

**A DESCRIPTION OF SAFETY AND HEALTH COMMITTEES AMONG
SELECTED INDUSTRIES IN NAIROBI**

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DECLARATION

I, Mary Chepngeno Sang, do hereby declare that this research is my original work and has not been presented to any other institution for the purpose of obtaining a degree.

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Date 13th September 2010

APPROVAL.

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DEDICATION

This work is dedicated to my parents, Joel and Elizabeth, for always appreciating my effort.

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LIST OF ABBREVIATIONS

AIHA	American Industrial Hygiene Association
°C:	Degrees in Celsius
DOHSS	Directorate of Occupational Health and Safety Services
°F:	Degrees in Fahrenheit
FINNIDA	Finnish International Development Agency
GDP :	Gross Domestic Product
GNP :	Gross National Product
GoK	Government of Kenya
HSE .	Health and Safety Executive
ILFS	Integrated Labour Force Survey
ILO :	International Labour Organization
OSH .	Occupational Safety and Health
OSHA	Occupational Safety and Health Administration
PASW	Predictive Analytics Software
PHC.	Primary Health Care
SOPs.	Standard Operating Procedures
UCC:	Union Carbide Corporation
UCIL:	Union Carbide India Limited
UK	United Kingdom
USA	United States of America
WHO :	World Health Organization
WSHA	Workplace Health and Safety Agency

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DEFINITIONS OF OPERATIONAL TERMS

Accident: An unplanned, unwanted event that disrupts the orderly flow of the work process. It involves the motion of people, objects or substances

Director: The Director of Occupational Safety and Health Services appointed under section 23 of the Occupational health and Safety Act, 2007 of the laws of Kenya

Employee: A person who works under a contract of employment

Incident: Includes an accident or other occurrence, which resulted in or had the potential for causing an injury or occupational disease.

Occupational hygiene: The anticipation, recognition, evaluation, monitoring and control of conditions arising in or from the workplace, which may cause illness or adverse health effects to persons

Occupier: Person or persons in actual occupation of a factory, whether as the owner or not

Workplace: Any land, premise, location, vessel or thing at, in, upon or near which a worker performs his duty in accordance with his contract of employment.

ABSTRACT

Despite immense efforts, occupational accidents and injuries are still too frequent. Millions of workers become victims every year. The International Labour Organization (ILO) estimates that, globally, about 2.2 million people die every year from occupational injury and illness (ILO, 2005).

Apart from lowering economic costs, reducing the toll of occupational accidents and diseases has obvious implications in terms of the alleviation of human suffering. Paying attention to occupational safety and health should, therefore, be given high priority not only on moral, as a concern, but also on economic grounds. Healthy workers are more likely to have higher work motivation, enjoy greater work satisfaction and contribute to better quality goods and services. The health, safety and well-being of working people, therefore, is of utmost importance for overall socio-economic, equitable and sustainable development.

The main objective of this study was to describe the safety and health committees in various industries in the city of Nairobi. It was a descriptive study with the population of study comprising of staff members from 103 randomly selected industries in Nairobi. Interviews were used to collect primary data while secondary data were derived from the administrative and personnel reports. Data analysis was done using Predictive Analytics Software (PASW).

The Ministry of Labour reports that more than half of the industrial accidents and injuries in Kenya go unreported. It further estimates that reported occupational fatalities and injuries for the years 2000-2004 are: 1528, 1923, 1332, 1599 and 1387 respectively. Major challenges included balancing of committee duties with the company duties, inadequate time for training and

inadequate funds and facilities. Generally the committees had had a positive impact on safety at the various workplaces.

Fifty percent (50%) of the committee members were between 25 and 40 years, 60% were males while 73% were married. Fifty percent (50%) of the committees had 1 to 3 members from management while 28% had between 4 and 6. Thirty eight percent (38%) had 7 to 9 representatives from workers while 33% had between 4 and 6. Forty percent (40%) of the committees met weekly, 29% monthly and 13% when summoned. Sixty percent (60%) of the committees contributed to decision-making at the workplace through giving views and 32% through giving directions. Forty-five percent (45%) communicated with workers through meetings and 38% through postings in notice boards. Forty-five percent (45%) maintained records in disaster accident registers, 35% in safety and health registers and 14% in bar graphs. Forty-three percent (43%) of the committee members were trained in first aid, 23% in disaster management and 17% in material and equipment handling and fire fighting.

Eighty-five percent (85%) of the managers had had their expectations fulfilled as far as the committees were concerned. This was the case with 83% of the workers.

Study recommendations included full co-operation from management and workers, regular training and that the relevant authority (Directorate of Occupational Health and Safety Services, Ministry of Labour) should be more active. More research should be undertaken on areas such as where emphasis on type of training should be

It is hoped that the findings of this study will help policy makers improve the concept of Safety and Health Committees and safety and health in general. This will, in turn, contribute to the reduction of morbidity, mortality, occupational accidents and injuries.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the problem

Progress in protecting workers' health has always been and continues to be a priority objective for the International Labour Organization (ILO). Despite immense efforts made since the 1970s, occupational accidents and diseases are still too frequent. Their costs to society and the enterprise, as well as to the workers affected and their families continue to be unacceptably high.

The ILO estimates that, globally, about 2.2 million people die every year from occupational injury and illness. Of this total, about 350,000 deaths are due to fatal occupational injuries. The ILO utilizes a variety of national reports to generate estimates, and states that the global workforce of 2.8 billion persons suffer some 270 million serious non-fatal injuries and 160 million work-related diseases. This takes into account non-recorded, part-time, children, and other informal sector workers (ILO 2005). These social costs can no longer be tolerated as the inevitable price of progress. Reducing the toll of occupational accidents and diseases has obvious implications in terms of the alleviation of human suffering. The related economic costs place a considerable burden on the competitiveness of enterprises. It is estimated that the annual losses resulting from work-related diseases and injuries, in terms of compensation, lost work-days, interruptions of production, training and retraining, medical expenses, and so on, routinely amount to over 4 per cent of the total gross national product (GNP) of all the countries in the world. The annual cost of accidents in the manufacturing sector of the United States of America (USA) alone is more than US\$190 billion (ILO 1998).

The Bhopal disaster was an industrial catastrophe that took place at a pesticide plant owned and operated by Union Carbide India Limited (UCIL) in Bhopal, Madhya Pradesh, India on December 3, 1984. Union Carbide Corporation (UCC) admitted in their own investigation report that most of the safety systems were not functioning on the night of December 3, 1984 (UCC, 1985). During the nights of 2-3 December, a large amount of water entered tank 610. A runaway reaction started, which was accelerated by contaminants, high temperatures and other factors. The reaction generated a major increase in the temperature inside the tank to over 200°C (400°F). This forced the emergency venting of pressure from the holding tank, releasing a large

volume of toxic gases. The reaction was sped up by the presence of iron from corroding non-stainless steel pipelines. It is estimated that 20,000 have died since the accident from gas-related diseases. Another 100,000 to 200,000 people are estimated to have permanent injuries (Eckerman et al, 2005). The corporation believes that the accident was the result of sabotage, stating that safety systems were in place and operative. It also stresses that it did all it could to alleviate human suffering following the disaster (UCC, 1985).

The Health and Safety Executive (HSE) is a non-departmental public body in the United Kingdom. It is the body responsible for the encouragement, regulation and enforcement of workplace health, safety and welfare, and for research into occupational risks in England and Wales and Scotland. The HSE was created by the Health and Safety at Work etc. Act 1974, and has since absorbed earlier regulatory bodies such as the Factory Inspectorate and the Railway Inspectorate. The HSE is sponsored by the Department for Work and Pensions. As part of its work HSE investigates industrial accidents, small and large (Department for Work and Pensions, 2008).

The Executive is further obliged to keep the Secretary of State informed of its plans and ensure alignment with the policies of the Secretary of State, giving effect to any directions given to it (Health and Safety at Work etc. Act, 1974). It is also responsible for the Employment Medical Advisory Service, which operates as part of its Field Operations Directorate (HSE, 2000).

The Health and Safety Executive (HSE), has developed a methodology to calculate the costs of workplace accidents and ill health to individuals, employers and society as a whole.

The study revealed that, for the year 1995-96 (a 12-month period), costs were:

- for individuals : US\$8.96 billion, with costs in future years of US\$2.24 billion;
- for employers : US\$5.6-11.7 billion, representing 4-8 per cent of gross trading profits;
- for society as a whole : in the region of US\$15.8-22.5 billion, equal to around 2 per cent of gross domestic product (GDP); and the average annual growth of GDP in the period 1986-96 was 2.6 per cent.

In other words, the cost of accidents and ill health at work wiped out nearly all economic growth (London, Health and Safety Executive (HSE) Books, 1999).

These estimates are sufficient to demonstrate beyond any doubt that a significant reduction in the incidence of occupational accidents and diseases over a reasonable period of time will produce valuable economic benefits. Paying attention to occupational safety and health should therefore be given a high priority not only on moral but also on economic grounds

The Bureau of Labor Statistics of the United States Department of Labor compiles information about workplace fatalities in the United States. Since 1992, the year with the most workplace fatalities was 1994 with 6,632 fatalities, and the lowest in 2002 with 5,534 (<http://www.hse.gov.uk/statistics/tables/agegen1.htm>)

The incidence of workplace fatalities varies enormously between countries. There appears to be a significant difference between developed and developing countries

- a factory worker in Pakistan is eight times more likely to be killed at work than a factory worker in France;
- fatalities amongst transport workers in Kenya are ten times those in Denmark;
- construction workers in Guatemala are six times more likely to die at work than their counterparts in Switzerland (World Bank *World Development Report*, 1995).

Generally, small workplaces have a worse safety record than large ones. It seems that the rate of fatal and serious injuries in small workplaces (defined as less than 50 employees) is twice that in large workplaces (defined as those with more than 200 employees)

In most countries males comprise the vast majority of workplace fatalities. In the EU as a whole, 94% of deaths were of males (Department for Work and Pensions, 2008). In the UK the disparity was even greater with male comprising 97.4% of workplace deaths (HSE, 2008).

Healthy workers are more likely to have higher work motivation, enjoy greater job satisfaction and contribute to better-quality products and services, thereby enhancing the overall quality of life of individuals and society. The health, safety and well being of working people are thus prerequisites for quality and productivity improvements, and are of the utmost importance for overall socio-economic, equitable and sustainable development.

1.1.1 OVERVIEW OF OCCUPATIONAL SAFETY AND HEALTH IN KENYA

The status of occupational safety and health conditions in Kenya is an issue of growing importance to industrialists, practitioners, the government and other stakeholders. Occupational safety and health issues are anchored in the Ministry of Labour, Department of Occupational Health and Safety. The Occupational Safety and Health Act, 2007, Chapter 514, of the Laws of Kenya is an act of parliament meant to provide for the safety, health and welfare of workers and all persons lawfully present at workplaces. The Occupational Safety and Health Act, 2007 replaced The Factories Act Cap 514 of the laws of Kenya, which came into operation on 1st September 1951, and which has since been repealed.

In 2004, a subsidiary legislation of The Factories Act Cap 514 (Legal Notice No.31) was enacted to provide for the formation of Safety Committees by the occupier of every factory or other workplaces. The Committee is responsible for all health and safety issues of enterprises including undertaking safety audits.

The Ministry of Labour reports that more than half of the industrial accidents and injuries in Kenya go unreported. Reported occupational fatalities and injuries from the years 2000-2004 are: 1528, 1923, 1332, 1599 and 1387 respectively. This is viewed against the background that factories and other workplaces have to be registered by the Department of Occupational Health and Safety, but by the end of 2004 only 11,387 such enterprises are registered excluding the 1.3 million micro and small enterprises (*juakali*)*.

Most of the reported accidents are those seeking compensation under the Work Injury Benefits Act, 2007 of the laws of Kenya. In the year 2003, data indicated that mining, construction and transport accounts for 41% of accidents in Kenya, machine operators and assemblers 28% while other occupations share 31% of workplace accidents. This shows that these occupations are injury prone while matters of safety are treated casually by both the employer and employees. In relation to age groups 44.4% of the injuries occurred to persons in the age group of 20 to 29 years, 25% to the age group of 30 to 39 years and 24% to the age group below 20 years (Kangethe, 2003)

**juakali* means "hot sun"

1.1.2 OCCUPATIONAL SAFETY AND HEALTH COMMITTEES

A Joint Safety and Health Committee is a committee made up of worker and employer representatives working together to identify and resolve health and safety problems in the workplace. Worker representatives must be chosen by and represent the workers. To be successful, the committee must operate in an atmosphere of cooperation and be effective in promoting and monitoring a sound occupational health and safety programme. Consulting employees about health and safety can result in:

- healthier and safer workplaces – because employee input is valuable to identify hazards, assess risks and develop ways to control or remove risks;
- better decisions about health and safety – because they are based on the input and experience of a range of people in the organization, including employees who have extensive knowledge of their own job and the business;
- stronger commitment to implementing decisions or actions – because employees have been actively involved in reaching these decisions;
- greater co-operation and trust – because employers and employees talk to each other, listen to each other and gain a better understanding of each other's views;
- joint problem-solving (Workplace Health and Safety Agency, WSIIISA, 1994).

While the employer is ultimately responsible for the overall safety programme, the committee is responsible for identifying and recommending solutions to problems. The individual worker has a responsibility to report problems to the supervisor or employer (Workplace Health and Safety Agency, WSIIISA, 1994).

1. Joint safety and health committees provide a valuable framework for discussion and for concerted action to improve safety and health. They should meet regularly and should periodically inspect the workplace.
2. Workers safety delegates, workers safety and health committees, and joint safety and health committees (or, as appropriate, other workers representatives) should be given adequate information on health and safety matters, enabled to examine factors affecting health and safety, encouraged to propose safety and health measures, consulted when major new safety and health measures are envisaged

and before they are carried out, ready to seek the support of workers for health and safety measures

3. They should also be consulted in planning alterations of work processes, work content or organization of work which may have safety or health implications for workers and given protection from dismissal and other measures prejudicial to them while exercising their functions in the field of occupational health and safety as workers' representatives or as members of health and safety committees. They should be able to contribute to the decision-making process within the enterprise regarding matters of health and safety and allowed access to all parts of the workplace.
4. They should be able to communicate with workers on health and safety matters during working hours at the workplace, free to contact labour inspectors and able to contribute to negotiations within the enterprise on occupational health and safety matters. They should also be granted reasonable time during paid working hours to exercise their health and safety functions and to receive training related to these functions and should be able to have recourse to specialists for advice on particular health and safety problems. Members are entitled to time away from their regular job duties to attend and prepare for meetings

Although the periodic meeting is a major event, it should not be the only time when members concern themselves with the program. Not all safety related problems can wait until the next meeting to be solved. Outside the regular meeting, members should monitor ongoing health and safety procedures

5. Hazards can be identified and recommendations made to workers and employers that will eliminate hazards and improve conditions. It is useful for Joint Health and Safety Committees to confirm that all reportable incidents/accidents have been investigated as required
6. Good record keeping is an essential component of successful health and safety programmes for the prevention of occupational injury and disease. For occupational health and safety information to be useful, it must be reliable and accurate.

Records and statistics can be used to collect and analyze data on causes of injury and disease so that specific control measures can be taken. They can also be used to identify specific work locations, departments, occupations and tasks (such as heavy lifting) where there is a high risk of injury and or illness so that prevention efforts can be directed in those areas. They also provide employers, managers, health and safety representatives and Joint Health and Safety Committees with factual information needed to objectively evaluate health and safety programs and measure the progress and effectiveness of accident and injury prevention efforts.

7. For a Joint Health and Safety Committee to function effectively, members must take appropriate education and training. Education and training should cover the information members need to assist in creating a safe and healthy workplace.
8. The committee should establish procedures for self-monitoring in an effort to ensure that objectives are being reached. The effectiveness and credibility of both the committee and the employer can be measured by results. The committee itself is only an advisory body and only the employer representatives have the authority to translate the committee's decisions into action (Workplace Health and Safety Agency, WSHSA, 1994).

Safety committees or joint safety and health committees have already been set up in larger enterprises in a number of countries. Smaller firms sometimes group together to set up regional health and safety committees for each branch of activity. The most promising results seem to have been achieved when management has concentrated on increasing workers' awareness of their important role in health and safety and encouraged them to assume their responsibilities more fully

The protection of workers from occupational accidents and diseases is primarily a management responsibility, on a par with other managerial tasks such as setting production targets, ensuring the quality of products or providing customer services. Management sets the direction for the company. The strategic vision and mission statement establish a context for growth, profitability and production, as well as placing a value on workers' safety and health throughout the enterprise. The system for managing safety and health should be integrated within the company's

business culture and processes. If management demonstrates in words and action, through policies, procedures and financial incentives, that it is committed to workers' health and safety, then supervisors and workers will respond by ensuring that work is performed safely throughout the enterprise.

Occupational safety and health should not be treated as a separate process, but one that is integral to the way in which activities take place in the company. Its various functions and procedures should be embedded in other management system and business processes in the enterprise, as well as within comparable structures in the community. In order to achieve the objective of safe and healthy working conditions and environment, employers should institute organizational arrangements adapted to the size of the enterprise and the nature of its activities.

1.2 STATEMENT PROBLEM

Millions of workers die or are injured or fall ill every year as a result of workplace hazards. The suffering in terms of human life is enormous, while the economic costs of the failure to ensure occupational health and safety are so great that they may undermine national aspirations for sustainable economic and social development. Improving occupational health and safety is in the best interests of all governments, employers and workers (I.L.O, 2005).

Despite this worrying situation, international awareness of the magnitude of the problem remains surprisingly modest. The inadequate dissemination of knowledge and information hampers action, especially in developing countries. It also limits the capacity to design and implement effective policies and programmes. The fatality, accident and disease figures are alarming but investment decisions continue to be made in disregard of safety, health and environmental considerations. In the scramble for capital, globalization and increasingly stiff competition tend to deflect attention from the long-term economic benefits of a safe and healthy work environment.

While the international press reports on major industrial accidents, the many work-related deaths that occur every day go virtually unrecorded. Workers continue to face serious risks. To reduce the human suffering and financial loss associated with these risks, there is a need for increased and sustained action to protect occupational health and safety, and the environment.

The enactment of legislature to pave way for the establishment of safety and health committees was done in an effort to mitigate the situation. Insight into the functions being carried out by these committees would be useful in establishing their impact at the workplace.

1.4 JUSTIFICATION FOR THE STUDY

Many deaths and injuries occur as a result of workplace hazards. These have great social and economic implications. This led to the establishment of the Safety and Health Committees Rules, Legal Notice No. 31, of May 2004, a subsidiary legislation of The Factories Act Cap 514 to provide for the formation of Safety Committees by the occupier of every factory or other workplaces. The Committee is to be responsible for all health and safety issues. Insight into the functions being carried out by these committees would be useful in establishing their impact at the workplace.

Findings will help highlight areas which need to be addressed, helping policy makers improve the concept of Safety and Health Committees and safety and health in general. This, will in turn, contribute to the reduction of morbidity, mortality, occupational accidents and injuries. It will also help in providing information that could be used for further research.

1.3 OBJECTIVES OF THE STUDY

1.3.1 GENERAL OBJECTIVE

To describe the roles and functions of safety and health committees among selected industries in Nairobi.

1.3.2. SPECIFIC OBJECTIVES

1. To determine the demographic profiles of study participants and positions held at work;
2. To determine the composition of members of the committee.
3. To ascertain the functions being carried out by the committee;
4. To establish the period of operation of the various workplaces;
4. To find out if committee members have undergone any training;
5. To find out the impact the committees have had at the workplace;
6. To highlight the difficulties experienced by the committee in carrying out their functions and recommendations by the study participants.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.0.1 OCCUPATIONAL SAFETY AND HEALTH COMMITTEES

In the 1970s, most Canadian provinces passed legislation enabling the establishment of Joint Health and Safety Committees (Workplace Health and Safety Agency, WSHSA, 1994). The UK and USA established similar legislation in the 1970s (Beaumont, et al, 1982 ; Leopold, et al, 1982). While these committees have been in existence in most medium and large sized workplaces for over a quarter of a century few studies have attempted to measure their effectiveness.

In the United States, Cook and Gautschi used data from 113 manufacturing companies in Maine over a six-year period (Cooke, et al, 1980). After controlling for the number of employees in the plants and the impacts of business cycles, they found that the presence of a Joint Health and Safety Committee in the plant was associated with a small decrease in time loss claims due to injury.

In contrast, in a study of 127 large manufacturing firms in Massachusetts, Boden, et al, (1984) determined that the presence of a Joint Health and Safety Committee did not reduce the number of health and safety complaints. However, interviews with managers and labour members of Joint Health and Safety Committees in 13 of these firms revealed that Joint Health and Safety Committees, which were rated as effective by respondents needed fewer health and safety inspections. The study appeared to indicate that the presence of a Joint Health and Safety Committee may not be enough and that the key to success with these committees may be in ensuring their effectiveness. The study was conducted to determine if the existence of a joint labour-management health and safety committee was correlated with either the number of Occupational Safety and Health Administration (OSHA) complaints or hazardousness, as measured by OSHA serious citations, virtually no effect could be detected in a sample of 127 Massachusetts manufacturing firms. At a sample of 13 firms, interviews of health and safety committee members were conducted. Committee attributes and perceptions about committee

effectiveness were compared with the number of OSHA complaints and serious citations. There were fewer complaints and fewer serious citations at firms with health and safety committee that were perceived as effective. Results of the study suggest that the objective attributes of the committee may be less important to its success than the commitment of management and labour to solving workplace safety problems.

In the UK, Reilly used a sample from the Workplace Industrial Relations Survey of manufacturing plants and found that workplaces with joint committees had, on average, 5.7 fewer injuries per 1000 employees compared with workplaces without Joint Health and Safety Committees (Reilly, et al, 1995).

Tuohy and Simard (1993), found, in a study of Quebec and Ontario workplaces, that Joint Health and Safety Committees with equal numbers of union and management representatives had both lower injury rates and demonstrated enhanced problem solving expertise compared to workplaces without these committees (Tuohy, et al, 1993). They showed that the capacity of Joint Health and Safety Committees to function effectively was correlated with the amount of training and information available to Joint Health and Safety Committee members.

In a review of these studies, O'Grady concluded that Joint Health and Safety Committees may have a role in improving workplace health and safety but that the presence of Joint Health and Safety Committees in workplaces do not necessarily lead to improvements in injury rates. He determined that the critical issue was the effectiveness of Joint Health and Safety Committee.

2.0.2 OCCUPATIONAL SAFETY AND HEALTH COMMITTEES IN KENYA

In Kenya, the enactment of the Factories Act Cap 514 in 1951 saw the emergence of occupational safety and health in Kenya. The crafting of this legislation was prompted by the enactment of the Workers' Compensation Act Cap 236 in 1948. However, it was not until 1974 that the then Minister for Labour requested the International Labour Organization (ILO) during the 62nd International Labour Conference for assistance to strengthen factory inspection and in the establishment of specialized inspections.

This culminated in the ILO Finnish International Development Agency (FINNIDA) Project that commenced in 1978 that established specialized divisions, namely engineering, medical and hygiene in support of the general inspection and field services. This led to the recruitment and training of three medical officers, four nurses, four hygienists and the establishment of laboratory and work environment monitoring services. This was the first time that coherent occupational health services (OHS) were offered in Kenya (Kangethe, 2003).

In 1990 the Act was amended to include the following aspects, among others

- i. Other places of work;
- ii. List of occupational diseases;
- iii. Establishment of health and hygiene standards;
- iv. Reporting of occupational diseases;
- v. Direct penalties for medical practitioners failing to report occupational diseases that they diagnose;
- vi. Pre-employment, periodic and post-employment medical examinations;
- vii. Research into causes of work-related diseases among others (Government of Kenya (GoK), Sessional Paper No. 2 of 2004)

With the introduction of "Other Places of Work", occupational health services were by law extended to cover, in addition to factories, other workplaces, including agriculture and workplaces employing more than two persons, such as the informal sector. However, the provision of services in practice focused mainly on factories industries and commercial agricultural farms. Over the years only minimal occupational health services have been offered to small enterprises and the informal sector due to limited resources (GoK, Sessional Paper No. 2 of 2004).

In addition to routine and specialized inspections, the directorate provides medical surveillance and runs a workers' clinic that is supported with medical supplies by the Ministry of Health Medical Supplies Department. Patient referrals, where necessary, are made to the district, provincial and national public hospitals although these have no occupational health services per se. The Department is also staffed with occupational hygienists who provide workplace

environmental monitoring and teaming up with the engineers and other personnel provide advice on the prevention and control of workplace hazards

In addition to the Ministry of Labour and Human Resource Development, the Ministry of Health has established an Occupational Health Division currently manned by one officer at the headquarters. The unit oversees the work of several nurses and public health officers who have graduated with a diploma in occupational health and safety from the Medical Training Center and who are deployed countrywide within the public health care system (PHC).

One of the unique features of the occupational health system in Kenya is that it places a penalty to medical practitioners who fail to report any occupational disease once they diagnose it to the Director of Occupational Safety and Health Services.

One study found that establishments with joint consultative committees, where all employee representatives were appointed by unions, had significantly fewer workplace injuries than those where the management alone determined health and safety arrangements (Reilly, et al, 1995).

While the international press reports on major industrial accidents, the many work-related deaths that occur every day go virtually unrecorded. Workers continue to face serious risks. To reduce the human suffering and financial loss associated with these risks, legislature was enacted to pave way for the establishment of safety and health committees. Insight into the functions being carried out by these committees would be useful in establishing their impact at the workplace.

environmental monitoring and teaming up with the engineers and other personnel provide advice on the prevention and control of workplace hazards.

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CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 RESEARCH DESIGN

This was a descriptive cross-sectional study. It sought to describe the state of affairs, as they existed at that particular time (Coggon, et al, 1997). It provided a systematic description that was as factual and accurate as possible.

3.2 AREA AND POPULATION OF STUDY

The study was conducted among selected industries in the city of Nairobi. The study was conducted in Nairobi as there is a wider variety of workplaces and a random sample of these places of work is likely to lead to a more representative sample.

Nairobi is the capital and largest city of Kenya. Kenya has a large economy, which, has slowed down since the mid-1990s due to a number of factors including deteriorating infrastructure, telecommunications, labour unrest, and loss of investor confidence (ILO, 1999). Agriculture dominates the Kenyan economy in terms of its share of GDP. The city and its surrounding area also form the Nairobi Province. The records of the Ministry of Labour, Directorate of Occupational Health and Safety Services (DOHSS) showed the number of industries in Nairobi, in May 2009, to be 655.

3.2.1 Population

The study population comprised Safety and Health Committee members at the selected workplaces, members of staff from management and members of staff not from management in those workplaces.

Inclusion and Exclusion Criteria

Inclusion criteria: industries with more than 20 employees as stated in section 9 of the Occupational Safety and Health Act, 2007, of the Laws of Kenya.

Exclusion criteria:

1) industries with less than 20 employees;

ii) Industries with no safety and health committee.

3.2.2 Sample size determination

The following formula was used to calculate the sample size (Kothari, 1990)

$$n = \frac{z^2 \times D \times Q \times N}{e^2 (N-1) + z^2 \times p \times q}$$

Where:

n - is the sample size,

z - is the number relating to the degree of confidence. In this case a 95% confidence interval will be used. This value was therefore 1.96.

N - is the population (total number of registered industries in Nairobi)

E - is the error, in our case 10%.

P - is the proportion in the target population estimated to have characteristics being measured

q - is 1-p

The sample size, therefore, was:

$$n = \frac{1.96^2 \times 0.5 \times (1-0.5) \times 655}{0.1^2 (655-1) + 1.96^2 \times 0.5 \times (1-0.5)}$$

$$n = 83.87 \text{ or } 84$$

Therefore 84 industries needed to be sampled

3.3 SAMPLING DESIGN

Reference was made to a list of all the registered workplaces in Nairobi obtained from the Office of the Director of Occupational Health and Safety Services, Ministry of Labour in May 2009. This was then used as a sampling frame. This method of sampling involved using random numbers to pick up the unit with which to start (Kothari, 1990). This way, all the industries in the sampling frame had an equal probability of being selected (Grimes, et al, 2002). "Representative

sampling is the only justified procedure for choosing individual objects to use as the basis of generalization, and is therefore usually the only acceptable basis for ascertaining truth." (Andrew A. Marino) (Brown, et al, 1999). The sampling interval was then determined. This involved dividing the total population by the sample size.

The sample size was increased slightly from 84 to 103 in case some of the selected respondents refused to cooperate or were not available when they are called upon for the purpose of being interviewed.

3.4 DATA COLLECTION

Interviewing method was used to collect data. This was administered with the aid of an interview guide. Pre-testing of data collection tools helped ensure respondents understood what the questions being asked wanted to bring out. This helped to ensure as much of the information needed to meet the objectives of the study was captured. Pretesting was done among selected industries in Nakuru. This is a town outside Nairobi, the city of interest, and therefore did not interfere with the results of the study. Questions which were vague were rephrased until they conveyed the required message to all respondents (Mugenda, 2003).

Interviews were conducted with members of the Safety and Health Committee in the industries, which were selected for the study so as to obtain information concerning the Committees at their workplaces (Appendix 5). Members of staff were also interviewed (one from management and two, not from management) so as to be able to effectively assess the impact the Committees have had at the workplace (Appendix 6 and 7).

Three research assistants were selected and trained jointly to ensure uniformity. They needed to at least have completed their high school education. They were advised to study the interview guide in detail, familiarize themselves with it. They had to be able to conduct the interviews without backtracking or re-reading the interview guide. Interviewers practiced interviewing and received constructive feedback until their performance reached the desired objectivity and reliability (Mugenda, 2003)

Consent forms which contained a summary of the research accompanied every interview guide. The summary included the following

- Purpose of the study,
- Importance and significance of the study in simple language;
- A commitment to sharing the results when the study is completed,
- A brief assurance of confidentiality (see appendix 1 and 3).

3.4.1 ETHICAL CONSIDERATIONS

Before collecting data, clearance was granted by the Kenyatta National Hospital and College of Health Sciences, University of Nairobi Ethical Committee.

Participants were informed beforehand of the nature and purpose of the study. Since confidentiality was to be assured, consent forms were provided for the participants. Names of the participants and their places of work were not indicated.

3.5 RESEARCH PROCEDURES

The interview guides were designed on the basis of the research questions and the questions were standardized by ensuring each of the questions meant the same thing to each of the respondents. The selected industries were agreed upon and prior communication to the potential individual respondents was done through the telephone so as to book for an appointment. After confirmation of date and time, the principal investigator and research assistants went and conducted face-to-face interviews with the individuals. The interview guides were accompanied by a letter of introduction to the potential respondents, which stated the purpose of the research.

3.6 DATA PROCESSING, ANALYSIS AND PRESENTATION

When interviewing was complete, the data was edited by examining the collected raw data to detect errors and omissions and correct these where possible. This was done soon after the interview. To permit quantitative analysis, data was converted to numerical codes representing attributes or measurements of variables. Only one code was assigned to each response category. A codebook was designed to describe in detail the coding scheme to be followed. It contained all the information extracted from the interviews in an organized way (Mugenda, 2003).

In order to find out the functions the Safety and Health Committees were performing, frequency tables were utilized. These values were obtained using Predictive Analytics Software (PASW).

CHAPTER FOUR

4.0 STUDY FINDINGS

4.1 Objective 1: Socio-demographic characteristics of study participants and positions held at work

4.1.1 Socio-demographic characteristics of committee members and positions held at work

Close to 50% of the committee members fell in the range of between 25-29 and 30-34 years while 22% fell between 40 – 50 years. Over 60% were males while about 40% were females. Those married were 73% while 27% were single (Table 1)

Secondary school level of education had been attained by 76% while 19% had attained university education. Tertiary level of education had been attained by 4% while only 1% had primary school level education (Table 1)

Table 1: Socio-demographic characteristics of committee members (n=206)

Characteristic	No.	Percent
Age (years)		
18-24	6	3
25-29	50	24
30-34	52	25
35-39	47	23
40-44	31	15
45-50	12	6
>50	8	4
Total	206	100
Gender		
Male	128	62
Female	78	38
Total	206	100
Marital status		
Married	150	73
Single	56	27
Total	206	100
Level of education		
Primary	2	1
Secondary	157	76
Tertiary	8	4
University	39	19
Total	206	100

Twenty percent (20%) of the committee members were managers, 15% supervisors, 12% were sales and marketing executives and electrical technicians respectively, 6% were secretaries, receptionists and clerks respectively, while the least represented were nurses at 1% (Figure 1).

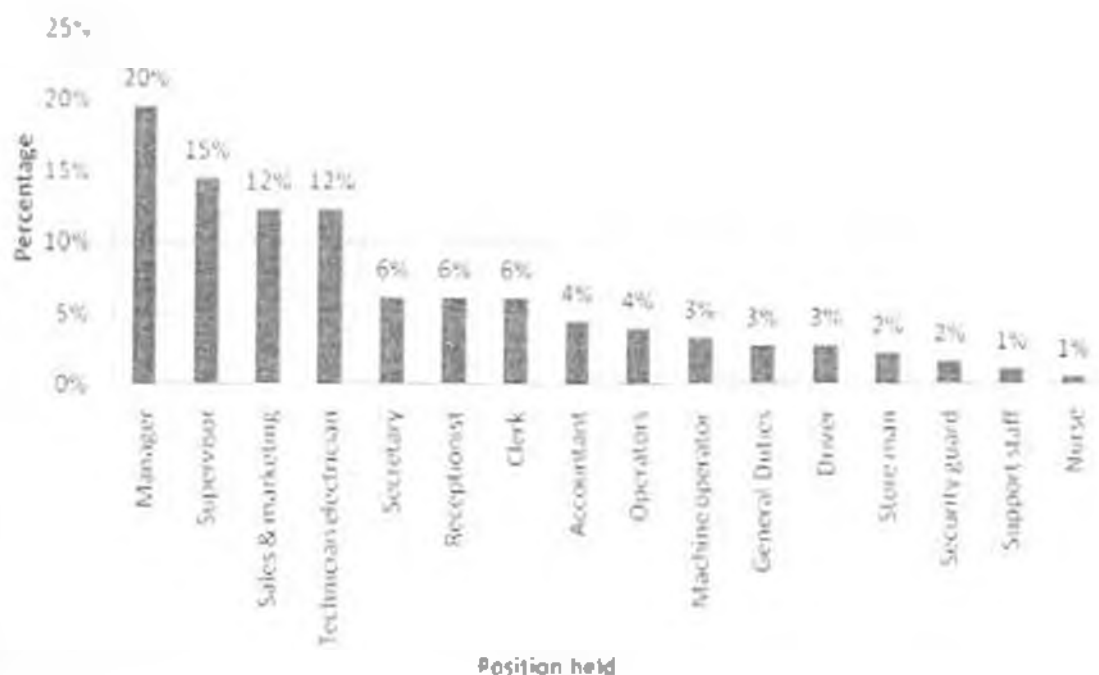


Figure 1: Positions held at work by committee members (n=179)*

*27 declined to answer

4.1.2 Socio-demographic characteristics of members of staff from management (managers) and positions held at work

Twenty-three percent (23%) of the respondents fell in age group 30 –34, an identical 22% fell in the age brackets 35-39 and 40-44, 17% were in the age group 25-29, 10% were in age group of 45-50, 4% were in the age group of 18-24, while 3% were over 50 years of age (Table 2).

Close to 60% were males while the remaining 40% were females. Eighty-two percent (82%) of the managers were married while 18% were single (Table 2)

Forty-two percent (42%) of the managers had attained university education, 34% had secondary school education while 24% had tertiary level education (Table 2).

Table 2: Socio-demographic characteristics of managers (n=101)

Characteristic	No.	Percent
1. Age (years)		
18-24	3	3
25-29	17	17
30-34	23	23
35-39	22	22
40-44	22	22
45-50	11	10
>50	3	3
Total	101	100
2. Gender		
	No.	Percent
Male	69	59
Female	32	41
Total	101	100
3. Marital status		
Married	83	82
Single	18	18
Total	101	100
4. Level of education		
Secondary	34	34
Tertiary	24	24
University	43	42
Total	101	100

Thirty-three percent (33%) of the managers had served as general managers, 17% as supervisors, an identical 9% had served as sales people and operators, 8% had served as accountants, 7% as nurses, 6% as secretary, 4% as receptionist, 2% general duties, while the remaining 1% had served as security guards, support staff, technicians and clerks (Figure 2)

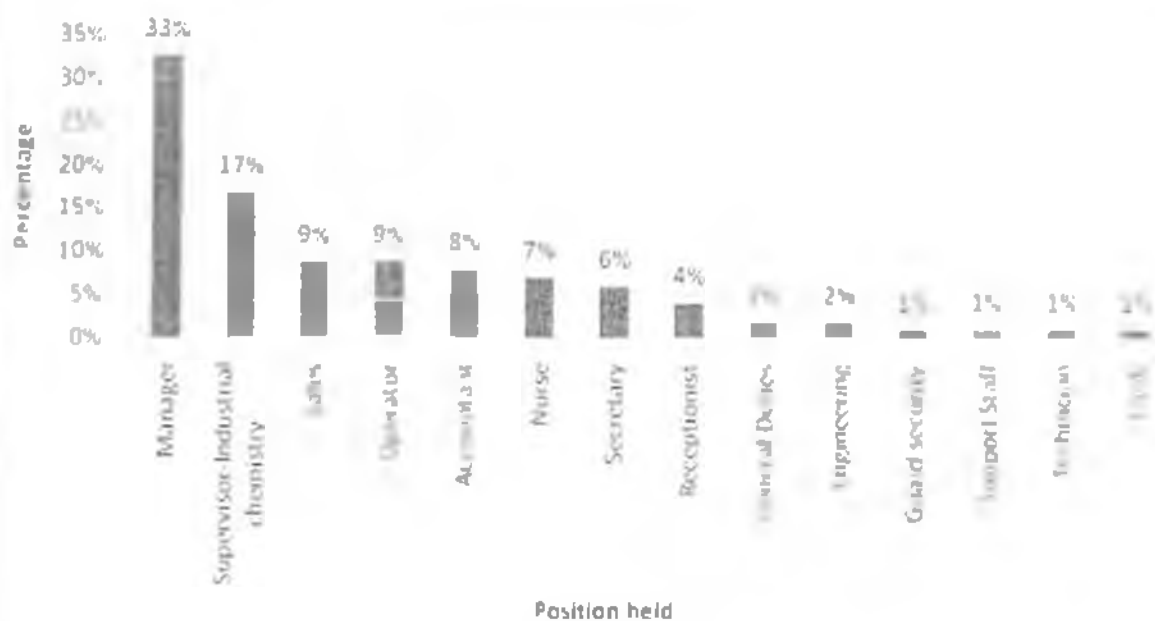


Figure 2: Positions held at work by managers (n = 101)

Fifty-four percent (54%) of the managers had served in their respective establishments for 1 – 5 years, 33% had served for 6-10 years, 7% for 11-15 years, 4% for 16-20 years, while 2% had served for more than 20 years.

4.1.3 Socio-demographic characteristics of members of staff not from management (workers) and positions held at work

Slightly over 50% of the workers were in the age bracket of between 2—30 years, 37% were in the age bracket of between 31-40 years, 9% fell in the age bracket of between 41-50 years, while 2% were above 50 years of age (Table 3).

The workers comprised of 55% males and 45% females. Sixty-two percent (62%) of the workers were married while 38% were single. Eighty-five percent (85%) had attained the secondary school education, 11% tertiary level of education, 3% primary school level of education, while 1% had attained university education (Table 3)

Table 3: Socio-demographic characteristics of workers (n= 187)

Characteristic	No.	Percent
1. Age (years)		
21-30	94	51
31-40	69	37
41-50	18	9
>50	6	3
Total	187	100
2. Gender		
Male	103	55
Female	84	45
Total	187	100
3. Marital status		
Married	116	62
Single	71	38
Total	187	100
4. Level of education		
Primary	6	3
Secondary	158	85
Tertiary	21	11
University	2	1
Total	187	100

Twenty-four percent (24%) of the workers served in their respective establishments in security, 14% as support staff, 11% as drivers, and an identical 10% served in general duties and as secretaries, 7% as clerical staff, 6% as technicians, 5% as supervisors and 4% in sales. A small percentage served as receptionists, operators, accountants, store men and nurses (Figure 3).

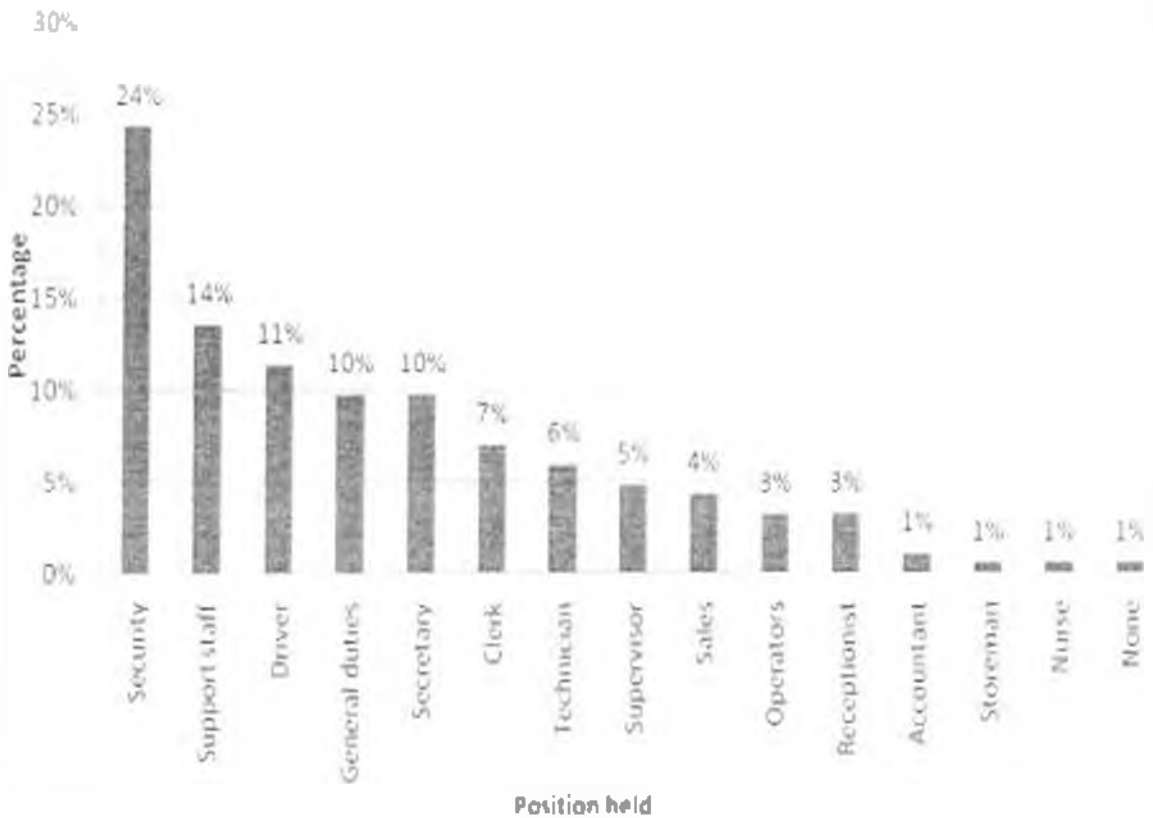


Figure 3: Positions held at work by workers (n=185)*

*2 declined to answer

Seventy-five percent (75%) of the workers had served their respective companies for between 1-5 years, 18% for between 6-10 years, 4% for between 11-15 years, 3% for between 16-20 years, while only 1% had served for over 20 years.

4.2 Objective 2: Composition of members of the committee

Fifty percent (50%) of the respondents have between 1-3 members as representatives from management, 28% have 4-6 members, 16% have 7-9 members, while 6% have more than 9 members as representatives from management (Figure 4).

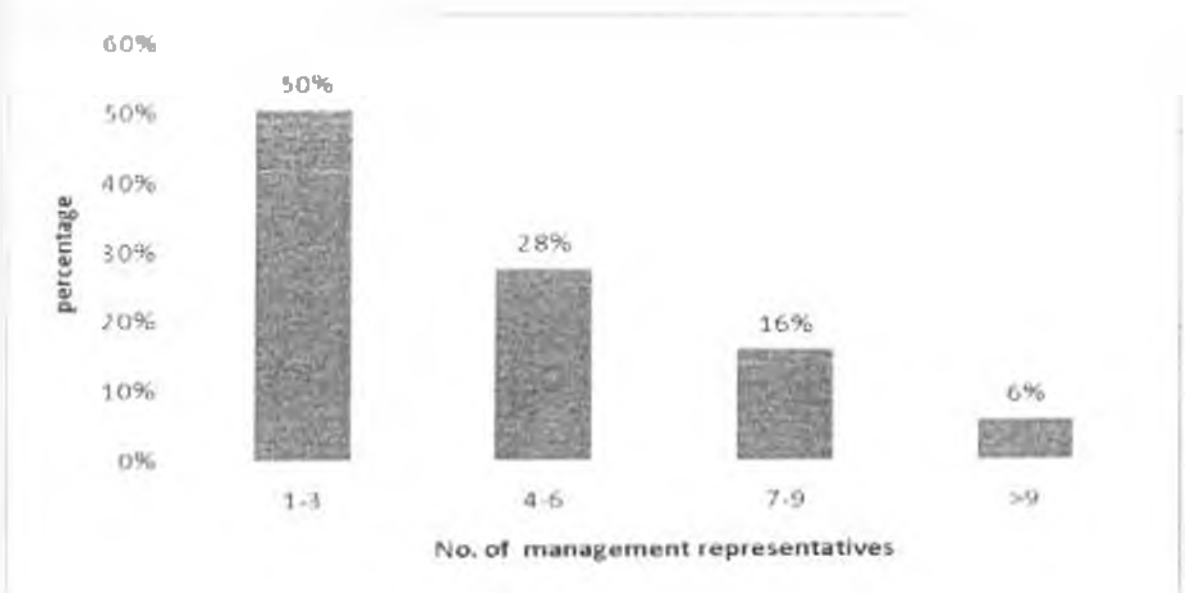


Figure 4: Percentage of committee members from management (n=206)

Thirty-eight percent (38%) indicated that 7-9 members came from workers, 33% indicated 4-6 members, 19% indicated more than 10 members while 10% indicated 1-3 members as representatives from workers (Figure 5).

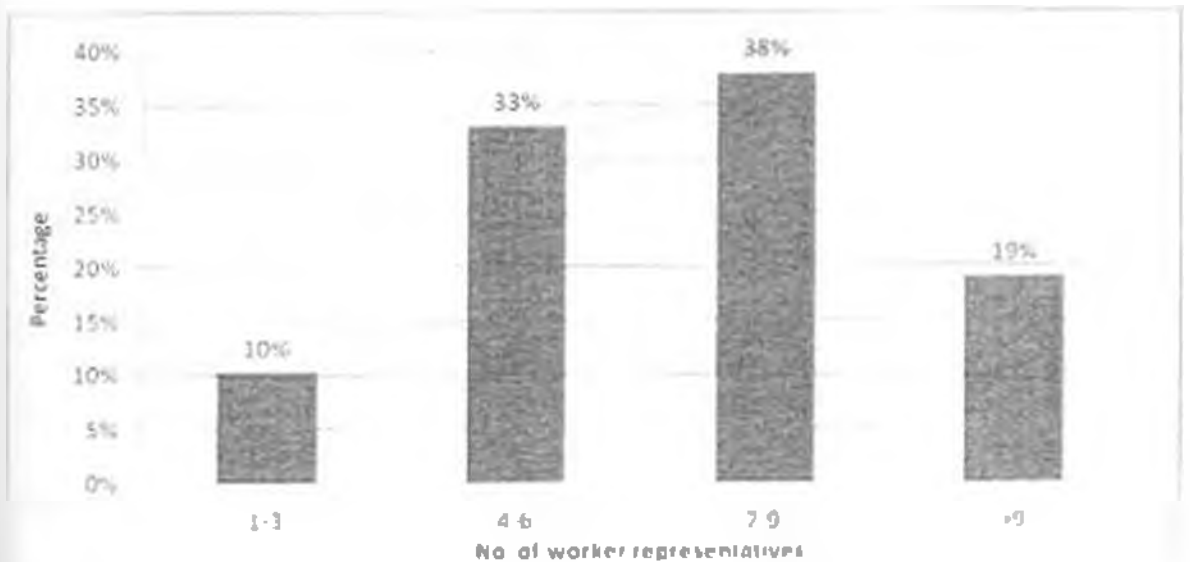


Figure 5: Percentage of committee members from workers (n=206)

Fifty-five percent (55%) of the committee members were appointed by chief executive officer while 45% were proposed by management. Sixty-four percent (64%) indicated that their chairmen were appointed by the chief executive officer, while 36% indicated that they were elected by the workers

4.3 Objective 3: Functions of the committees

4.3.1 Functions being carried out by the committees

Thirty-seven (37%) of the committees interviewed deal in monitoring, evacuation in emergencies and staff safety, 29% engage in conducting seminars and education to create awareness, 12% identify dangers at the workplace while 11% help in time of accident (Figure 6).

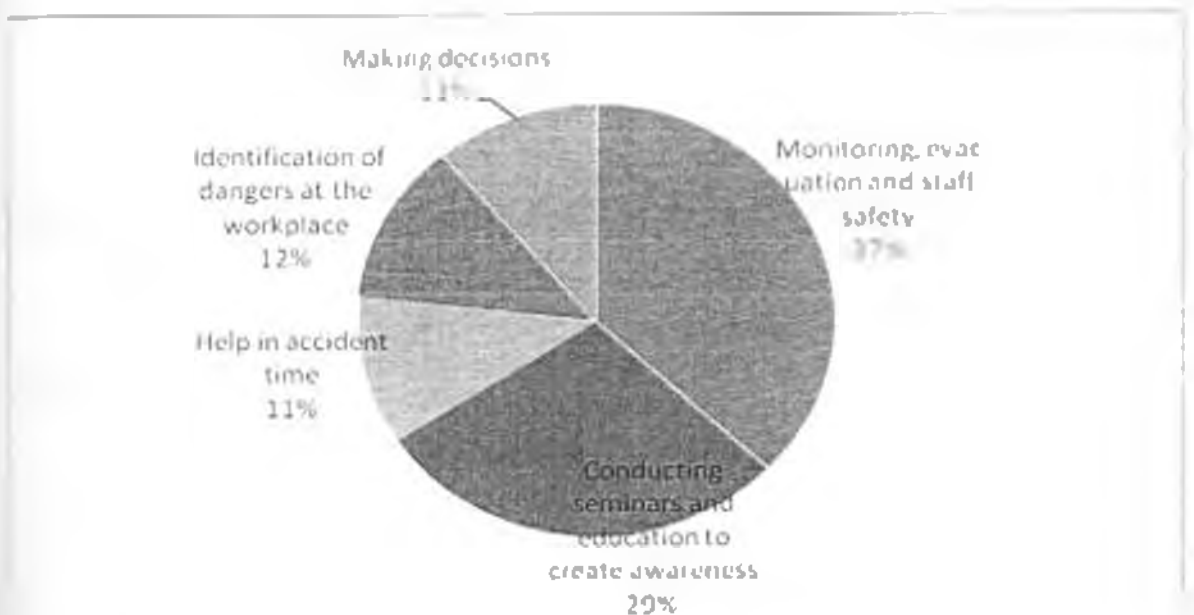


Figure 6: Functions carried out by the committees (n= 204)*

*2 declined to answer

4.3.2 How often committee members meet

Ninety-eight percent (98%) of the members stated that they held meetings compared to 2% who never held meetings. The study established that 41% of the members meet on a weekly basis,

30% on a monthly basis, 13% when summoned, 10% quarterly while 3% meet half yearly and yearly respectively (Figure 7).

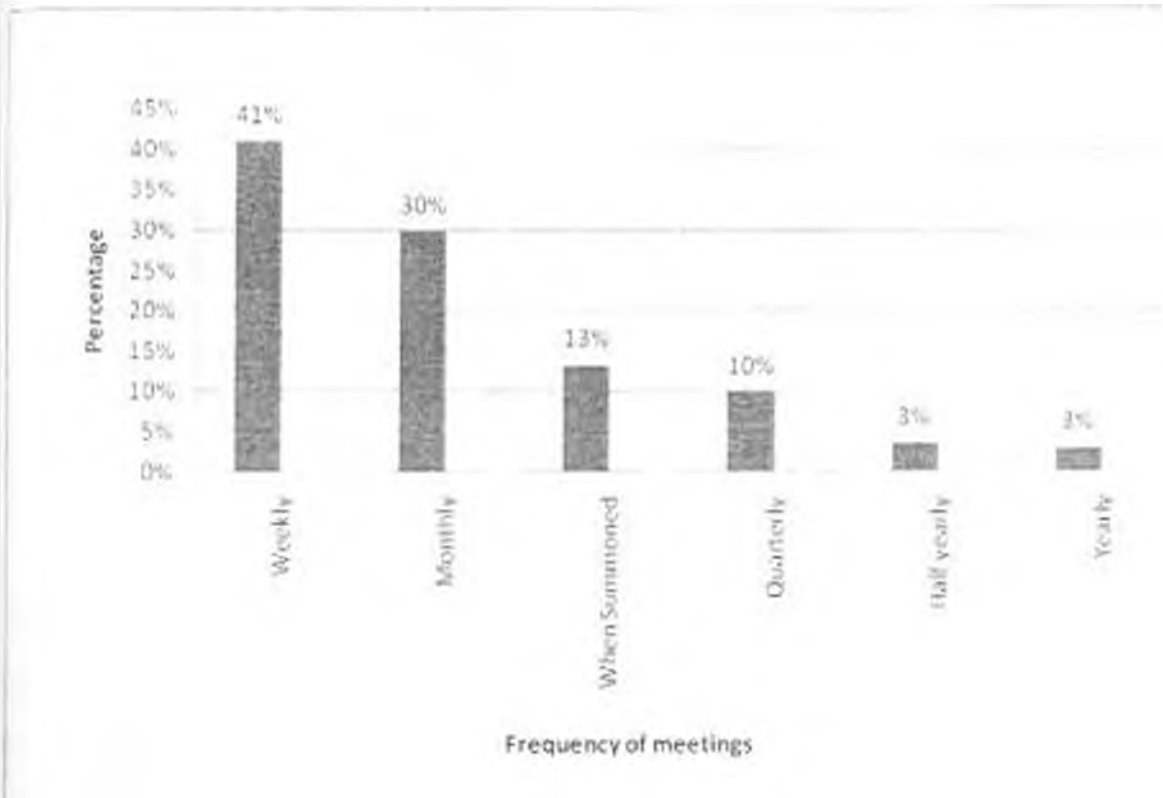


Figure 7: How often members meet (n = 205)*

* 1 declined to answer

Seventy-five percent (75%) of the respondents stated that their minutes were not accessible. Eighty-seven percent (87%) of the respondents indicated that they forward their meeting minutes to the DOHSS at the Ministry of Labour, while 13% did not forward their meeting minutes.

4.3.3 Contribution to decision-making

All (100%) of the committee members contribute to decision making at the workplace. Close to 60% of the respondents contribute to decision making through giving their views. On the other hand 32% contributed through giving directions while the rest contributed through influencing the rules and policies of the company (Figure 8).

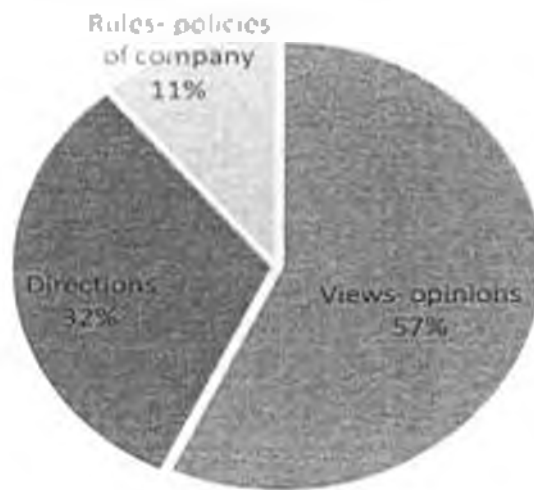


Figure 8: Contribution by members to decision-making (n= 206)

All (100%) of the committee members communicated with workers on health and safety matters at the work place. The findings demonstrated that 45% of the members communicate with workers through meetings or briefings, 38% through posting in notice boards while 9% do it through presentations in form of pie-charts/graphs and pamphlets

Ninety-eight percent (98%) of the members identified hazards through monitoring of the health and safety procedures at the workplace, while 2% did it through scanning the work environment. All (100%) of the respondents stated that they had statistics for accidents, dangerous occurrences and cases of ill health.

4.3.4 How statistics are recorded

Forty-five percent (45%) of the members maintain their records in disaster accident registers, 35% in safety and health registers, 14% in bar-graphs and charts, while 5% do it through emails (Figure 9). Majority of the respondents were willing to have their registers accessed for the study.

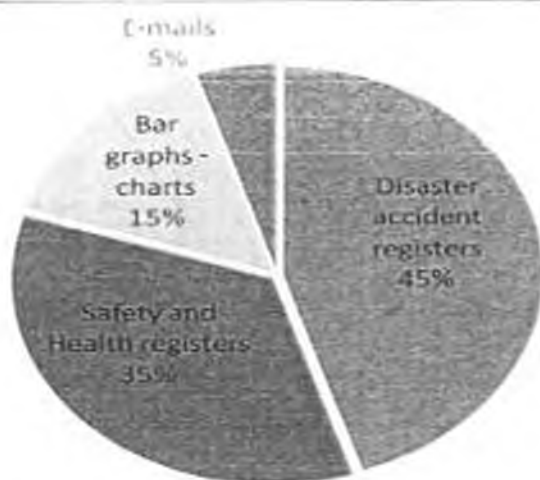


Figure 9: How statistics are recorded (n=206)

4.3.5 Frequency of reporting of incidences

Eighty-three percent (83%) of the respondents report incidents to the management immediately while 17% report to management upon request. Thirty-two percent (32%) of the respondents report incidents to the DOHSS upon request. A similar 32% report in a period of between 4 – 6 months. 19% do so quarterly while 17% do it yearly (Figure 10).

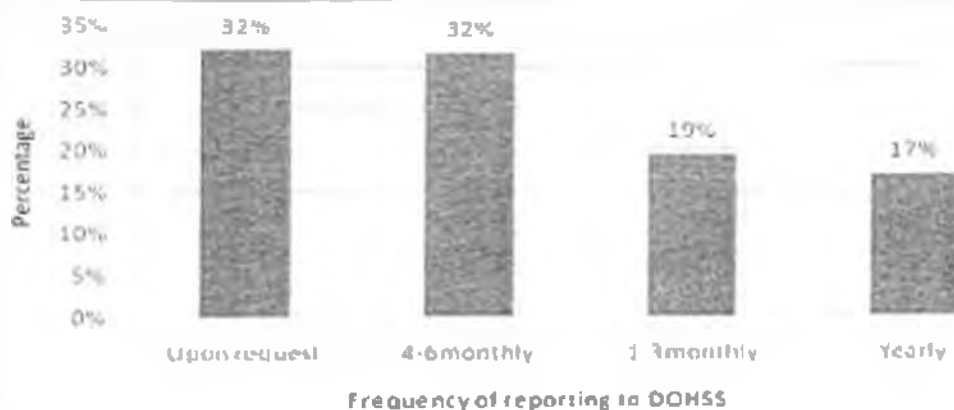


Figure 10: Frequency of reporting to the DOHSS (n=206)

Accidents, if fatal, should be reported within 24 hours and if not fatal, within 7 days of its occurrence (GoK, Section 21, the Occupational Safety and Health Act, 2007).

4.3.6 Establishment of procedures for self-monitoring

Eighty-five percent (85%) of the members had established procedures for self-monitoring, while 15% had not. Established procedures for self-monitoring included inspections as indicated by 37% of the respondents, first aid procedures to the hurt as indicated by 30%, reporting as indicated by 17% and audits, target setting and awareness creation as indicated by 15% (Figure 11).

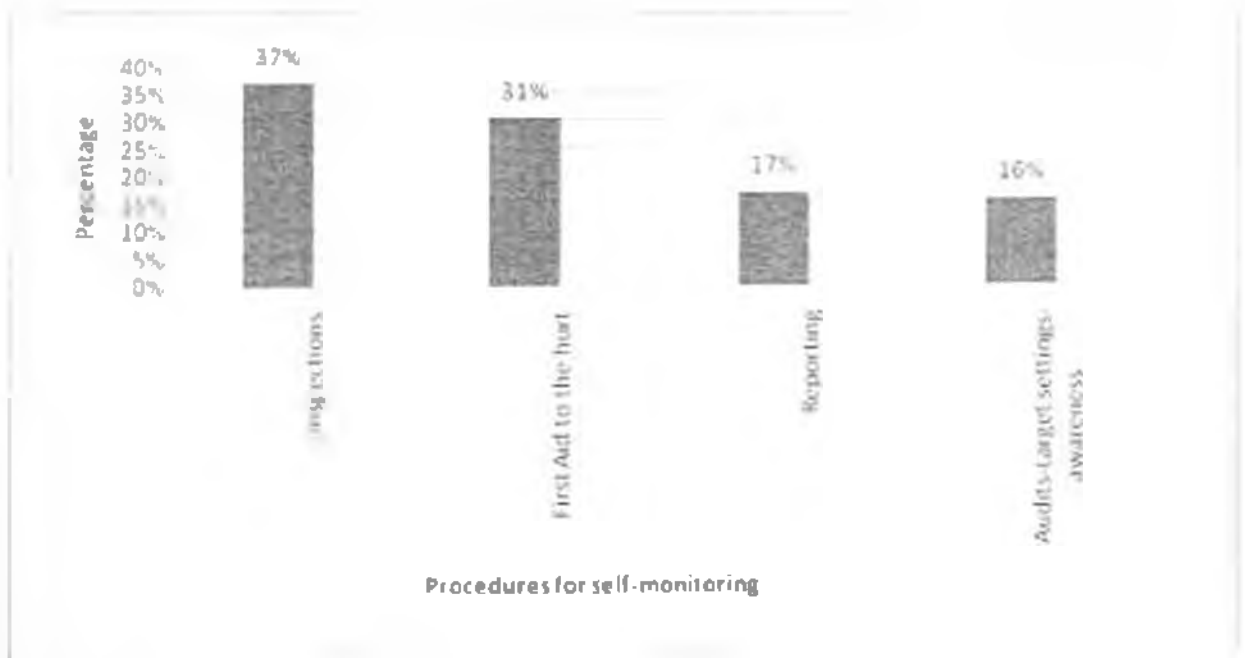


Figure 11: Procedures for self-monitoring (n=206)

4.4 Objective 4: Type of training undertaken by members

The types of training undertaken by the members included: 43% on First Aid, 23% on disaster management, 17% on material and equipment handling and a similar 17% on fire fighting (Figure 12).



Figure 12: Type of training undertaken (n=206)

All (100%) of the members stated that they had benefited from the training they undertook. Forty-one percent (41%) indicated that training was done the past year, 35% indicated it was done two years ago while 24% indicated that it was done in the current year (2009).

Majority of the respondents agreed that they had standard operating procedures (SOPs) which were followed when accidents occurred. The SOPs used included, identification-investigation-notification as indicated by 65% of the members and achievement of targets as indicated by 35%.

4.5 Objective 5: Period of operation of establishments

Fifty-six percent (56%) of the establishments visited had been in operation for more than 20 years, 17% for between 6 – 10 and 1 – 5 years and 5% for between 11 – 15 and 16 – 20 years (Figure 13). Forty percent (40%) and 34% of the committees were established in 2008 and 2007 respectively while 24% were established in 2009.

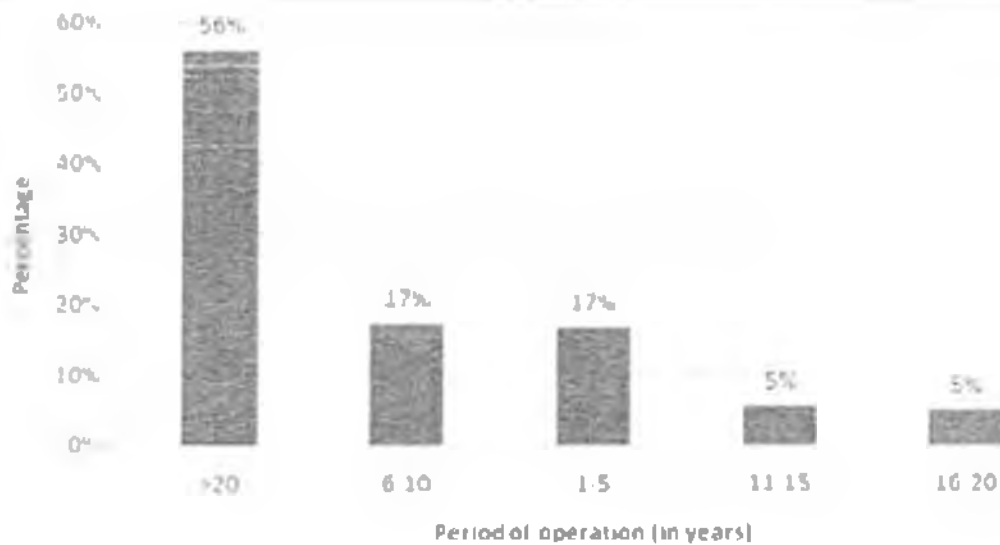


Figure 13: Period of operation of the establishments (n=204)*

*2 declined to answer

Fifty-seven percent (57%) of the managers had a workforce of more than 100 employees, 23% had 50-99 employees, while 20% had less than 49 employees. Fifty-five percent (55%) of the managers had less than 49 female employees in their organizations, 23% had more than 100 while 22% had between 50 and 99 female employees. Forty percent (40%) of the managers had more than 100 male employees in their organizations, 34% had less than 49 while 26% of the respondents had 50-99 male employees.

4.6 Objective 6: Impact of the committees at the workplace

Twenty-six percent (26%) of the workers reported that committees have had a positive impact in the establishment, as could be evidenced in the reduction of incidences, 24% cited that it had created awareness, 23% felt it had brought about a better working environment while 18% felt it was not applicable in their departments (Figure 14)

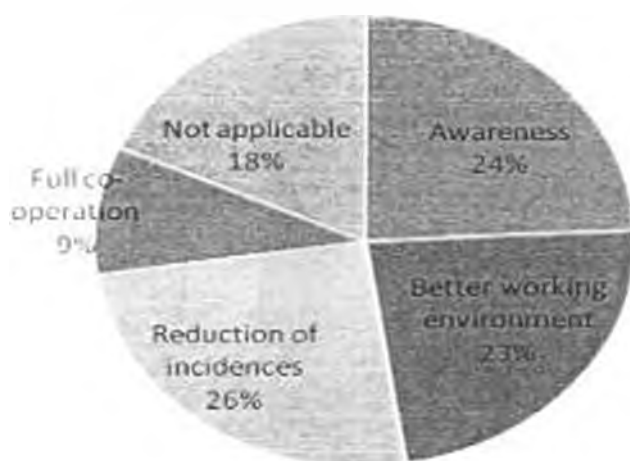


Figure 14: Type of impact (n=181)*

*6 declined to answer

Forty-three percent (43%) of the managers cited government policy as the reason that prompted the establishment of safety and health committee, 32% cited nature of business, 22% cited ignorance, while 3% cited statistics of incidents. Eighty-five percent (85%) of the managers felt their expectations regarding the committees had been fulfilled while 13% felt their expectations had not been fulfilled.

Thirty-six percent (36%) of the managers cited reduced levels of incidences, 35% cited creation of awareness and 16% cited effective supervision, while 12% did not agree that it fulfilled their needs and cited lack of co-operation (Figure 15).

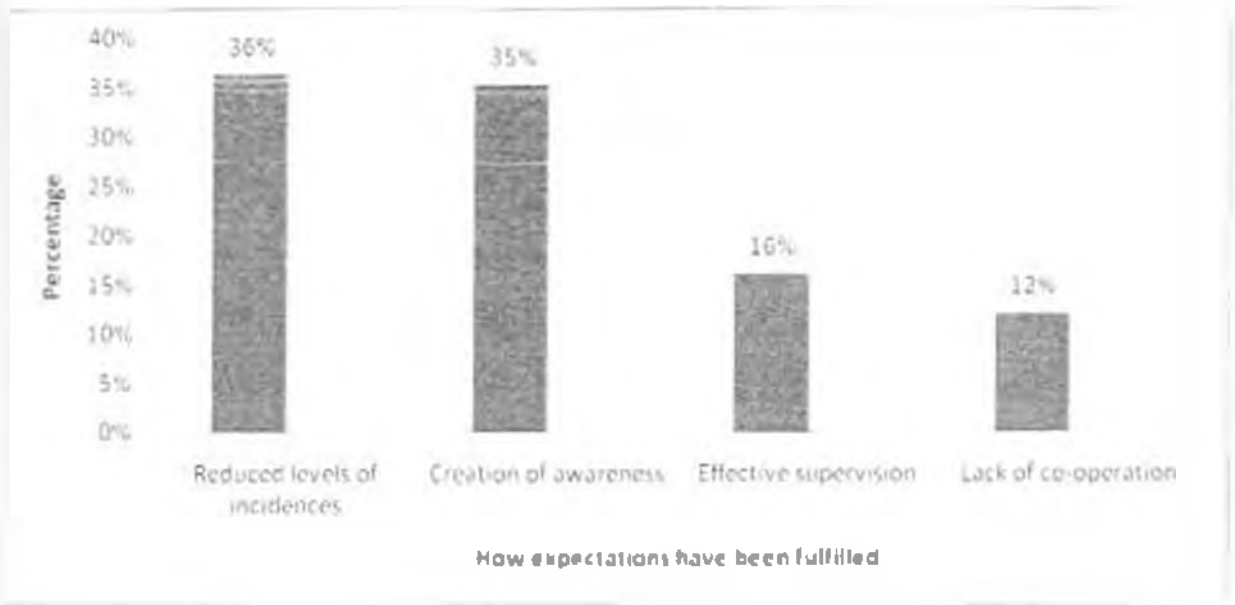


Figure 15: Percentage distribution of managers based on fulfilment of expectations (n = 99)*

*2 declined to answer

Fifty-nine percent (59%) of the managers cited that the management had assisted the committee by allocating time for training, 22% cited allocation of facilities while 19% cited allocation of funds. Ninety-two percent (92%) of the managers agreed that the committee had improved their respective establishments, while 8% did not.

Thirty-five percent (35%) of the managers cited improved health standards, 31% cited awareness creation, and 30% cited that it has led to proper organization and co-operation while 3% cited that morale had been boosted as a result of establishment of the committee.

Eighty-three percent (83%) of the workers agreed that the safety and health committee had had impact on the establishment while 17% disagreed.

4.7 Objective 7: Challenges faced by committees and recommendations by study participants

The safety and health committee members felt that some of the difficulties they faced included, balancing of committee duties with company duties as indicated by 42%, lack of experience due to inadequate training as indicated by 22%, inadequate funds as indicated by 20% and inadequate first aid kits as indicated by 16% (Table 4).

The managers felt that some of the challenges faced by the committee included inadequate time for training as reported by 30% of the managers, increased workload on committees as cited by 25%, inadequate funds and facilities as cited by 17% while 14% cited lack of co-operation and lack of experience respectively (Table 4)

Twenty-seven percent (27%) of the workers felt that there were no challenges facing the committee in discharging their functions, 21% cited inadequate funding in medical facilities and inadequate time for training while working respectively, 16% cited lack of co-operation, 14% cited a lack of awareness (Table 4).

Table 4: Challenges faced by members of the committee

Type of respondent	No.	Percent	Challenge
1. Committee members	86	42	Balancing of committee duties
	46	22	Lack of experience, funding
	42	20	Inadequate kits
	32	16	Inadequate first aid kits
Total	206	100	
2. View of managers	30	30	Inadequate time for training
	25	25	Increased workload on committees
	17	17	Inadequate funds, facilities
	14	14	Lack of co-operation
	14	14	Lack of experience
Total	100*	100	
3. View of workers	46	27	None
	38	21	Inadequate funding of medical facilities
	38	21	Inadequate time for training
	29	16	Lack of co-operation
	27	15	Lack of awareness, ignorance
Total	178**	100	

*1 declined to answer

**9 declined to answer

Recommendations by study participants

Full co-operation and regular training was recommended by 44% of the committee members. Those who felt that the relevant authority should be more active were 31% while 18% felt the committee should be strengthened. Seventeen percent (17%) felt there should be adequate handler facilities (Table 5).

Thirty-four percent (34%) of the managers recommended that there should be full co-operation and collaboration. 18% cited need for adequate facilities and awareness creation through seminars and education respectively. Fifteen percent (15%) cited relevant authorities to assist. 9% cited beefing up of committees to have adequate members. 4% cited need for regular trainings, while 2% cited the need for allocation of funds to run the project (Table 5).

Thirty-five percent (35%) of the workers recommended better training facilities, 27% recommended support from management, 20% recommended that relevant authority should chip in while 18% recommended creation of awareness (Table 5).

Table 5: Recommendations by the various respondents

Type of respondent	No.	Percent	Recommendation
1. Committee members	69	34	Full co-operation, regular training
	63	31	Relevant authority to be active
	38	18	Committee establishment
	36	17	Adequate handler facilities
Total	206	100	
2. View of managers	45	34	Full co-operation, collaboration
	24	18	Adequate facilities
	24	18	Seminars, education, awareness
	20	15	Relevant authorities to be more active
	12	9	Sufficient members of committee
	5	4	Regular training to be carried out
	2	2	Allocation of funds to run project
Total	100	100	
3. View of workers	77	35	Better training facilities
	57	27	Support from management
	43	20	Relevant authority to chip in
	38	18	Creation of awareness
Total	215	100	

CHAPTER FIVE

5.0 DISCUSSION, CONCLUSIONS AND RECOMENDATIONS

5.1 DISCUSSION

5.1.1 DESCRIPTION OF THE SAFETY AND HEALTH COMMITTEES'

Members of the safety and health committees comprised 62% males and 38% females with diverse professional backgrounds. The largest proportion of the companies visited had been in operation for more than 29 years and most of the health committees had been established in between the year 2007 and 2008 as a sign that the Occupational Safety and Health Act, Chapter 514, of the Laws of Kenya was being complied with by most of the companies. In close to the three quarters of the companies visited, the committees' main role was in monitoring, evacuation and staff safety while at the same time creating awareness through educating members of staff. The composition of membership of the committee was from all cadres in the organization; ensuring fair representation. This was in line with a study which found that establishments with joint consultative committees had significantly fewer workplace injuries than those where the management alone determined health and safety arrangements (Reilly, et al, 1995)

A large proportion of the committee members were appointed to the committee and mainly met on a weekly basis with the staff members. Their meeting minutes are usually forwarded to the DOHSS at the Ministry of Labour as required by law

The members agreed that they contribute to the decisions that are arrived at with regards to matters of health and safety. The committee communicates with workers verbally and also through postings of notices to the staff notice boards. They are able to identify all the hazards at the work place through monitoring of the health and safety procedures. They also keep the statistics for accidents, dangerous occurrences and cases of ill health in their respective companies as required by law and the aforesaid records could be accessed on request. The accidents are reported to the management immediately they happen before the same is done to the DOHSS. A large proportion of the incidents are reported on bi-annual basis and in most cases it is done on request. The committees have established procedures for self-monitoring, which include inspection, first aid procedures and audits. From the study, it emerged that training was a

key pillar for the committee members and that these trainings included first aid and disaster management among others which were quite helpful in managing health and safety at workplace. The committees had set standard operating procedures in reacting to accidents at workplace, which included identification, investigation and notification.

Some of the challenges identified by the respondents included balancing of committee duties with the company duties and inadequate time for training. Tuohy and Simard (1993) showed that the capacity of Joint Health and Safety Committees to function effectively was correlated with the amount of training and information available to Joint Health and Safety Committee members.

5.1.2 INTERVIEWS CONDUCTED WITH MEMBERS OF STAFF FROM MANAGEMENT

In this category the respondents (101) comprised of about 60% male and 40% female; a large proportion of who had attained university education. A large number of the industries had a workforce of over 100 employees in their companies. From the study findings, many of the health and safety committees were established as a result of government policy and the nature of their business. A large number of the respondents agreed that the establishment of the health and safety committees had fulfilled their expectations because the reduction of accidents and creation of awareness, which was achieved as a result of allocating time for training. This had resulted in a general improvement of safety through improved health standards due to awareness created by the committee. This is in agreement with the study done in the UK by Reilly who used a sample from the Workplace Industrial Relations Survey of manufacturing plants and found that workplaces with joint committees had, on average, 5.7 fewer injuries per 1000 employees compared with workplaces without Joint Health and Safety Committees (Reilly, et al, 1995). This was, however, in contrast with a study done in Massachusetts by Boden, et al, (1984) who determined that the presence of a Joint Health and Safety Committee did not reduce the number of health and safety complaints. The study was conducted to determine if the existence of a joint labour-management health and safety committee was correlated with either the number of Occupational Safety and Health Administration (OSHA) complaints or hazardousness, as measured by OSHA serious citations. Virtually no effect could be detected in a sample of 127 Massachusetts manufacturing firms. The study appeared to indicate that the presence of a Joint Health and Safety Committee may not be enough and that the key to success with these

committees may be in ensuring their effectiveness. This was in agreement with O'Grady who concluded that Joint Health and Safety Committees may have a role in improving workplace health and safety but that the presence of Joint Health and Safety Committees in workplaces do not necessarily lead to improvements in injury rates. He determined that the critical issue was the effectiveness of Joint Health and Safety Committee member training (O'Grady, et al. 2000)

Based on the managers' point of view, challenges faced by the committees included inadequate time for training, increased workload on committees, inadequate funds and facilities, lack of co-operation and lack of experience

5.1.3 INTERVIEWS CONDUCTED WITH MEMBERS OF STAFF NOT FROM MANAGEMENT

The respondents (187) comprised 55% males and 45% females with many having attained Secondary school education and having diverse training backgrounds which ranged from security, driving, secretarial, electronics and clerical.

Based on the study findings, a large number of the respondents agreed that the health and safety committee had had a positive impact in their respective establishments and this could be attested by the reduction of incidents due to awareness creation which has in turn led to a better working environment because they were involved in the establishment of these committees. Tuohy and Simard (1993), found, in a study of Quebec and Ontario workplaces, that Joint Health and Safety Committees with equal numbers of union and management representatives had both lower injury rates and demonstrated enhanced problem solving expertise compared to workplaces without these committees (Tuohy, et al. 1993).

Not enough funds being allocated to health and safety and inadequate training emerged as factors that hampered discharging of the committee functions.

5.2 CONCLUSION

There are generally more males than females at the various workplaces with a 6 to 4 ratio. There were also more married than single people. Committees comprised of both managers and workers as could be seen from the age brackets involved. Most of the managers were between 30-40 years, while most workers were between 21-30 years. Committee members were mostly

between 25-35 years. Most of the committee members and workers had attained secondary school education while most managers had attained University education.

Committee members met, ensured staff safety, created safety awareness among members of staff and contributed to decision-making at the workplace. This was going on at most of the places of work.

Some of the challenges identified by the respondents included balancing of committee duties with the company duties and inadequate time for training, inadequate funds and facilities.

Generally the committees had had a positive impact on safety at the various workplaces.

5.3 RECOMMENDATIONS

Co-operation from both the management and members of staff is vital in matters concerning health and safety. This will ensure adequate funds are set aside for health and safety. Emphasis should be placed on training and the relevant authority (Directorate of Occupational Health and Safety Services, Ministry of Labour) should be more active especially assisting in organizing training so as to create awareness.

More research should be undertaken on areas such as where emphasis on type of training should be. Nation-wide campaigns to create awareness in occupational health and safety would be useful. School curriculums should also incorporate aspects of occupational safety and health so that the aspect remains etched in the minds of those who will later seek employment in the various places of work.

5.4 LIMITATIONS OF THE STUDY

It was difficult to interview two members of staff from management in every industry because of a busy schedule, leading to availability of a relatively small sample size in that category of respondents. Some of the respondents agreed to answer most of the questions but declined to answer a few, so only those questions which were answered were considered in the analysis. This contributed to a decrease in sample size for some of the questions, therefore an increase in bias. Due to a relatively small number of respondents from each workplace, it was not possible to ensure representation from various departments; especially among the workers.

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APPENDICES

APPENDIX 1: CONSENT SEEKING INFORMATION SHEET [INTERVIEW]

Study title: A description of safety and health committees among selected Industries in Nairobi

Introduction

Hello. My name is Mary Sang, a post-graduate student at the University of Nairobi. I am trying to describe, as part of my course work, health and safety committees and the effect they have had on the workplace.

What is this research activity?

The aim of this study is to gain in-depth understanding on safety and health committees among industries in this country. The law requires the various workplaces to have safety and health committees. We seek to find out the impact these committees have had

Who are we approaching?

We are approaching a range of people to help us with the interviews, workers in the workplaces, members of staff from management and members of the safety and health committees.

What are we asking people to do?

We would like to ask you some questions and record your answers.

Agreeing to be interviewed will involve:

- a. Giving up 20 - 30 minutes of your time so I can gather your views on the impact safety and health committees have had at your workplace.
- b. Agreeing that we can record your comments (see consent sheet)
- c. Allowing us to use what you say in the interview, together with the comments of others, to make a realistic description of the status-quo as far as safety and health committees are concerned at your place of work.

Confidentiality.

Your name and job title will not be used in any reports of this work. Only a code number will appear on the record made of the interview(s) and only the researcher will have access to the link between the code numbers and individuals. We will offer you the opportunity to change the record of the interview until you are happy with it if you would like. No one other than the researcher and yourself will be allowed to see the record of the interview without your permission.

Risks of the research.

We do not believe there are any risks to taking part in this research.

Benefits of the research

We are unable to offer any individual benefits for participating in this research. However, the findings of this study will be given to the establishment to help implement better policies.

Do you have any questions?

(Record the questions asked and the answers provided)

Thank you !

APPENDIX 2: CONSENT AGREEMENT FOR RESPONDENTS

I have been informed about the study entitled:

A description of safety and health committees among selected industries in Nairobi

Under the direction of Ms. Mary Sang and have been provided with information concerning this study to help me understand it. The implications, duration, purpose, voluntary nature and inconveniences or risks that may reasonably be expected have been explained to me by:

_____ (name of person taking consent).

I have been given the opportunity to ask questions concerning the study and these have been answered to my satisfaction. If I have further questions, I may contact:

*Ms. Mary Sang
P.O. Box 1321
Tel: 0721-921832
Nakuru.*

I understand that I may at any time during the study revoke my consent without any loss or penalty and that the information I have contributed will then be destroyed.

I confirm that I:

- 1) Agree to be interviewed
- 2) Agree / Not Agree* for a tape recording of the interview to be made in addition to written notes (if recording device available).

* Delete as appropriate.

Signed: _____ Date ____ / ____ / _____

Signature of person taking consent

Once again, Thank for agreeing to participate in this study.

Study title: A description safety and health committees among selected industries in Nairobi

Introduction

Hello. My name is Mary Sang, a post-graduate student at the University of Nairobi. I am trying to describe, as part of my course work, health and safety committees and the effect they have had on the workplace.

What is this research activity?

The aim of this study is to gain in-depth understanding on safety and health committees among industries in this country. The law requires the various workplaces to have safety and health committees. We seek to find out the impact these committees have had.

Who are we approaching?

We are approaching your institution to allow me to have access to documents that describe the day-to-day functions of the safety and health committees in your establishment.

What are we asking?

We seek permission have access to documents describing the functions of the safety and health committees your establishment

- Agreeing to access to the documents will involve

- a. Providing the documents that explain or describe the functions of the safety and health committees
- b. Agreeing that I derive information from the documents relating to my study
- c. Allowing me to use this information, together with that from interviews to find out the status-quo as far as safety and health committees are concerned

Confidentiality:

Considering the sensitive nature of some of the documents I might come across, only general information will be used. We will offer you the opportunity to view the information derived to

ascertain that I have derived the information correctly. No one other than the researcher and yourself will be allowed to see the data without your permission.

Risks of the research.

I do not believe there are any risks to taking part in this research.

Benefits of the research

I am unable to offer any individual benefits for participating in this research. However, the findings of this study will be given to the establishment to help implement better policies.

Do you have any questions?

(Record the questions asked and the answers provided)

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.....

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.....

.....

Thank you !



APPENDIX 4: CONSENT AGREEMENT FOR WORKPLACE AUTHORITY ON DOCUMENT REVIEW

I have been informed about the study entitled

A description of safety and health committees among selected industries in Nairobi

Under the direction of Ms. Mary Sang and have been provided with information concerning this study to help me understand it. The implications, duration, purpose, voluntary nature and inconveniences or risks that may reasonably be expected have been explained to me by:

_____ (name of person taking consent).

I have been given the opportunity to ask questions concerning the study and these have been answered to my satisfaction. If I have further questions, I may contact:

Ms. Mary Sang
P.O. Box 1321
Tel: 0721-921832
Nakuru.

I understand that I may at any time during the study revoke my consent without any loss or penalty and that the information I have contributed will then be destroyed.

I confirm that I:

- 1) Agree to provide access to the documents requested
- 2) Agree / Not Agree* for written notes to be made.

* Delete as appropriate.

Signed: _____ Date ____ / ____ / _____

Signature of person taking consent

Once again, Thank for agreeing to participate in this study.

APPENDIX 5: IN-DEPTH INTERVIEW GUIDE FOR THE SAFETY AND HEALTH COMMITTEE MEMBER

Demographic Data

Age.....
Gender.....
Marital status.....
Level of education.....
Professional training.....
Position at the workplace

Introduction

How long has this establishment been in operation?

When were safety and Health Committees introduced in this establishment?

About safety and health committees

What are the functions of the committee?

How many representatives from management?

How many representatives from among the workers?

How are members of the Committee chosen?

Is the chairman elected or appointed?

Functions of the committee

Do you, as members, meet?

a. Yes

b. No

If yes, how often?

May we be allowed to look at the minutes?

Are minutes forwarded to the Directorate of Occupational Safety and Health Services of the Ministry of Labour?

Do you, as members, contribute to decision-making at the workplace?

a. Yes

b. No

If yes, how?

Do you, as members, communicate with the workers on health and safety matters?

a. Yes

b. No

If yes, how?

Do you, as members, identify hazards at the workplace?

a. Yes

b. No

If yes, how?

Are there statistics for accidents, dangerous occurrences and cases of ill health?

a. Yes

b. No

If yes, how are they recorded?

May we be allowed to see them?

Are accidents reported?

a. Yes

b. No

If yes, after how long is the incident reported to management?

After how long is the incident reported to the Directorate of Occupational Safety and Health Services?

Have you, as members of the committee, established procedures for self-monitoring?

a. Yes

b. No

If yes, which ones?

Have you, as members, undergone any training?

a. Yes

b. No

If yes, can you narrate the type of training you have undergone?

Has the training been of help to you?

How long ago was the training done?

Are there standard operating procedures (SOPs) to be carried out when any accident or dangerous occurrence takes place?

a. Yes

b. No

If yes, which are these?

What are some of the difficulties are you are experiencing / have experienced as a member of the safety and health committee?

Are there recommendations you wish to make that may help improve the concept of safety and health committees?

Thank you !

APPENDIX 6: IN-DEPTH INTERVIEW GUIDE FOR MEMBERS OF STAFF FROM MANAGEMENT

Demographic Data

Age.....
Gender.....
Marital status.....
Level of education.....
Professional training.....

Introduction

What is the size of your work force?
How many are females?
How many are males?
How long have you served in the establishment?
In what capacity?

About the safety and health committees

What prompted the decision to establish a safety and health committee?
Have your expectations been fulfilled?
Why, or why not?
What has management done to assist the Safety and Health Committee?
Has the safety and health committee improved the establishment?
If yes, how?
What would say are challenges faced by the committee in discharging its functions?

Recommendations

What recommendations would you wish to make that may help improve the concept of safety and health committees?

Thank you!

APPENDIX 7: IN-DEPTH INTERVIEW GUIDE FOR A MEMBER OF STAFF not FROM MANAGEMENT

Demographic Data

Age.....
Gender.....
Marital status.....
Level of education.....
Professional training.....

Introduction

How long have you served in the establishment?

In what capacity?

About the safety and health committees

Has the safety and health committee had an impact on the establishment?

If yes, in what way?

Are the workers involved in the role of the committee in the establishment?

What would you say are the challenges faced by the committee in discharging its functions

Recommendations

What recommendations would you wish to make that may help improve the concept of safety and health committees?

Thank you !

APPENDIX 8: MAP OF NAIROBI



APPENDIX 9: RESEARCH APPROVAL



KENYATTA NATIONAL HOSPITAL

KENYATTA NATIONAL HOSPITAL
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Telegrams: KNT/KEP Nairobi
e-mail: KH.Hospital@KenyaHealth.go.ke
20th February 2010

Mary Chepkorir Sarjo
Dept of Community Health
School of Medicine
University of Nairobi

Dear Mary

RESEARCH PROPOSAL -AN ASSESSMENT OF FUNCTIONS OF SAFETY AND HEALTH COMMITTEES AMONG SELECTED INDUSTRIES IN NAIROBI (P201/2009)

This is to inform you that the Kenyatta National Hospital Ethics and Research Committee has received and approved your above cited research proposal for the period 20th February 2010 to 19th February 2011.

We wish to emphasize to request for a renewal of the approval 150 days prior to the expiry of the approval beyond the deadline given. Clearance for export of biological specimens must also be obtained from KNH/EMC for your study.

On behalf of the Committee I wish you fruitful research and look forward to receive a summary of the research findings at a completion of the study.

This information will form part of database that will be consulted in all research processing of research study so as to minimize or avoid duplication.

Yours sincerely

PROF. C. KIGONDU
AG. SECRETARY, KNH/UN-ERC

- cc: The Chairperson, KNH/UN-ERC
- The Deputy Director, CS, KNH
- The Dean, School of Medicine, UoN
- The Chairman, Dept of Community Health, UoN
- Supervisors: Prof. M. M. Wasani, Dept of Community Health, UoN
- Mr. Lumbwa, Nyaraka, Dept of Community Health, UoN