working environment, systems of work, information provision, and supervision at work, protective equipment, and communication at work, working hours, and work load

3.7.2.3 Knowledge factors

The knowledge factors included aware of importance of occupational safety, orientation at work, knowledge of safety measures at work, aware of rights at work, work experience/length of service.

3.8 Data collection tools and data collection techniques

This study used the researcher administered questionnaires which were structured and semi-structured key informant interview guides to collect data in our study. The data was collected with the help of research assistants. These were trained prior the pretesting of data collection. This enabled the researcher to have a high response rate and good quality data. Probing was done to respondents who did not freely give some important information.

3.8.1 Questionnaire

The researcher asked the respondents questions and filled the questionnaire. This was done because some respondents could not know how to write and could prefer someone to write for them. The questionnaire had both open ended and closed ended questions

3.8.2 Key Informant Interview (KII) guides.

Key informant interview guide was used, where the managers or supervisors were asked specific questions relevant to the study. The researcher had to introduce himself/herself first and then get consent from the respondent of a given restaurant, and if the respondent allowed the discussion to continue, then questions were asked and recorded at same time by the researcher.

3.9 Data analysis

The analysis of the data was done at the end of the data collection. The responses were classified and summarized on the basis of the information provided by the respondents. The analysis was done using both qualitative and quantitative tools. With the quantitative tools, the analysis was done using the statistical package for social sciences (SPSS 16.0) programme, Microsoft excel, absolute figures, tables, percentages and statistical tools such as graphs, charts were used. Whereas qualitative made use of descriptions, analysis of feedback from interviews.

3.10 Quality control

Different restaurants were included in the study and all restaurant workers were interviewed to avoid bias. The quality of data was ensured by checking the completeness of the questionnaire administered with the approval of the supervisor. In cases of the inconsistency in the questionnaire, clarifications were made for the respondents so as to ensure that the tool collected the data it was intended for.

3.11 Steps to minimize errors

Before entering data into the computer, the questionnaires were checked for errors and coding was done to avoid the repetition of some questionnaires. The questionnaires were also numbered on the data-entry interface to avoid repetition. Frequency tables were run on all variables to identify errors and missing data.

3.12 Plan for dissemination

After the study, a report will be made which will be kept in the University library for future use to those who will be carrying out a study related to this one. Copies will also be distributed to the different restaurants where the study was done to be used as a tool for improving their adherence to occupational safety and health measures.

3.13 Ethical issues

Before the data collection exercise, the researcher obtained the approval from the University (International Health Science University). The researcher also obtained the permission from the owners of the restaurants where the research took place. An informed consent was always obtained from the respondents (workers) before asking questions. For the case of confidentiality, the respondents were assured that their information will be confidential and will also be used in the study carried out. The respondents were also not forced to participate if they were not willing.

3.14 Limitations to the study

- The researcher met respondents who were not willing to give their information in regards to the study.
- Some restaurants were not willing to share their information so we had to find those who were willing to share their information.
- One of the key informants refused to participate in the interview probably in fear of the owners.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 Introduction

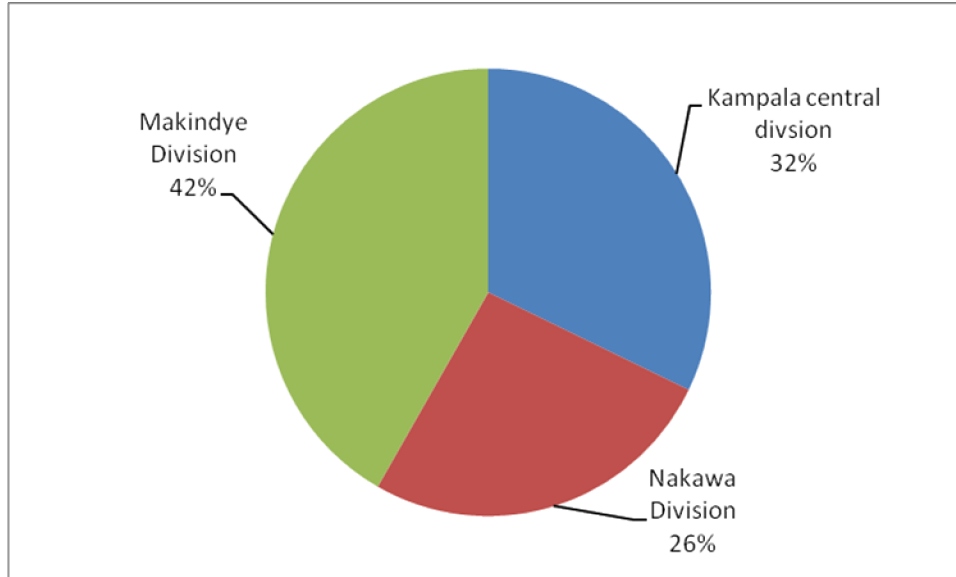
This chapter covers the presentation of responses, analysis and interpretation of the findings using Statistical Package for Social Sciences (SPSS) and some of the statistical tools employed for the analysis were Chi-square (X^2) test and P-value to determine the extent of the influence or the relationship between the dependent and independent variables. The chapter also presents the results of the analysis and interpretation in form of texts, figures, tables, graphs and charts.

The researcher in attempt to collect data relevant to the study distributed 230 copies of questionnaires to the four different restaurants. All the copies were well filled, returned and the analysis was based on all the 230 copies with a response rate of 100%. The study intended to interview all managers from the respective restaurants as key informants. However, only 3 (75%) out of the 4 managers were interviewed.

In our study, restaurant population was dominated by males with 124(53.9%) and females contributing 106 (46.1%). The age distribution indicated that the majority of the workers (142; 61.7%) were between the ages of 25 and 34 years. The majority of the workers also had their work experience between the years 1 and 2 with 112 (48.7%). When it came to the level of education, many of the workers (158; 68.7%) reported to have stopped in secondary as their highest qualification. With the monthly income, majority of the restaurant workers (144; 62.6%) were earning between 100,001/= and 150,000/=.

The restaurants included in the study were found in the 3 different Divisions as shown in figure 4.1 below.

Figure 4.1: The distribution of the respondents (%) in the different Divisions.



Most of the workers were in Makindye Division (42%), followed by Kampala central (32%) and the least were from Nakawa Division (26%).

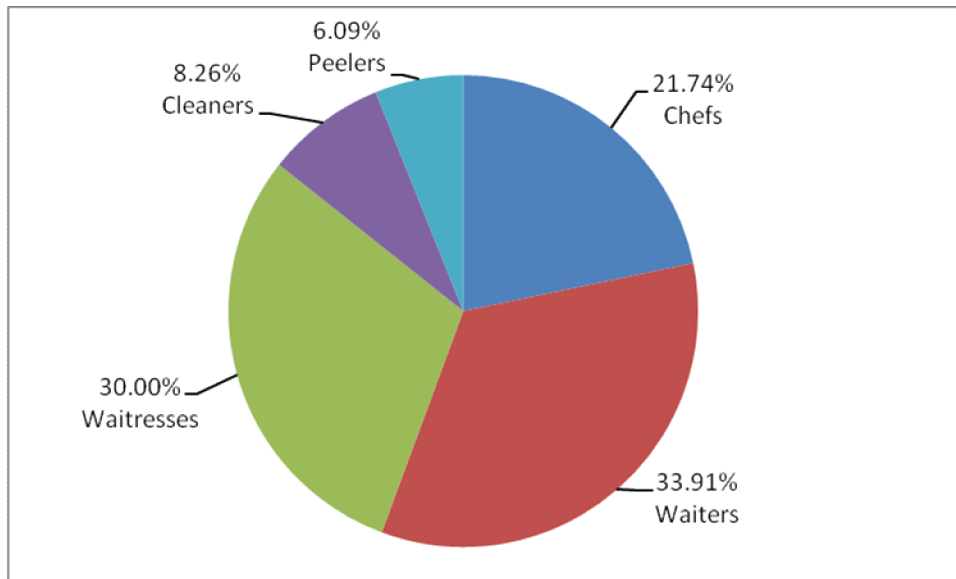
The restaurants in our study also had different number of workers as shown in table 4.0.1.

Table 4.1: Distribution of the restaurants in Kampala and the number of workers.

Restaurant	Chicken Tonight	Legend	Mateos	Terracota
Division	Kampala central	Nakawa	Kampala central	Nakawa
	Nakawa			
	Makindye			
Waitresses	56	7	4	2
Waiters	56	11	9	2
Cleaners	14	3	2	0
Chefs	30	9	9	2
Peelers	14	0	0	0
Total	170	30	24	6

Chicken tonight had the biggest number of respondents (170) and Terracota had the least number of respondents (6).

Figure 4.2: The response rate of all the restaurant workers.



Out of the 230 respondents interviewed, the majority of the respondents were waiters (33.91%) as shown in figure 4.0.2.

4.1 Level of Adherence to OSH measures among restaurant workers

The purpose of this analysis was to find out from the respondents if they adhered to the OSH measures.

Table 4.2: Distribution of restaurant workers to the level of adherence to OSH measures. (n=230)

Variable	Yes (%)	No (%)
Wears closed shoes every day	172 (74.8)	58 (25.2)
Use gloves every day	12 (5.2)	218 (94.8)
Use of preferred lifting and handling	19 (8.3)	211 (91.7)
Use of safety signs when performing certain tasks	28 (12.2)	202 (87.8)
Use of standard operation procedures (SOPs) for some tasks	18 (7.8)	212 (92.2)
Wears apron everyday	145 (63.0)	85 (37.0)

Wears cool clothes to avoid heat stress	215 (93.5)	15 (6.5)
Design cleaning schedules everyday	221 (96.1)	9 (3.9)
Wears rubber-soled shoes	197 (85.7)	33 (14.3)
Use the waste bins all the time to dispose waste	227 (98.7)	3 (1.3)

Table 4.2 shows how many of the 230 workers adhere with the different OSH measures. The most measure that the workers complied to was using the waste bins all time to dispose waste with 227 (98.7%) and 3 (1.3%) non-adherences. The use of gloves every day was mostly non-complied to with 218 (94.8%) and with 12 (5.2%) adherence.

In support of the above, one key informant said that *“the accidents that the workers sustain are mostly due to cuts from knives, broken bottles and glasses.”* **(Manager from Legend restaurant, Nakawa Division)**

Another key informant said that *“the most accidents that the workers experience are burns.”* **(Manager from Mateos restaurant, Kampala central)**

And another key informant said that *“the most accidents the workers usually experience are cuts.”* **(Manager from Chicken tonight restaurant, Kampala central)**

According to the key informants above, very few the restaurant workers use the required PPEs or follow the safety measures to prevent burns and cuts or it would mean that the PPEs are not provided.

Figure 4.3: The level of adherence to OSH measures among restaurant workers.

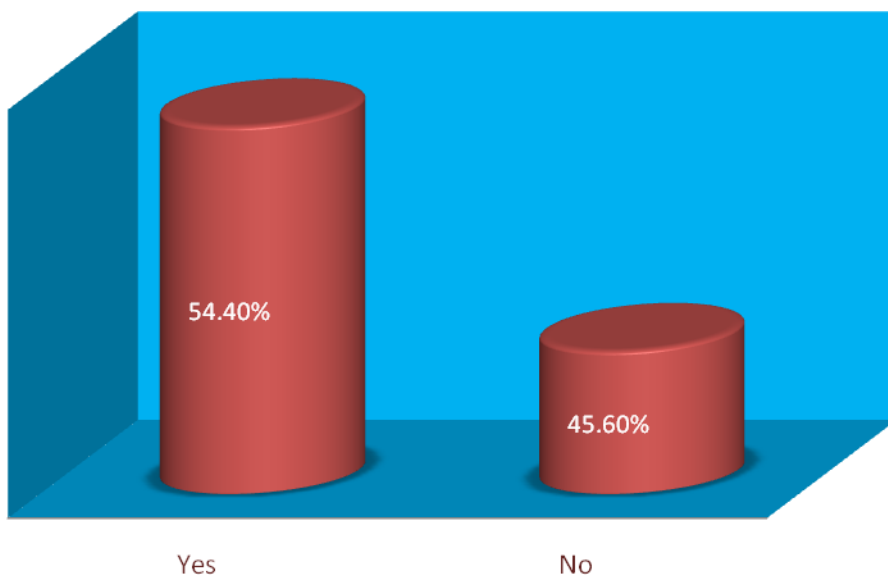


Figure 4.3 shows the overall level of adherence which was derived from the respondent's level of adherence in table 4.2, where by 54.40% of the respondents adhered to OSH measures while 45.60% of the respondents did not adhere with the OSH measures.

4.2 Socio-demographic factors influencing the level of adherence to OSH measures.

In the study, it was important to understand the participation of respondents by gender. Table 4.3 presents the data on the respondents age distribution, work experience, educational level and monthly income.

Table 4.3: Socio-demographic factors of restaurant workers

Variables	N (n=230)	Percentage (%)
Gender		
Male	124	53.9
Female	106	46.1
Age		
15-24	84	36.5
25-34	142	61.7
34 or greater	4	1.7
Work experience (years)		
≤1	44	19.1
1-2	112	48.7
3-4	65	28.3
>4	9	3.9
Education level		
Primary	1	0.4
Secondary	158	68.7
Tertiary	69	30.0
Others.. (trainings in the related fields)	2	0.9
Monthly income		
≤50,000/=	1	0.4
50,001- 100,000/=	30	13.0
100,001 – 150,000/=	144	62.6
150,001 – 300,000/=	49	21.3
>300,000/=	6	2.6

From table 4.3, the data revealed that the restaurant population is dominated by males with 124(53.9%) and females contributing 106 (46.1%). The age distribution indicated that the majority of the workers (142; 61.7%) were between the ages of 25 and 34 years followed by 84 (36.5%) between the ages 15 and 24. The least percentage (1.7%) was of those at 34 years or greater.

The majority of the workers had their work experience between the years 1 and 2 with 112 (48.7%) followed by 65 (28.3%) between years 3 and 4. The majority of the workers (158; 68.7%) reported to have stopped in secondary as their highest qualification, followed by 69 (30.0%) who reached tertiary level, primary was 1(0.4%) and others (hands on/on job training in the related fields) were 2 (0.9%).

The monthly income of the majority of the restaurant workers (144; 62.6%) was between 100,001/= and 150,000/=. Only 6 (2.6%) workers were earning above 300,000/= and only 1(0.4%) restaurant worker was earning 50,000/= or less per month.

Table 4.4: Bivariate analysis of Socio-demographic factors influencing the level of adherence to OSH measures.

Variable	N (%)	Adhered	No adherence	χ^2	p-value
Gender					
Male	124 (53.9)	51 (35.2)	73 (85.9)	55.46	<0.001*
Female	106 (46.1)	94 (64.8)	12 (14.1)		
Age					
15-24	84 (36.5)	52 (35.9)	32 (37.6)	2.40	0.301
25-34	142 (61.7)	89 (61.4)	53 (62.4)		
34 or greater	4 (1.7)	4 (2.8)	0 (0.0)		
Work experience (years)					
≤1	44 (19.1)	27 (18.6)	17 (20.0)	5.41	0.144
1-2	112 (48.7)	78 (53.8)	34 (40.0)		
3-4	65 (28.3)	34 (23.4)	31 (36.5)		
>4	9 (3.9)	6 (4.1)	3 (3.5)		
Education level					
Primary	1 (0.4)	0 (0.0)	1 (1.2)	6.62	0.085
Secondary	158 (68.7)	106 (73.1)	52 (52.0)		
Tertiary	69 (30.0)	37 (25.5)	32 (37.6)		
Others (trainings in the related fields)	2 (0.9)	2 (1.4)	0 (0.0)		
Monthly income					
≤50,000/=	1 (0.4)	1 (0.7)	0 (0.0)	23.82	<0.001*
50,001- 100,000/=	30 (13.0)	29 (20.0)	1 (1.2)		
100,001 – 150,000/=	144 (62.6)	85 (58.6)	59 (69.4)		
150,001 – 300,000/=	49 (21.3)	24 (16.6)	25 (29.4)		
>300,000/=	6 (2.6)	6 (4.1)	0 (0.0)		

* Statistically significant associations

Table 4.4 shows how gender, age, work experience, educational level and monthly income influence the OSH measures. The data revealed that gender (p-value <0.001) and monthly income (p-value <0.001) have a significant influence on the restaurant worker's adherence to OSH measures. The other factors age (p-value 0.301), work experience (p-value 0.144) and education level (p-value 0.085) had a p-value more than 0.05 hence were however found not to have a significant influence on the restaurant worker's adherence to OSH measures.

4.3 Knowledge factors influencing the level of adherence to OSH measures.

In this study it was also essential to discover if the level of knowledge of the restaurant workers influences the level of adherence to OSH measures.

Table 4.5: Knowledge factors influencing the level of adherence to OSH measures.

Variable	N (n=230)	Percentage (%)
Aware of risks associated with this work		
Yes	226	98.3
No	4	1.7
Aware of precautionary measures against risks		
Yes	129	56.1
No	101	43.9
Aware of importance of personal protective equipments		
Yes	227	98.7
No	3	1.3
Aware of the right to safety at work		
Yes	224	97.4
No	6	2.6

From table 4.5 above, it was discovered that most of the respondents were aware of the risks associated with work (98.3%), aware of importance of personal protective equipments (98.7%), and were also well aware of their right to safety (97.4%). Awareness of the precautionary measures against risks had the least percentage of respondents (56.1%).

Table 4.6: Bivariate analysis of Knowledge factors influencing the level of adherence to OSH measures.

Variable	N (%)	Adhered	No adherence	χ^2	p-value
Aware of risks associated with this work					
Yes	226 (98.3)	143 (98.6)	83 (97.6)	0.297	0.472
No	4 (1.7)	2 (1.4)	2 (2.4)		
Aware of precautionary measures against risks					
Yes	129 (56.1)	89 (61.4)	40 (47.1)	4.46	0.035*
No	101 (43.9)	56 (38.6)	45 (52.9)		
Aware of importance of PPE					
Yes	227 (98.7)	145 (100)	82 (96.5)	5.19	0.023*
No	3 (1.3)	0 (0.0)	3 (3.5)		
Aware of the right to safety at work					
Yes	224 (97.4)	141 (97.2)	83 (97.6)	0.04	0.852
No	6 (2.6)	4 (2.8)	2 (2.4)		

***Statistically significant associations**

From table 4.6, the questions regarding the awareness of precautionary measures against risks (p-value 0.035) and awareness of the importance of personal protective gears (p-value 0.023) were found to have some statistically significant influence on the restaurant worker’s adherence to OSH measures. However being aware of the risks associated with the work (p-value 0.472) and being aware of the rights to safety (p-value 0.852) were found to have no significant influence on the restaurant worker’s adherence to OSH.

In support of the above, one key informant stated that *“The worker’s adherence to OSH measures is influenced by their ignorance or lack of knowledge about the importance of adhering to safety measures.”* **(Manager from Mateos, Kampala Central Division).**

Another key informant also stated that *“The workers adherence to OSH measures is influenced by their ignorance and not being well trained”* **(Manager from Chicken tonight, Kampala Central Division).**

4.4 Institutional factors influencing the level of adherence to OSH measures.

Institutional factors were also found to have an influence of OSH measures and questions were derived from factors as shown in table below.

Table 4.7: Institutional factors influencing the level of adherence to OSH measures.

Variables	N (n=230)	Percentage (%)
Distance to work		
≤1km	26	11.3
1-5km	152	66.1
6-10km	51	22.2
>10km	1	0.4
Trained on work		
Yes	226	98.3
No	4	1.7
Refresher training		
Yes	40	17.4
No	190	82.6
Regular waste collection		
Yes	211	91.7
No	19	8.3
Written safety procedure		
Yes	5	2.2
No	225	97.8
Cleaning schedule prepared		
Yes	220	95.7
No	10	4.3
Supervision done		
Yes	227	98.7
No	3	1.3
Company provides personal protective equipment		
Yes	146	63.5
No	84	36.5

From table 4.7 most of the respondents (66.1%) were found to live not so far from the work place (1-5) km. A big number of the workers (98.3%) were trained on getting the job but most of them said they never had refresh training (82.6%). Slightly less than a half of the respondents (36.5%) claimed that management never provided the PPEs. Other factors like regular waste collection (91.7%), having a cleaning schedule (95.7%) and supervision done (98.7%) were found to be done mostly by the restaurant workers. Almost all the respondents (97.8%) claimed that they are not provided with standard operation procedures (SOPs).

Table 4.8: Bivariate analysis of Institutional factors influencing the level of adherence to OSH measures.

Variable	N (%)	Adherence	No adherence	χ^2	p-value
Distance to work					
≤1km	26 (11.3)	16 (11.0)	10 (11.8)	7.92	0.048*
1-5km	152 (66.1)	104 (71.7)	48 (56.5)		
6-10km	51 (22.2)	25 (17.2)	26 (30.6)		
>10km	1 (0.4)	0 (0.0)	1 (1.2)		
Trainings on safety at work					
Yes	226 (98.3)	144 (99.3)	82 (96.5)	2.53	0.112
No	4 (1.7)	1 (0.7)	3 (3.5)		
Refresher training					
Yes	40 (17.4)	24 (16.6)	16 (18.8)	0.19	0.661
No	190 (82.6)	121 (83.4)	69 (81.2)		
Regular waste collection					
Yes	211 (91.7)	132 (91.0)	79 (92.9)	0.26	0.612
No	19 (8.3)	13 (9.0)	6 (7.1)		
Standard operation procedures (SOPs)					
Yes	225 (97.8)	142 (97.9)	83 (97.6)	0.02	0.887
No	5 (2.2)	3 (2.1)	2 (2.4)		
Cleaning schedule prepared					
Yes	220 (95.7)	145 (100)	75 (88.2)	17.8	<0.001*
No	10 (4.3)	0.0 (0.0)	10 (11.8)		
Supervision at work					
Yes	227 (98.7)	144 (99.3)	83 (97.6)	1.15	0.283
No	3 (1.3)	1 (0.7)	2 (2.4)		
Company provides personal protective equipment					
Yes	146 (63.5)	110 (75.9)	36 (42.4)	25.95	<0.001*
No	84 (36.5)	35 (24.1)	49 (57.6)		

***Statistically significant associations**

Table 4.8, provides data concerning the institutional factors influencing the OSH measures. Factors like, cleaning schedule prepared on a daily basis (p-value <0.001) and the company providing personal protective equipment (p-value <0.001) were found to have a significant influence on the workers adherence to OSH measures. Distance to work (p-value 0.048) was too found to have some mild influence on the workers adherence to OSH measures. However refresh training (p-value 0.661), regular waste collection (p-value 0.612), standard operation procedures (SOPs) (p-value 0.887) and supervision (p-value 0.283) were found to have no significant influence on the workers adherence to OSH measures.

In support of the above, one key informant stated that *“They introduce the worker to the work area, train and teach them on how to use the different equipments. They assemble the workers every month 2-3 times for refresh trainings.”* He also said that *“The executive chef provides the required PPE for the worker and supervise on their use and that this should be done constantly.”* **(Manager from Legend restaurant, Nakawa Division).**

Another key informant also stated that *“They provide PPEs like long sleeved shirts to workers to prevent burns.”* **(Manager from Mateos restaurant, Kampala Central Division).**

Another Key informant said that *“They provide aprons and gloves as measures for safety.”* **(Manager from Chicken tonight restaurant, Kampala Central Division)**

And another one said that *“They provide the standard operation procedures (SOPs) for the workers in order to adhere to safety rules.”* **(Manager from Legend restaurant, Nakawa Division)**

Table 4.9: Multivariate analysis of factors associated with the level of adherence to OSH measures.

Variable	N (%)	OR (95%CI)	P-value
Gender			
Male	124 (53.9)	2.4 (1.1-5.3)	0.029 *
Female	106 (46.1)	1	
Aware of precautionary measures against risks			
Yes	129 (56.1)	16.9 (6.7-42.7)	<0.001*
No	101 (43.9)	1	
Management provides safety equipment			
Yes	146 (63.5)	3.2 (1.5-6.8)	0.003*
No	84 (36.5)	1	

***Statistically significant associations**

The analysis from table 4.9 was done to determine how all the factors in the study influenced adherence to OSH measures. The data provided shows only three factors that proved to have a statistically significant influence on adherence to OSH measures; under gender the males were 2.4 times more likely to adhere to OSH measures than the female workers (OR=2.4, 95% C.I 1.1-5.3, P-value=0.029). The restaurant workers who said they were aware of the precautionary measures were 17 times more likely to adhere to safety measures than workers who were not aware (OR=16.9, 95% C.I.6.7-42.7, P-value= <0.001). The workers who said that management provides safety equipments were 3 times more likely to adhere to safety measures than those who claimed that management did not provide anything (OR=3.2, 95% C.I 1.5-6.8, P-value= 0.003).

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter contains the discussion of the findings that have been reported in chapter four. The responses of the interviewees are discussed in terms of the objectives of the study. The chapter includes a discussion in relation to various literacy reports, dealing with aspects raised in the discussion. This involves a general analytical reflection of the discussed material from a theoretical framework's point of view.

5.1 Level of Adherence to OSH measures among restaurant workers

Adhering to safety rules and regulations at the workplace is vital and this determines the level of adherence with the safety rules. Researchers show, however, that non adherence to safety measures like use of PPE is a top issue among workers (Kelly M. Pyrek, 2011). This is in line with the findings of our study where only 54.40% of the 230 respondents interviewed complied with OSH measures. However, these findings are slightly lower than the level of adherence reported in the study done in South Africa which reported that the workers had a higher a level of adherence at 75% (Kwayiba, 2009).

The low levels of adherence could be due to the worker's unsafe actions like negligence, availability and accessibility of the safety measures (Melanie, 2006). In our study, the main OSH measures complied to by the respondents were closed shoes, aprons, cool clothes, designing cleaning schedules, putting on rubber-soled shoes and using waste bins. Measures like gloves were less used and the reasons given by the workers were that the management never provides the needed PPE, others say they do use them but not always, and others think they do not need gloves for their type of work, for example the waiters and waitresses yet they clean the sitting areas using detergents. Three of the key informants emphasized that the most of the accidents the workers experience are cuts which are due to knives, broken bottles and glasses. This shows that the workers do not adhere to use the required safety measures like gloves.

The preferred method of lifting and handling objects was also least adhered to. This is because when workers were asked how they lift objects at work, they said that objects were carried

anyhow because they did not know how to do it right or were not aware of the dangers of poor lifting and handling. This can be dangerous to their health when safety measures like safety signs and standard operation procedures (SOPs) are not provided (Melanie, 2006). In our study majority of the respondents claimed that such measures were not provided by management.

5.2 The socio-demographic factors affecting the adherence to OSH measures of the employees in restaurants

5.2.1 Age

According to the other researchers, age is found to be an influencing factor to the workers adherence to OSH measures. This is because as one grows old, the experience in a task increases hence influencing the choice of whether to adhere to the OSH measures or not. In our study majority of the workers were found to be in the age bracket of 25-34 (61.7%). This could probably be due to the fact that there are high rates of unemployment in Kampala and individuals in such age bracket are always fresh from school and trying to find jobs hence ending up as restaurant workers. However on the bivariate analysis, age was found to have no influence (p-value=0.301) on the workers adherence to OSH measures. This is in contrast with the findings in the ILO report on global trends and challenges on OSH among restaurant workers which noted that young workers are more likely not to adhere to OSH measure due to their lack of experience and knowledge of the safe work procedures and because of their lack of the physical and psychological maturity to sense danger of not adhering to safety rules (ILO, 2011).

5.2.2 Gender

Gender was too considered as one of the factors that influenced workers adherence to OSH measures. This is because of how gender roles and gender relations are enacted in the workplaces or how the sex-related variations in body composition can influence the workers adherence to OSH measures. In our study 53.9% of the workers were males. This could be due to the fact that males are more likely to go for such risky jobs than females. According to the analysis at the bivariate level, gender was found to have a large influence (p-value=<0.001) on workers adherence to OSH measures. These findings were in line with the ILO report (2008) where the men were more likely not to adhere with the OSH measures because they tend to adopt less preventive and protective measures of carrying out work than females. However, when further analyzed at multivariate level, males were found to be 2.4 times more likely to adhere to OSH

measures than their fellow female restaurant workers. This could probably be due to the fact that the males get to experience a lot of accidents since they are more likely to take risks than the females (Megan, 2009) therefore forcing them to adhere to OSH measures like wearing PPE.

5.2.3 Work experience/length of service

Experience is said to contribute to the workers knowledge depending on the number of years a person spends doing that type of work (Melanie, 2006). Our study showed that majority (48.7%) of the workers had worked from 1-2 years. This is probably because the restaurant industry is dominated by youths who have just left school and have less work experience. However, at the bivariate analysis, experience was found to have no influence (p-value= 0.144) on the workers adherence to OSH measures. These findings were in contrast with Megan's findings in Canada about the OSH of workers in restaurants which stated that employees with 1 or 2 years of experience tend not to know or do much about safety (Megan, 2009). The contrast could be due to the fact that some individuals who have experienced a workplace accident in their current job and have been in their current job for less than 12 months consequently know the value in adhering with safety rules or measures and have a shorter time for which they are at risk of suffering a workplace injury (Abigail, 2001).

5.2.4 Level of education

According to the researchers, level of education was found to provide appropriate skills needed to make healthy lifestyle choices (Kwayiba, 2009). In our study, a majority (68.7%) were found to have stopped at the secondary level. This especially in Uganda could be due to low levels of income which makes it impossible for the majority to continue with higher education. It could also be due to the lack of enough schools and structures. Level of education at the bivariate analysis (p-value=0.085) was however found not to have an influence on the workers adherence to OSH measures. These findings were however in contrast with the findings in Kwayiba's study (2009) on OSH administration measures in South Africa which stated that those with less education tend to run greater risks compared to those with higher education because they choose to adhere with the safety measures at work than those with less education. The findings in this study were also not in line with the findings in Lominsuk's (2009) study in Uganda on health hazards and practices of workers in a sugar factory which stated that the workers who never

studied beyond secondary had fewer skills to make the right choices as regards their safety at work. The contrast among these findings could be due to the fact that most the workers never reached tertiary level where OSH skills and knowledge are more emphasized.

5.2.5 Monthly income

Monthly income was included in the study because it's said that when the workers are satisfied with the salary, they will be motivated in performing their duties safely hence adhere to OSH measures. In our study many of the respondents were found to be earning between 100,001-150,000 (62.6%) and this could be so because the majority in restaurant industry are waiters and waitresses who earn almost the same amount. Monthly income was found to have an influence on the workers adherence at the bivariate level ($p\text{-value} < 0.001$). This is in line with the findings in Kwayiba's study (2009) which noted that most workers tend to prioritize access to wages over labor conditions resulting in them compromising their lives as victims and risking their lives at work. The results were also in line with the 2009 report by North Carolina institute of Medicine on socioeconomic determinants of health which stated that persons with low income levels are more likely not to adhere to safety measures because they engage in risky health behaviors and experience greater levels of stress than those earning higher incomes. However at the multivariate analysis, salary level was found to have no influence on the workers adherence to OSH measures. This is not in line with findings in Remy's study about the restaurant worker's wages which noted that workers earning low wages are more likely not to adhere to health and safety measures because are not provided with health and safety training (Remy K. et al, 2005). The difference in the findings could mean that workers are either forced to follow the safety procedures regardless of their monthly income or they are motivated in other ways like free lunch which gives them energy to adhere to safety measures.

5.3 Knowledge of employees in restaurants about occupational safety and health measures.

5.3.1 Aware of the risks with the work

The employee's awareness about the risks entailed in their work is vital because it helps them to avoid injuries. This so because they would be able to differentiate between what is wrong or right as regards to safety. In our study, majority of the workers (98.3%) claimed to be aware of the risks with their type of work. This could be due to the fact that the workers are well

oriented and trained about the risks entailed with their type of work. However when bivariate analysis was done, awareness of the risks with the work was found to have no influence (p -value=0.472) on the workers adherence to OSH measures. These findings were not in line with findings in an accident and illness program in Slippery Rock University U.S where it was revealed that workers would adhere if they received accident and illness prevention orientation as appropriate such as their responsibilities when they are at risk of injury (Slippery Rock University, 2013). The findings in our study were also not in line with the findings in a publication on guidelines on OSH in the service sector which stated that employees do not adhere with the safety rules or measures because they do not have sufficient knowledge concerning; risks entailed by unsuitable work posture, improper use of technical equipment, unsuitable manual handling and overloading of joints and muscles. (Abu Bakar, 2004). The findings were not in line probably because the workers were not provided with the information about the risks at work or that workers were not aware that the management is supposed to provide such information.

5.3.2 Aware of the precautionary measures against risks

In order to reduce the risks of hazardous work or the risks of exposure to the hazards, the workers are supposed to be trained on the precautionary measures against those risks in order to avoid recurrence of accidents/injuries. This is so because they can only adhere to the safety measures only if they have knowledge and skills about those measures. In our study, only 56.1% of the respondents claimed to be aware of the precautionary measures against risks. These findings were in line with the findings in Kwayiba's study (2009) about OSH administration measures in South Africa which noted that only 57% of the 61 respondents interviewed had a high level of awareness. This could be due to the fact that there are still gaps in the knowledge of most of the workers. The factor under study was found to have an influence on the workers adherence to OSH measures both at the bivariate (p -value=0.035) and multivariate analyzes (p -value=<0.001). The findings were also in line with the findings in Kwayiba's study (2009) which noted that some workers were aware of the difference between the safe working conditions and an unsafe one by knowing the importance of good housekeeping while others did not know the difference by claiming that the workplace had already been made safe for working hence caring less about the safety measures. The findings in the literature review and our findings may imply

that the kind of training offered by the employers leaves some individuals ignorant because it is usually of poor quality.

5.3.3 Aware of the importance of the PPE

Unless the workers are aware of the importance of the PPE, the employers can never guarantee that the workers will use the PPE. This is so because some workers choose not to use the PPE as required due to their ignorance about the importance of PPE. In our study majority of the respondents (98.7%) claimed to be aware of the importance of the PPE. This could be due to the fact that most of the workers have been trained or that they have had enough experience that their knowledge increased with time about the importance of PPE. In this study, awareness of the importance of the PPE was found to have an influence ($p\text{-value}=0.023$) on the workers adherence to OSH measures. These findings were in line with the findings Kwayiba's study (2009) which noted that some workers would only use the PPE simply to keep to the rules and not to land into trouble in case of an emergency otherwise the workers would work without the PPE because they do not know the importance of wearing protective equipments. However when awareness of the importance of the PPE was further analyzed at the multivariate level, it was found to have no influence on the workers adherence to OSH measures. These findings were contrary with findings in Kelly's article on addressing the challenges of PPE non-adherence in which she noted that despite the fact that workers are required to use personal protective equipments to reduce their exposure to hazards, the vast majority do not wear PPE (Kelly M. Pyrek, 2011). The disparity could be due to the fact that most of the workers use the PPE just to follow the rules and regulations of the workplace but not because they are aware of the importance of using PPE. This was further emphasized by one of the key informants who said that they threaten the workers to lose their jobs if they choose not to adhere to the safety measures. Another key informant said that most of the workers do not use the PPE due to their ignorance.

5.3.4 Aware of the rights to safety

OSH recognizes that all workers have a fundamental right to a workplace that neither impairs their health nor imperils their safety. This can be achieved by both the employer and employees working together although some workers may not know that they have the right to work in a safe environment. In our study majority (97.4%) of the respondents claimed to be aware of the rights

to safety. This could be due to the fact that majority of the workers have heard about the rights from friends or media but not from the employers. This could be so because the employers might be having the fear of losing their workers due to poor working conditions. When a bivariate analysis was done in our study on the factor under study, it was found to have no influence (p-value=0.852) on the workers adherence to OSH measures. These findings were however not in line with the findings in the South African Labor Guide report on “what every worker and employer should know about” which stated that employees will adhere to the OSH measures if their right to information is fulfilled like being informed about health and safety hazards of any work being done, anything being produced, processed, used, stored, handled or transported, and any equipment or machinery being used (The South African Labor Guide, 2013). The findings were also in contrast with the findings in Nicholas’s study on unsafe working conditions among employees which noted that some employees do not know that they have a right to a safe and health workplace. This is was further emphasized in Nicholas’ study which stated that when such ignorant workers are threatened to lose their jobs for failing to work in unsafe work conditions they decide not to adhere with the safety rules in order to keep their jobs (Nicholas A, et al, 1977).

5.4 The institutional factors affecting the adherence to OSH measures of the employees in restaurants

5.4.1 Distance to work

Workers in most cases have to commute to work daily and how they get there depends on how long their distance to work is to work. In our study it was discovered that majority of the workers (66.1%) stayed within 1-5km from the workplace. This could be so due to the fact that many try to find places to stay near their place of work in order to keep time. When further analyzed, distance to work was found to have some mild influence (p-value= 0.048) on the workers adherence to OSH measures. The findings in our study were in line with the findings in the report on managing of workers in Queensland which noted that excessive hours an employee spends travelling to work may reduce the time available for sleep and recovery between shifts. This increases the levels of fatigue influencing workers’ behavior and attention to using safety measures during work because they never think clearly (Queensland Department, 2013). However when further analyzed at the multivariate level, distance to work was found to have no

influence on the workers adherence to OSH measures. These results were however contrary with Richard's findings which stated that employees who commute to work daily are often exposed to slow traffic and long hours which makes them tired and become an easier target to stress. So by the time they reach work, they be irritable and not in their right state of mind to perform their tasks in a safe way (Richard, 2007). The difference in the findings could be due to the fact that some workers are able to recover from the fatigue or stress and are able to perform their tasks safely.

5.4.2 Training on safety

All workers in the food service industry are required to be trained because before one can adhere with any rule one has to show understanding of the rule (Alexander C., et al, 1998). This means the workers have to be trained about the rules that govern OSH measures before handing over the jobs to them. This will help them understand the importance of OSH rules and adhere. According to our study, many of the workers (98.3%) claimed that they were trained at work. This could be due to the fact that the employers take training to be vital or a primary need for all new workers. This is proved by one of the key informant who said that all new workers are showed what to do which includes training them on how to use certain equipments and another key informant went on to say that the worker's adherence to OSH measures is also influenced by poor quality training. However in our study, training was found not to have an influence ($p\text{-value}=0.112$) on the workers adherence to OSH measures. These findings were however in contrast with the findings in Alexander's study on OSH training in Columbia which stated that training deficits lead to workers non adherence to OSH measures (Alexander C., et al, 1998). This could be due to the fact that the workers are at least provided with the basic knowledge about OSH measures making them more likely to conform to the workplace regulations. Therefore training should always be made a first priority at work especially for the new workers in order to tame them into adhering to the OSH measures.

Refresh training was also studied because when the workers are trained for the first time as new workers, no one can guarantee that they remember all that was taught. This means that they need to be reminded of their responsibilities as regards to safety and health in order to maintain their level of adherence to OSH measures. According to our findings, majority (82.6%) of the respondents claimed not to have refresh training at their places of work. This could be so due to

the weak policies or lack of policy enforcement which gives the owners freedom to do as they please. When analyzed at the bivariate level, refresh training was found to have no influence (p-value=0.661) on the workers adherence to OSH measures. This could be so because the workers use knowledge and skills acquired in first training. The findings were however not in line with the findings in the report for the Victorian Department on human services which noted that workers need further training so that they are appropriately equipped to carry out their new roles in a way that conforms to the safety rules. Refresh trainings prevents workers from forgetting the lessons learnt and falling into unsafe work habits (Victorian Government Department of Human Services, 2003). However the findings in the report for the Victorian Department were in line with what one of the key informants said, that they do refresh trainings for the old workers at least 2-3 times a month.

5.4.4 Working Environment

Workplaces are meant to be kept safe for the employees but it is also important to keep the work areas clean by providing waste bins and regularly collecting the waste to avoid biological hazards. The workers are supposed to be urged to adhere on using the bins provided in order to prevent the risks and hazards that would result in poor waste disposal. In our study, majority (91.7%) claimed that the waste was regularly collected. This could be due to the fact that the restaurants produce a lot of waste and that the only way to keep customers is by keeping the work place clean. Regular waste collection was analyzed at the bivariate level and it was found to have no influence (P-value=0.612) on the workers adherence to OSH measures. These findings were however not in line with the findings in the report on workplace housekeeping in Canada which noted that inadequate waste bins and irregular collection of waste contributes to poor housekeeping and non adherence (CCOHS, 2011).

Workplaces can as well be maintained with the help of a cleaning schedule. These are meant to be prepared on a daily basis. Majority (95.7%) of the respondents claimed to have the cleaning schedules prepared on a daily basis. This could be so because majority thinks that they feel it is their obligation to work in a clean environment. When a bivariate analysis was done in our study, preparing a cleaning schedule on a daily basis was found to have influence (p-value <0.001) on the workers adherence to OSH measures. These findings were in line with the line with the findings in the report on workplace housekeeping in Canada which noted that poor maintenance

of workplace or the working area affects the work practices of the employees (CCOHS, 2011). However, when further analyzed at the multivariate level, cleaning schedule was found to have no influence on the workers adherence to OSH measures. This could be so because in most cases with or out the cleaning schedule prepared, the work places are cleaned because it is everyone's duty to tidy up the work area at which they work at the end of every work shift (Kwayiba, 2009) and without good housekeeping, preventive measures like specialty foot wear or training on the techniques of walking will never be fully effective.

5.4.4 Systems of work

Systems of work if put in place can provide the employees with necessary information about the hazards and risks at work how to avoid them, and provide the safe procedures for some tasks. This so because during training, not all safe working procedures are provided like how to clean a deep fryer, so it would be vital if the workers are provided with safety procedures hence adhere to OSH measures. Majority (97.8%) of the respondents at work claimed not to have standard operation procedures (SOPs). This could be due to the weak policies and the employers thinking that the training which the new employees get is enough. One of the key informants claimed to have written work procedure on how to prevent accidents but when the workers asked whether they had them, they said such procedures were never provided or pinned. Standard operation procedures (SOPs) were analyzed at the bivariate level and it was found to have no influence (P -value=0.887) on the workers adherence to OSH measures. These findings were however not in line with the findings in a focus report on preventing injuries to hotel and restaurant workers in Columbia which stated that standard operation procedures (SOPs) are developed to guide the employees on how their work is expected to be carried out safely and ensure adherence (WCB, 2001). The difference in the findings could be due to the fact that the workers are shown what to do during the training and it seems not really necessary for them to pin the procedures or the employers themselves might not be aware of the importance of standard operation procedures (SOPs). Therefore the employers should ensure that the employees are provided with quality training and the safety procedures pinned on notice boards in order to help the workers to adhere to the safety rules.

5.4.5 Supervision

Supervision is always necessary in order to monitor work processes. This is necessary because some workers choose not to adhere to the OSH measures like wearing gloves because there is no one watching them and others may not adhere because the supervisors do not show them how to carry out certain tasks safely. Majority (98.7%) of the respondents said to have supervisors and this is so probably to make sure the workers have been properly instructed and directed in the safe performance of their duties and to ensure that trained workers adhere with the directions provided (WCB, 2001). When supervision was analyzed at the bivariate level, it was found to have no influence ($p\text{-value}=0.283$) on the worker adherence to OSH measures. These findings were however not in line with the findings in the Slippery Rock University program in U.S which noted the employees will only use the appropriate safety devices, safeguards, and personal protective equipments if they are supervised (Slippery Rock University, 2013). The difference in the findings could be due to the fact the employees do not always need the supervisors to be around to adhere to OSH measures. Workers cannot also adhere if not trained or when the required equipments are not provided.

5.4.6 Personal Protective Equipments

PPE provides safety for the workers when carrying out their duties and in order for the workers to adhere to the measures, they should be provided by the employers at no cost. PPEs include things like; gloves, aprons, rubber-soled shoes and closed shoes. In our study majority (63.5%) of the respondents claimed that the company provides them with the required PPE. This was so probably due to the fact majority of the employers are aware of the consequences of using workers unprotected like having to pay a lot of medical costs in case of an accident. However, when analyzed at both the bivariate ($p\text{-value} < 0.001$) and multivariate levels ($p\text{-value} < 0.003$), providing personal protective equipment was found to have a large influence on adherence to OSH measures. These findings were in line with Melanie's study in South Africa which noted that PPE in the Food Service Units was most likely to be insufficient or causing great discomfort for the individuals causing some workers to choose not to follow the safety procedures or measures (Melanie, 2006). Employees are also some times forced not to adhere with the safety rules and regulations because most of occupational health practices for example PPE are not adequately followed (Lominsuk, 2009). However the employees are more likely to adhere if the

required PPE is provided because they will be motivated to do the right thing (National Restaurant Association, 2012). One of the key informants interviewed said that they had an executive chef who would take care of providing the required PPE, making sure the workers know how to use them and use the PPE whenever necessary though during the interview, some workers claimed not to have or use the PPE always. This means that the provision of PPEs should be done, educate the workers on their importance and use in order for them to adhere to the safety rules.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

This chapter therefore proposes to make recommendations and conclusions on the basis of the research findings.

6.1 Conclusions

- The study revealed that the level of adherence is still low and this was attributed to negligence of the workers, availability and accessibility of the safety measures.
- Gender was found to have a large influence on workers adherence to OSH measures.
- There are still gaps in the knowledge of most of the workers given the fact that the level of knowledge of the precautionary measures against risks of the workers was found to be low and this was also found to influence the workers adherence to OSH measures.
- Majority of the workers were provided with PPE but they still never used them as required and others were never provided with PPE. Provision of PPE was also found to have an influence on the workers adherence to OSH measures.

6.2 Recommendations

- The workers should be taught by management the importance of adhering to OSH measures and also encouraged to always use or follow those safety measures.
- Emphasis should be put on the female restaurant workers on the use and adherence to OSH measures.
- During the trainings, the management should inculcate safety consciousness in the minds of all workers especially the females in order to increase on their adherence. Restaurant management should clearly show both sexes the likely risks entailed in their type of work, the likely accidents if they do not adhere to the OSH measures and the precautionary measures to prevent the risks and accidents.
- In order to reduce the gaps in the knowledge of the workers, the employers should endeavor to train all workers with less knowledge about the precautionary measures against the risks at work and the importance of PPE and to carry out refresh trainings to maintain the knowledge of workers about OSH measures.

- Lastly, restaurant management should consider motivating all workers in claiming for and owning PPEs in order to increase their level of adherence to OSH measures.

REFERENCES

1. Abigail McKnight, Peter Elias and Linda Wilson, 2001. Institute for employment research: *Work place injuries and work force trends*. Contract research report 281. Pg 12-21.
http://www2.warwick.ac.uk/fac/soc/ier/publications/2001/mcknight_et_al_2001_hse_crr_01281.pdf [accessed on 12/04/2013].
2. Abu Bakar Che'Man, 2004. Journal of OSH: *Introduction*. Vol. 1 No.1. Pg 14-15.
<http://www.niosh.com.my/download/jurnal/janNew.pdf> [Accessed on 02/02/2013].
3. Alexander Cohen and Michael J. Colligan, 1988. *Assessing occupational safety and health training*. National Institute for Occupational Safety and Health. Publication No. 98-145. Pg 47-48. <http://oshatrain.org/courses/pdf/assesstraining.pdf> [accessed on 12/04/2013]
4. Alfred J. Filiaggi and Theodore K. Courtney, 2003. Workplace safety: *Restaurant hazards*. Professional safety journal. Pg 22.
<http://www.asse.org/professionalsafety/pastissues/048/05/010503as.pdf> [accessed on 12/04/2013].
5. Bae Systems, 2009. Annual report 2009: *Health and safety*. <http://bae-systems-corporate-responsibility-report-2009.production.investis.com/basis-of-reporting/health-safety.aspx> [Accessed on 31/01/2013].
6. Canadian Centre for Occupational Health and Safety (CCOHS), 2013. Safety hazards: *prevention of slips, trips and trips*. Canada. Pg 1.
http://www.ccohs.ca/oshanswers/safety_haz/falls.html [Accessed on 21/01/2013].
7. Center for disease control (CDC), 2011. Global collaborations: *OSH Risks*. National Institute for Occupational Safety and Health. Program portfolio. Pg 1.
<http://www.cdc.gov/niosh/programs/global/risks.html> [accessed on 23/06/2013].
8. Center for disease control and prevention (CDC), 2012. NIOSH program portfolio: *Traumatic injury*. USA. Pg 1. <http://www.cdc.gov/niosh/programs/ti/projects.html> [Accessed on 17/01/2013].

9. Center for Disease Control (CDC), 2012. NIOSH program portfolio: *Respiratory diseases*. USA. Pg 1. <http://www.cdc.gov/niosh/programs/resp/risks.html> [Accessed on 20/01/2013].
10. Dembe A E, J B Erickson, R G Delbos and S M Banks, 2005. The influence of overtime and long work hours on occupational injuries and illnesses: *New evidence from the United States*. Occupational and Environmental Medicine journal. Vol. 62, issue 9. <http://oem.bmj.com/content/62/9/588.full> [Accessed on 01/02/2013].
11. Ezekiel M. Makori, O. M. J. Nandi, J. K. Thuo, Kadian W. Wanyonyi 2012. *Influence of occupational health and safety programmers on performance of manufacturing firms in Western Province*. Kenya. Vol. 4(4). Pp 46-58. <http://www.academicjournals.org/ajhc/PDF/pdf2012/May/Makori%20et%20al.pdf> [accessed on 29/04/2013].
12. Government of Western Australia Department of Commerce, 2012. *OSH in the Fast Food Industry*. Worksafe newsletter. Pg 5. http://www.commerce.wa.gov.au/worksafe/PDF/Infokits/Fast_food_industry_2012.pdf [Accessed on 20/02/2013].
13. International Labor Organization (ILO), 2011. Global Trends and Challenges on Occupational Safety and Health: *Introductory Report*. Turkey. Pg 1-17. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/publication/wcms_162662.pdf [Accessed on 29/01/2013].
14. International Labor Organization (ILO), 2012. *Safety and health at work*. <http://www.ilo.org/global/topics/safety-and-health-at-work/lang--de/index.htm> [accessed on 16/01/2013]
15. International Labor Organization (ILO), 2013. *International labour standards on OSH* <http://www.ilo.org/global/standards/subjects-covered-by-international-labour-standards/occupational-safety-and-health/lang--en/index.htm> [Accessed on 31/01/2013].
16. International Labor Organization (ILO), 2008. *Providing safe and healthy workplace for both women and men*. Geneva background brochure. Pg 2. http://www.ilo.org/wcmsp5/groups/public/@dgreports/@gender/documents/publication/wcms_105060.pdf [accessed on 22/06/2013]

17. International Labor Organization (ILO), 2010. *Plan for Action (2010-2016)*, Geneva report. Pg 1.
http://www.ilo.org/wcmsp5/groups/public/@ed_norm/@normes/documents/policy/wcms_125616.pdf [accessed on 23/06/2013].
18. Jantjie Xaba, Pat Horn and Shirin Matala, 2002. Employment sector report 2002/10: *The informal sector in Sub-Saharan Africa*. Pg 32.
http://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_122204.pdf [Accessed on 29/01/2013].
19. Jenny Hedden, 2002. Strengthen your safety net: *Kitchen safety is no accident*. National restaurant association article.
<http://cf.restaurant.org/tools/magazines/rusa/magArchive/year/article/?ArticleID=497>
 [Accessed on 21/01/2013].
20. Joan Burton, 2010. World Health Organization (WHO) Healthy Place Framework and Model: *Background and Supporting Literature and Practices*. Summary report. Pg 2-3.
http://www.who.int/occupational_health/healthy_workplaces_workshop_report.pdf
 [Accessed on 29/01/2013].
21. Kelly M. Pyrek, 2011. *Addressing the challenges of PPE non-adherence*. Infection control today article. Pg 1.
<http://www.infectioncontroltoday.com/articles/2011/10/addressing-the-challenges-of-ppe-non-adherence.aspx> [accessed on 05/08/2013].
22. Kiconco Patrick K., 2008. *Occupational Safety and Health Issues in Uganda*. Development trend article. <http://pkatabaazi.blogspot.com/2008/02/occupational-safety-and-health-issues.html> [Accessed on 29/01/2013].
23. Kwayiba T.F., 2009. CHAPTER ONE: *Introduction Safety and Health in the workplace*. South Africa. Pg 4-100. <http://ufh.netd.ac.za/bitstream/10353/217/2/mini-dissertation.pdf>
 [Accessed on 18/02/2013].
24. Lominsuk Robert Taban, 2009. *Assessment of health hazards and practices of workers in Sugar Corporation of Uganda Lt (SCOUL)*. Unpublished dissertation. School of Public Health, Uganda.
25. Megan Tranter, 2009. *Occupational health and safety of young, part-time workers in United Kingdom and Canada*. Australia. Pg 88-138.

- http://www.unsworks.unsw.edu.au/primo_library/libweb/action/dlDisplay.do?vid=UNSWORKS&docId=unsworks_7900&fromSitemap=1&afterPDS=true [accessed on 12/04/2013].
26. Melanie Samatra Ross, 2006. *A Description of the Occupational Safety of Large scale Food Service Units in the Metropole Region under the Management of The Provincial Administration Western Cape*. South Africa. Pg 70.
http://etd.uwc.ac.za/usrfiles/modules/etd/docs/etd_init_4706_1180439346.pdf [Accessed on 08/02/2013].
27. Nicholas A. Ashford and Judith I. Katz, 1977. Unsafe working conditions: *employee rights under the labor management relations Act and the occupational safety and health Act*. Vol. 52 No.5. Pg 826-835.
<http://dspace.mit.edu/bitstream/handle/1721.1/1551/%2311.PDF?sequence=1> [accessed on 22/06/2013]
28. North Carolina Institute of Medicine, 2009. Prevention Action plan: *Socioeconomic Determinants of Health*. Chapter 11. Pg 243, 245, 261. www.nciom.org/wp-content/uploads/NCIOM/.../Prevention-Chpt11.pdf [accessed on 11/12/2013].
29. Queensland Department, 2013. Workplace health and safety Queensland: *Managing fatigue*. The restaurant opportunities center of New York report. Pg 2-5.
<http://www.deir.qld.gov.au/workplace/hazards/fatigue/managing/index.htm> [accessed on 02/07/2013].
30. Remy Kharbanda and Andrea Ritchie, 2005. Behind the kitchen: *Pervasive inequality in New York City's thriving restaurant industry*. New York. Ezine article.
www.urbanjustice.org/pdf/publications/BKDFinalReport.pdf [accessed on 14/04/2013].
31. Richard Onebamoi, 2007. 6 main causes of stress. *Work stress*.
<http://ezinearticles.com/?6-Main-Causes-of-Stress&id=4511565> [accessed on 25/07/2013].
32. SafeWork SA, 2012. *Workplace health and safety handbook*. Pg 19.
www.safework.sa.gov.au/uploaded_files/hsr_handbook.pdf [accessed on 09/12/2013].
33. Sai Global Limited, 2013. Occupational Health and Safety: *Occupational health and safety management systems and registration*. <http://www.saiglobal.com/Assurance/ohs/> [accessed on 07/10/2013].

34. Slippery Rock University, 2013. Environmental Health and Safety: *Accident and illness prevention program*.
<http://www.sru.edu/financeandadministrativeaffairs/EnvironmentalHealthandSafety/Pages/AccidentandInjuryIllnessPreventionProgram.aspx> [accessed on 25/04/2013].
35. The HeraldOnline, 2012: *Adherence to safety, health regulations*. 28 May.
<http://www.herald.co.zw/talk-show-for-the-city-of-kings-2/> [Accessed on 27/01/2013].
36. The South African Labor Guide, 2013. What Every Worker and Employer Should Know About: *Health and safety in the workplace*. Department of labour article.
<http://www.labourguide.co.za/health-and-safety/what-every-worker-and-employer-should-know-about-739> [accessed on 12/04/2013].
37. Uganda National Bureau of Standards (UNBS), 2012: *Systems certification*.
<http://www.unbs.go.ug/index.php/certification/systems-certification> [Accessed on 31/01/2013].
38. U.S Department of Labor, 1981. *Occupational Safety and Health Act No. 101*. Pg 7.
<https://www.dir.ca.gov/dosh/DoshReg/EmpRecExhibit1.pdf> [Accessed on 31/01/2013].
39. Victorian Government Department of Human Services, 2003. *Occupational health and safety management framework model*. Pg 45-46.
<http://health.vic.gov.au/ohs/mgtframe.pdf> [accessed on 21/06/2013]
40. Workers Compensation Board (WCB), 2001. Focus report: *Preventing injuries to hotel and restaurant workers*. Pg 20-50.
http://www.worksafebc.com/publications/reports/focus_reports/assets/pdf/focushotel.pdf [Accessed on 19/01/2013].
41. Worksafe NB, 2011. Health and safety Orientation: *What you need to know*. Pg 16.
http://www.worksafenb.ca/docs/WorkSafeNBOrientationGuide_e.pdf [accessed on 21/06/2013].
42. World Health Organization (WHO), 2013. Occupational health: *Workplace health promotion*. Pg. 2
http://www.who.int/occupational_health/topics/workplace/en/index1.html [Accessed on 31/01/2013].

43. World Health Organization (WHO), 2013. Health topics: *Occupational health*.
http://www.wpro.who.int/vietnam/topics/occupational_health/en/ [Accessed on
31/01/2013].

**APPENDIX A1: CONSENT FORM FOR THE RESEARCH QUESTIONNAIRE
ADHERENCE TO OCCUPATIONAL SAFETY AND HEALTH MEASURES AMONG
EMPLOYEES IN RESTAURANTS: A CASE STUDY ON THE SELECTED
RESTAURANTS IN KAMPALA DISTRICT.**

Introduction and Consent form for the questionnaire

Dear sir/Madam,

My name is Ajambo Zipporah and I am undertaking research assessing the level of adherence to occupational safety and health measures as part of the requirement for my Bachelors Degree at the International Health Sciences University, under the supervision of Dr. Peter Kirabira.

The purpose of this study is to identify the possible factors that directly or indirectly affect the continuous use of OSH measures at workplaces. Am sure your opinion will be very important because it may help in the provision of useful recommendations to ensure good use of safety and health measures.

As part of this research, I am conducting interviews with the use of questionnaire with all the works to find out the factors that influence their adherence to OSH measures. Participation is free and voluntary and you may choose not to take part. If you choose to participate, it may take 15-20 minutes to complete. The questionnaire may be completed while you work. All the information that you provide will be confidential and will only be used for research purposes.

At this point, if you allow me, I would like to ask you some questions about the study.

Respondent's signature..... Date.....

Researcher's signature Date.....

APPENDIX A2: CONSENT FORM FOR KEY INFORMANT INTERVIEW GUIDE
Introduction and Consent form for the KII Guide

Dear sir/Madam,

My name is Ajambo Zipporah and I am undertaking research assessing the level of adherence to occupational safety and health measures as part of the requirement for my Bachelors Degree at the International Health Sciences University, under the supervision of Dr. Peter Kirabira.

The purpose of this study is to identify the possible factors that directly or indirectly affect the continuous use of OSH measures at workplaces. In the study, key informants were also included as an approach to help us gain an in-depth understanding of what influences the restaurant worker's adherence to OSH measures and what can be done to increase the level of adhere at workplaces.

We will be interviewing the managers/supervisors found at the different restaurant and the findings will be incorporated into the report with the results from the questionnaires.

You have been chosen as someone who would be able to provide us with an insight about the factors that influence the workers adherence to OSH measures and am sure your opinion will be useful in providing recommendations to ensure good use of safety and health measures.

Participation is voluntary. You can choose whether to take part or not or you do not have to answer all of the questions. The interview is expected to take around 15 minutes.

At this point, if you allow me, I would like to ask you some questions about the study.

Respondent's signature..... Date.....

Researcher's signature Date.....

APPENDIX B: THE RESEARCH QUESTIONNAIRE
QUESTIONNAIRE FOR ASSESSING ADHERENCE TO OCCUPATIONAL SAFETY
AND HEALTH MEASURES AMONG EMPLOYEES IN RESTAURANTS: A CASE
STUDY ON THE SELECTED RESTAURANTS IN KAMPALA DISTRICT.

SERIAL NO: **NAME OF RESTAURANT:**

LOCATION OF RESTAURANT: DIVISION.....

SECTION I: KNOWLEDGE FACTORS

1. What type of task do you do?
2. Have u had any accident in that period? 1. Yes [] 2. No []
3. Are you aware of the risk(s) associated with your type of work? 1. Yes [] 2. No []
4. Do you know the precautionary measures for the risk(s)? 1. Yes [] 2. No []
5. Do you know the importance of personal protective gears? 1. Yes [] 2. No []
6. Do you know how to use the protective gear(s) meant for your task? 1. Yes [] 2. No []
7. Are you aware that you have the right to work in a safe and healthy environment? 1. Yes [] 2. No []
8. Do you know that you have a right to be informed about the hazards for your type of work and the measures against those hazards? 1. Yes [] 2. No []

SECTION II: SOCIO-DEMOGRAPHIC FACTORS

9. Sex: 1. Male [] 2. Female []
10. Age: 1. ≤ 15 [] 2. 15 -24 [] 3. 25- 34 [] 4. > 35 []
11. For how many years have you been doing such type of work?
1. <1 [] 2. 1-2 [] 3. 3-4 [] 4. >4 []
12. Educational level: 1. None [] 2. Primary [] 3. Secondary [] 4. Tertiary [] 5.
Others, specify.....
13. Monthly Income: 1. $\leq 50,000/=$ [] 2. 50,001-100,000/= [] 3. 100,001-150,000/= []
4. 150,001-300,000/= [] 5. $\geq 300,001/=$ []

SECTION III: INSTITUTIONAL FACTORS

14. How far is your residence from your work place? < 1km [] 1-5km [] 6-10km []
>10km []
15. Were you interviewed before getting this job? 1. Yes [] 2. No []
16. Were you trained on how to do your work in a safe way? 1. Yes [] 2. No []
17. Do you have refresh trainings? 1. Yes [] 2. No []
18. Is the waste regularly collected? 1. Yes [] 2. No []
19. Are written safety procedures on how to do certain tasks safely pinned or posted for you?
1. Yes [] 2. No []
20. Do you have a cleaning schedule prepared on a daily basis? 1. Yes [] 2. No []
21. Do you have supervisors? 1. Yes [] 2. No []
22. Does the company provide the protective equipments required? 1. Yes [] 2. No []

SECTION IV: ADHERENCE TO OSH MEASURES

23. Do you put on closed shoes every day at work 1. Yes [] 2. No []
24. Do you use gloves 1. Yes [] 2. No []
25. Do you use the preferred lifting and handling methods 1. Yes [] 2. No []
26. Do you use safety signs when doing certain tasks 1. Yes [] 2. No []
27. Do you use standard operation procedures (SOPs) for some tasks 1. Yes [] 2. No []
28. Do you put aprons everyday 1. Yes [] 2. No []
29. Do you put on cool clothes to avoid heat stress 1. Yes [] 2. No []
30. Do you design cleaning schedules everyday 1. Yes [] 2. No []
31. Do you put on rubber-soled shoes 1. Yes [] 2. No []
32. Do you use the waste bins all the time to dispose waste 1. Yes [] 2. No []

APPENDIX C: KEY INFORMANT INTERVIEW GUIDE

1. Do you have any records of accidents at work?
2. What are the common accidents/injuries do your workers usually get?
3. Do you carry out any training and orientations for the new workers, and provide them with guidelines on OSH measures?
4. What do you do to motivate your employees at the workplace?
5. What other safety measures do you have in place to prevent or minimize those accidents or injuries?
6. What recommendations would you give to improve restaurant workers' adherence to OSH measures in place.

APPENDIX D: STUDY BUDGET

Proposal writing costs

ITEMS	NO.	UNIT COST @	TOTAL
Note book	2	2,000	4,000/=
Pens	2	500	1,000/=
Pencils	2	200	400/=
Paper	240	200	48,000/=
Sub-total			53,400/=

Data collection costs

ITEMS	NO.	UNIT COST @	TOTAL
Phone calls	35	250	8750/=
Data analysis	1	300,000	300,000/=
Interpretation	1	50,000	50,000/=
Sub-total			358,750/=

APPENDIX E: WORK PLAN

19th Oct. 2012	Deadline for submission of Research topics
31st Oct. 2012	Allocation of Supervisors
31st May 2013	Submission of Full Proposal & Commencement of
	Data Collection
12 th July 2013	First full draft – all chapters of a dissertation
16 th Aug. 2013	Second Draft – all chapters
6th Sept 2013	Third draft-all chapters
30th Sept. 2013	Final draft and submission of 3 Spiral bound copies
	for marking with a Turnitin Report
15 th Nov. 2013	Return after marking
29th Nov. 2013	Submission

APPENDIX F: LETTER OF INTRODUCTION



making a difference to Health Care in Uganda

Office of the Dean, Institute of Health Policy and Management

Kampala, 25th March 2013

Innscor Uganda Limited
P.O Box 26599,
Kampala-Uganda

Dear Sir/Madam,

Re: Assistance for Research

Greetings from International Health Sciences University.

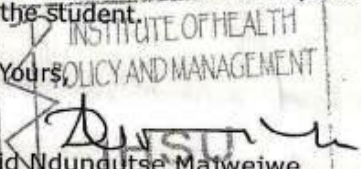
This is to introduce to you **Ms. Ajambo Zipporah, Reg. No. 2010-BSCPH-FT-038** who is a student of our University. As part of the requirements for the award of a Bachelors Degree of Public Health of this University, the student is required to carry out field research for the submission of a Research Project

Ms. Ajambo would like to carry out research on issues related to: **Adherence to Occupational Safety and Health Measures of Workers in Restaurants: A Case study on the Selected Restaurants in Kampala District**

I therefore request you to render the student such assistance as may be necessary for her research.

I, and indeed the entire University are thanking you in anticipation for the assistance you will render to the student.

Sincerely Yours,


Prof. David Ndungutse Majwejwe
Director, Institute of Health Policy & Management

International Health Sciences University
P.O. Box 7782 Kampala - Uganda - East Africa
tel: (+256) 0312 307400 - email: directorihpm@ihsu.ac.ug
web: www.ihsu.ac.ug

The Teaching College of International Hospital Kampala

APPENDIX G: MAP OF KAMPALA SHOWING THE DIVISIONS OF THE CITY

