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# THE ROLE OF UGANDAN BUSINESSES IN PROVIDING HEALTH SERVICES

REPORT OF A SURVEY OF UGANDA EMPLOYERS ON EMPLOYEE  
ATTRITION, SICK LEAVE AND HEALTH SERVICES PROVIDED

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# **THE ROLE OF UGANDAN BUSINESSES IN PROVIDING HEALTH SERVICES**

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ATTRITION, SICK LEAVE AND HEALTH SERVICES PROVIDED**

**Authors:**

Ivan Busulwa  
Leonor Guariguata

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## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante natal care
ARV	Antiretroviral
BUSPH	Boston University School of Public Health
DOT	Directly observed therapy
FP	Family Planning
FUE	Federation of Uganda Employers
GOU	Government of Uganda
HAART	Highly active antiretroviral therapy
HIPS	Health Initiatives for the Private Sector
HIV	Human Immunodeficiency Virus
HR	Human Resource
IAA	International Air Ambulance
IEC	Information, Education and Communication
JCRC	Joint Clinical Research Center
MOH	Ministry of Health
MR	Medical Retirement
NA	Not Available
NGO	Non-governmental organization
OI	Opportunistic infection
PART	Preventing AIDS and Accelerating Access to Antiretroviral Treatment
PEPFAR	Presidents Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
RH	Reproductive Health
STI	Sexually transmitted infection
TB	Tuberculosis
UIA	Uganda Investment Authority
UMA	Uganda Manufacturers Association
USAID	United States Agency for International Development
VBA	Visual Basic Application
VCT	Voluntary Counseling and Testing



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I am also grateful to all the Research Assistants who carefully collected and analyzed the data presented in the report. Special thanks go to Mr. Daniel Oloia who came up with systems to analyze the data for this research. Most of all, I would like to thank the managers, human resource persons and medical personnel who made themselves available for the interviews. Without their cooperation, this study would not have been possible.

Ivan Busulwa



## I. EXECUTIVE SUMMARY

This study presents a profile of the medical benefits provided by a sample of 82 Ugandan employers selected from the membership rolls of the Federation of Uganda Employers and the Uganda Manufacturers Association. The report provides an extension and update of an analysis performed in 2003 by Boston University School of Public Health and Makerere University Department of Social Work and Social Administration, under the USAID-funded ARCH (Applied Research in Child Health) Project. In addition, the study looks at trends in absenteeism and employee deaths at participating companies, and uses regression analysis to test the extent to which differences in attrition and absenteeism might be linked to the extent of corporate medical benefits.

The table below, divided by company size, shows the percent of employers surveyed that offer a specified service, and the percent of employees at the firms in each group that had access to the service through the employer. The reason we have included “Company” and “Workers” under each type of service is that the percent of employers providing a service usually differs from the actual number of people having access to that service. For example, the table below indicates that 50% of the ‘Large’ companies in Uganda are providing ART services (under the “Co.” column) whereas 75% of employees in the same size category (under the “Workers” column) have access to ART services.

Larger employers and multinationals were more likely than smaller or Ugandan owned firms to provide a particular benefit. Because the larger employers were more likely to offer benefits, the percentage of employees in the sample who have access to benefits is generally larger than the percentage of companies that offer the benefits.

**Percent of Companies Offering, and Workers Having Access to, Employer Sponsored Medical Services**

Company Size	HIV Prevention		VCT		ART		Malaria Treatment		TB Treatment		Antenatal Services	
	Co. <sup>1</sup>	Workers	Co.	Workers	Co.	Workers	Co	Workers	Co.	Workers	Co.	Workers
Very small (<25)	30%	28%	15%	13%	19%	18%	44%	48%	22%	23%	18%	7%
Small (25-99)	48%	52%	28%	25%	28%	28%	48%	50%	32%	31%	24%	12%
Medium (100-499)	65%	75%	40%	33%	25%	26%	65%	63%	45%	45%	45%	21%
Large (>500)	100%	100%	50%	72%	50%	75%	80%	90%	70%	88%	70%	40%
<b>TOTAL</b>	<b>61%</b>	<b>93%</b>	<b>33%</b>	<b>62%</b>	<b>29%</b>	<b>64%</b>	<b>61%</b>	<b>83%</b>	<b>39%</b>	<b>77%</b>	<b>39%</b>	<b>35%</b>

More than 4 out of 5 employees in these private sector companies have access to malaria treatment through the employer, 3 out of 4 have access to TB treatment, and 3 out of 5 have access to vital HIV services. Those concerned about gender equity may note that only 1/3 of the employees in the sample companies have access to employer supported antenatal care.

Probably because of their isolation, firms in rural areas and the agriculture sector are more likely to offer medical services. Firms in the retail and construction industries are least likely to do so.

<sup>1</sup> Co. = Company



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Although the two surveys are not directly comparable, firms in this survey are somewhat more likely to offer medical services than those surveyed five years ago. However, the level of HIV/AIDS services has not increased, perhaps because these services have now become widely available in the public sector.

Not every company surveyed could provide data on employee attrition due to illness. However, in those companies that provided the data, the trend in deaths (as a percentage of the workforce) is down, undoubtedly as a result of more widely available antiretroviral therapy. Although there was a spike in absenteeism during the heavy rains which led to malaria and cholera epidemics in 2007, the trend in absenteeism (among those companies that could provide the data) is flat to slightly down. This too may indicate the success of public and private ART.

Using regression analyses, we were not able to identify a specific relationship between employee attrition and the level of medical services provided. Larger companies---which were more likely to provide medical services---generally reported lower attrition, but the regression does not show a specific link between the breadth of these services and attrition. Analyses of absenteeism and medical services are also limited by the relatively small number of firms reporting this data. The provision of bed nets and VCT on site does seem to reduce absenteeism, but the breadth of medical services cannot generally be linked to reduced absenteeism. In fact, there appears to be somewhat higher absenteeism in companies with better medical services, but this may occur because these same companies have better absenteeism data and more benevolent sick leave policies.

The survey confirms that formal sector employers in Uganda are an important source of medical services for their employees. If they were to stop offering these services, the burden on the public health system would undoubtedly increase. The challenge for the private sector is to find mechanisms by which smaller Ugandan employers can offer the level of employee medical benefits now offered by larger companies.



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## II. OBJECTIVES

This study had three main objectives which can be categorized as follows:

1. **To understand the role that employers play in supporting health services in Uganda**

We measured the level of health services currently being offered by employers in Uganda. Services measured included those offered onsite in company clinics, those provided through direct reimbursement arrangements with outside providers, and services offered through health insurance. These services were further detailed into those offered by category of beneficiary to show which companies offered these to regular employees, dependents of employees, contract or part-time employees, contractor staff and community members.

2. **To analyze the impact of illness on absenteeism and attrition**

We investigated the trends of employee attrition over the years for those companies that could provide the necessary data. We also looked for evidence to suggest that widespread ART impacted on attrition by comparing attrition data, pre and post-ART service provision. The study further examined the various differences in attrition by company size and ownership.

3. **To determine if more extensive corporate medical benefits are linked to reductions in employee attrition and absenteeism**

We detailed all the medical benefits at each company and compared these with the corresponding attrition rates to determine to what extent the breadth of services impacted employee attrition and absenteeism. The hypothesis is that a company providing more extensive health benefits for its employees will have healthier employees and thus realize lower absenteeism and illness-related attrition.



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### III. BACKGROUND

Many large employers in Africa have traditionally offered some health services to their employees because of geographic isolation, occupational risks, or the lack of adequate public or private medical facilities. Some large African employers instituted programs for antiretroviral treatment of HIV positive workers before such treatment was widely available in the public sector.

In the past decade, African Governments and donors have pushed hard to expand HIV/AIDS services in the public and non-profit sector. But employer based (or financed) treatment could relieve the burden on the public sector by providing care for employees and their dependents. Company clinics or medical benefit programs can also offer other critical medical services - for malaria, TB and reproductive health. To understand the extent and pattern of employer sponsored medical benefit programs in Uganda, the HIPS project commissioned the survey of employers reported here.

This 2009 survey provides a useful update to a survey of Uganda employers conducted by Boston University with USAID sponsorship in 2003.<sup>2</sup> That study focused only on HIV/AIDS. At the time, only 16% of surveyed employers had an HIV/AIDS policy, 27% provided support for HIV testing and 32% offered ART to their employees. Over 50% of the surveyed multinational firms and parastatals provided employees with HIV/AIDS testing and treatment while the smaller and locally owned firms were less likely to do so.

This 2009 survey is more comprehensive than the 2003 survey because it had access to a better data base of Uganda employers, and employed a more reliable sampling technique. It also includes interviews on company provided TB, Malaria, and RH/FP company services. Comparison of the two surveys provides a useful insight on changes in the pattern of employer supported health care in Uganda. In subsequent sections as we analyze the new survey, we compare the results with the 2003 study to see if HIV testing and AIDS treatment by employers has become more routine.

Several important changes have occurred in Uganda since the 2003 survey. The economy has continued to improve. The conflict with the Lord's Resistance Army has ended, bringing stability to the war-torn northern region. The Government has expanded a program begun shortly before the prior survey to accredit private clinic sites for antiretroviral treatment. Accreditation is the process by which public and private health facilities are officially approved by the government to access and distribute the free ARVs provided by the Global Fund through the Ministry of Health. As part of this process, the former Business PART Project<sup>3</sup> worked with the AIDS Control Program (ACP) of the Ministry of Health and the USAID/DELIVER project, (which was in charge of managing the in-country ARV supply chain system) to have ARVs made available to accredited private health facilities.. Accredited private clinics now receive free antiretroviral drugs purchased with donor funds, on the condition that they do not charge patients for the ARVs dispensed.<sup>4</sup>

Many of the private health facilities Business PART worked with were company based clinics, and employers were encouraged to obtain accreditation and expand ARV treatment. Business PART brokered each partnership and provided support, including training for staff from the company clinic. By the end of 2007, Business PART had engaged 50 companies and 10 private health facilities to strengthen their HIV/AIDS prevention and treatment programs. Business PART had helped 21 of these sites acquire

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<sup>2</sup> Role of the Private Sector in Preventing and Treating HIV/AIDS in Uganda” Feeley, F, Bukuluki, P, Cowley, P. April 2004. USAID sponsored.

<sup>3</sup> Business Preventing AIDS and Accelerating Access to Anti-retroviral Treatment Project, a USAID funded project implemented by Emerging Markets Group 2005 - 2007

<sup>4</sup> Providers can charge their regular fees for consultations, laboratory tests, or treatment of opportunistic infections.



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MOH accreditation while these sites were providing ARVs to 1,303 employees, dependents and community members.

The success of the Business PART program encouraged USAID to expand the scope of work under the new HIPS program; this now provides a variety of support for employer-sponsored services that include not only HIV/AIDS, but also Tuberculosis, Malaria and Reproductive Health/Family Planning.

HIPS is currently working with 44 companies and 88 private clinics throughout Uganda to initiate or expand one or more of these services. All these company and clinic sites have incorporated at least one of these other health services in addition to HIV/AIDS prevention and treatment. 66 of these sites have been accredited by the MOH to extend AIDS treatment to their clients; they are currently providing lifesaving ARVs to 3,564 employees, dependents and community members.

HIPS also works closely with private sector employer organizations such as the Federation of Uganda Employers (FUE) and the Uganda Manufacturers Association (UMA) to strengthen their member services through involvement in national health policy issues and capacity building in health workplace programs. HIPS is further building the capacity of both associations so that they can better extend HIPS provided health services to their members after conclusion of the HIPS project.



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## IV. METHODOLOGY

The study was based on structured interviews with employers that were usually done with HR managers or staff members within the companies' HR departments. In many of the small firms without any designated HR personnel or departments, the owners or general managers were instead interviewed. A research team put together by the HIPS monitoring and evaluation department, under the leadership of Busulwa Ivan, interviewed the employers' representatives.

The HIPS project technical team helped design the questionnaire, attached in the appendix, based on that developed by BUSPH in 2003. The technical team supplemented the data collection tool with questions on the additional health interventions not studied in 2003. The questionnaire provided simple "yes/no" responses or quantifiable answers. Additional notes were taken during the interviews to give us more insight on some of the "yes/no" responses.

Firms for the employer interviews were originally identified using a combined database of FUE and UMA member companies. Both UMA and FUE have well over 500 members each but this list was limited to the database of active members (those who had met their previous years' subscription dues). This final list provided us with a combined total of 522 private sector members from which to choose.

All the companies on this list were segmented according to industry type and size (as defined by number of employees). A representative 10% sampling was done for each size category to give a total of 82 companies for the survey.

Within the quota of companies for each size category, specific employers were selected for interview using a random VBA Excel function that was run on the combined members' list. This function generated a unique set of numbers against which the sample companies were chosen. (See Appendix 2 for unique random number Excel function).

The method of sampling used here was more random than the 2003 survey where companies were identified using a database compiled by the Uganda Investment Authority (UIA). This UIA database did not contain many multi-national firms known to be active in Uganda then and to counter this, a selection of multinationals including some known to be providing antiretroviral drugs to employees, or considering doing so, was deliberately added to the 2003 interview list.

Of the 82 employers originally selected for the 2009 survey, 23 could not be found or would not agree to an interview. In these cases, another firm in the same industry and same size category (as defined by number of employees) was selected for interview.

A total of 82 corporate interviews were completed. It was most difficult to obtain interviews with the individually owned small and medium-sized firms, particularly in the manufacturing business, due to the continuous unavailability of key personnel for interviews.

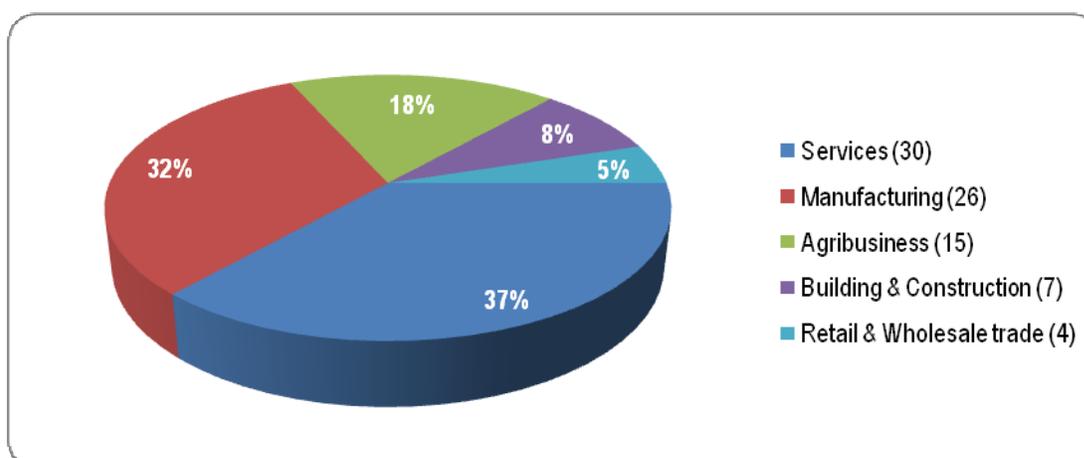
Data was compiled using Microsoft Excel and analyzed with SPSS, and Epi Info.



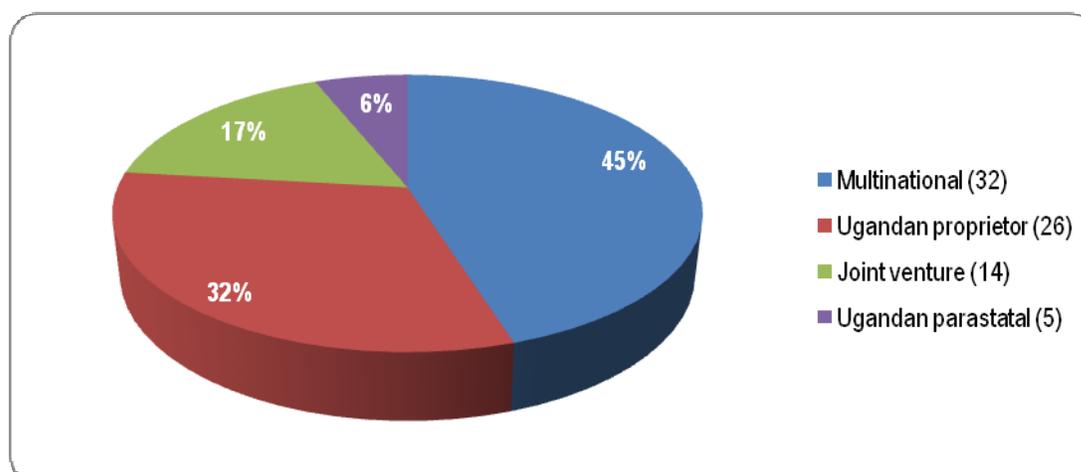
## V. RESULTS

The companies were categorized according to the 5 most predominant sectors: Services, Manufacturing, Agribusiness, Building & Construction and Retail & Wholesale trade. The “Services” sector, which was the largest, contained a variety of companies that included hotels, banks, security firms and institutions of learning.

**Figure 1: Types of Trade for Surveyed companies**



**Figure 2: Types of Ownership for Surveyed companies**





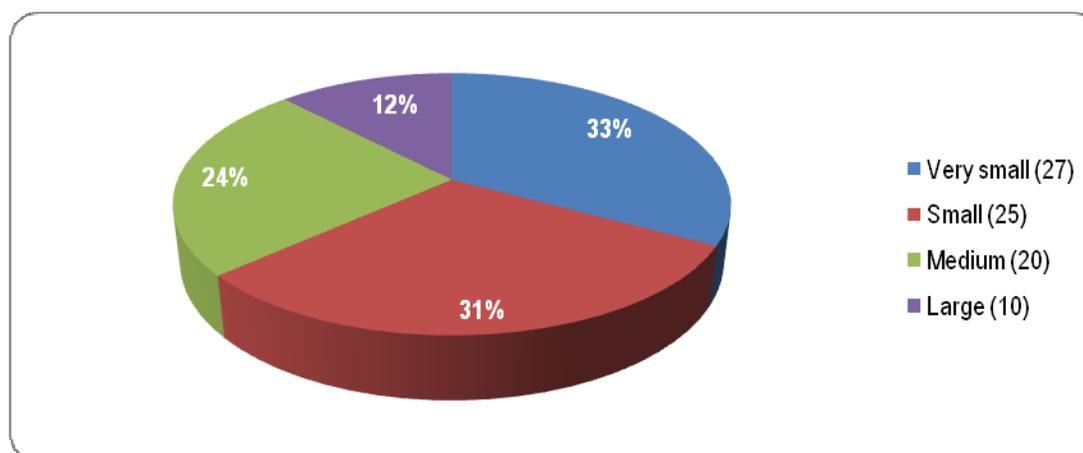
## A. Ownership Patterns

The survey showed diversity in services being provided to employees from the availability of medical benefits and sick leave to the existence of regular training programs on HIV/AIDS and Malaria. However, a general trend was apparent. The quantity and quality of health services provided at the workplace was higher in the multinational and joint venture companies than in the Ugandan parastatals and local firms owned/managed by individual proprietors. Whereas in 2003 the majority of the firms that offered better services were in more “advanced” sectors of the economy e.g. banking and telecommunications, many rural based firms, particularly those in the agricultural sector, are now offering a wide range of benefits to their employees. Firms in the “Building & Construction” business and those in the “Retail and Wholesale” trade had inferior worker health benefits unless they were employing a large number of people. The smaller wholly Ugandan owned companies in general provided the least services to their employees.

These conclusions are supported by the data in Tables 1 and 5. In Table 1 Firms are divided into the 5 predominant sectors while in Table 5, firms are divided into the 4 ownership categories: Multi-nationals, Partially state controlled ownership, Joint venture-ships and Local private ownership. “Multi-national” ownership refers to a subsidiary or affiliate of a large publicly-held company with global operations and headquarters in the developed world while “Joint venture” ownership refers to a company with both Ugandan and non-Ugandan shareholders, but which is not part of a sophisticated global corporation.

Most of our results have been segregated for each category of ownership and size. Four company sizes were considered: Very small (fewer than 25 employees), Small (25 to 99 employees), Medium (100 to

**Figure 3: Types of Size for Surveyed companies**



499 employees) and Large (500 employees and above).

## B. Services Provided

Overall, most of the companies interviewed extended at least one health service to their employees. Of the 5 services of interest, i.e. HIV Prevention, VCT, ART, Malaria Treatment and TB Treatment, 77% of interviewed companies provided AT LEAST ONE service while only 7% provided ALL the 5 services of interest. The services most commonly provided were Malaria Treatment and HIV Prevention education while the least provided service was Antenatal Care. A company was considered to be providing ‘HIV



Prevention’ services if it had any one of the following in place: an HIV/AIDS workplace policy, IEC materials on HIV, Peer education training programs for workers, Access to free condoms and Voluntary Counseling and Testing services.

**Table 1: Services Provided by Sector**

Sector (No. of companies)	HIV Prevention	VCT	ART	Malaria	TB	ANC
Services Industry (30)	67%	23%	40%	63%	50%	40%
Manufacturing (26)	42%	12%	12%	62%	35%	35%
Agribusiness (15)	60%	40%	47%	40%	40%	27%
Building & Construction (7)	14%	1%	0%	43%	0%	14%
Retail & Wholesale trade (4)	50%	0%	0%	25%	0%	25%

Table 1 above shows service provision by sector. Companies in the “Services” and “Agribusiness” sectors consistently extended the highest amount of benefits to their employees. The agricultural firms provide an extensive range of health benefits since they tend to run their own clinics, have large numbers of employees, are usually rural based and often, are the sole provider of health services within their catchment areas. The majority of companies in the services industry are urban based and tend to provide health services as part of a standard employee benefits package.

**Table 2: Modes of Offering and Accessing Health Services<sup>5</sup>**

Mode*	VCT		ART		MAL		TB		ANC		Total	
	Co. Workers											
Reimbursement	41%	9%	46%	10%	60%	65%	63%	23%	53%	35%	53%	28%
Insurance	37%	8%	50%	11%	36%	33%	47%	10%	47%	13%	43%	15%
Corporate clinic	59%	62%	33%	53%	50%	79%	28%	58%	28%	66%	39%	64%

Table 2 summarizes service provision by the 3 most common methods: Onsite corporate clinic, Direct reimbursement and Health insurance. At some companies, employees accessed a particular health service, e.g. VCT, through more than one avenue. As a result, columns can total to more than 100%.

The ‘Workers’ columns reflect the actual number of employees having access to services through a particular avenue while the ‘Co.’ columns merely represent the percent of companies providing these benefits. For example, 50% of the companies extending ART benefits do this through ‘Health insurance’ whereas only 11% of the total work force, from amongst the interviewed companies, has access to ART benefits through Health insurance. On the other hand, a lower percentage of employers (33%) provide ART benefits through ‘Corporate clinics’ whereas a higher percentage (53%) of the total workforce, from amongst the interviewed companies, has access to these benefits through onsite clinics.

Clearly, companies with smaller workforces are the ones that tend to extend employee health benefits through medical insurance. The larger companies prefer using onsite corporate clinics to provide these services.

At most companies, the dominant mode of health service provision was “Direct reimbursement” arrangements with neighboring clinics (53%). Once an employee was treated at any of the nearby clinics,

<sup>5</sup> Expressed as a % of the total number of companies that were offering a particular service. The ‘Total’ column represents a mean score of all health benefits offered through a specific mode. Co. = Company



he/she presented a receipt to the company and was reimbursed. Alternatively, the clinic remitted these receipts at the end of a period and had the reimburse costs incurred in treating its employees.<sup>6</sup>

43% of interviewed firms extended health benefits through a health insurance provider. This proportion of companies supports the trend that was observed during the 2003 study<sup>7</sup>. At the time, there was a general drift to replace company run reimbursement schemes and medical clinic arrangements with health insurance or third party administrator payment of claims. These options offered potential advantages in protecting the confidentiality of clients and promoting transparency through the minimization of unnecessary charges. This mode of service provision was common among the urban based companies.

39% of the interviewed companies had onsite clinics through which employees could access health services. For these companies, only severe cases were referred to neighboring health centers or larger government facilities. Most of the rural based firms favored this mode of service provision.

Table 2 further shows that malaria was mostly treated through offsite contracts with nearby health centers (60%) and through onsite corporate clinics (50%). Because of the high incidence of malaria, it makes sense for a company to provide treatment onsite or make it accessible at nearby clinics so that employees don't spend a lot of time away from work.

VCT was mostly provided through corporate clinics (59%) followed by neighboring private clinics (41%). This is probably because HIV testing kits are now more widely available than they were a few years ago and many medical personnel have been trained by NGOs to conduct counseling and testing.

**Table 3: Percent of Employees Having Access to Each Service**

Employee category <sup>8</sup>	HIV Prevention	VCT	ART	Malaria Treatment	TB Treatment	ANC
Very small (n=358)	28%	13%	18%	48%	23%	7%
Small (n=1,149)	52%	25%	28%	50%	31%	12%
Medium (n=4,260)	75%	33%	26%	63%	45%	21%
Large (n=19,151)	100%	72%	75%	90%	88%	40%
<b>Total (n=24,918)</b>	<b>93%</b>	<b>62%</b>	<b>64%</b>	<b>83%</b>	<b>77%</b>	<b>35%</b>

Table 3 compares company size and employee access to services. It shows the percentages of the number of employees, per size category, having access to a specific health service through their employer. For every service category, the larger sized companies were more likely to provide access for their employees than their smaller sized counterparts.

Table 4 compares company size to company provided services. The table details the percentage of companies, per each size category, that offered a particular health service.

The difference between Tables 3 and 4 is that whereas Table 3 shows the actual percent of employees per size category HAVING ACCESS TO a health service, Table 4 shows the percent of companies per size category OFFERING a particular health service.

<sup>6</sup> This alternative arrangement sometimes gives management access to information about a patient's diagnosis.

<sup>7</sup> The Role of the Private sector in Preventing and Treating HIV/AIDS in Uganda, 2004 by Feeley et al

<sup>8</sup> n = number of employees

**Table 4: Percent of Companies Providing Each Service**

Company number <sup>9</sup>	HIV Prevention	VCT	ART	Malaria treatment	TB treatment	ANC
Very small (n = 27)	30%	15%	19%	44%	22%	18%
Small (n = 25)	48%	28%	28%	48%	32%	24%
Medium (n = 20)	65%	40%	25%	65%	45%	45%
Large (n = 10)	100%	50%	50%	80%	70%	70%
<b>Total (n = 82)</b>	<b>61%</b>	<b>33%</b>	<b>29%</b>	<b>61%</b>	<b>39%</b>	<b>39%</b>

It is necessary to differentiate between these two tables since the total percentage for a given service in Table 4 above might be skewed by the presence of many small companies providing services to a small number of people overall, or by few large companies, providing services to a large number of people overall. For instance, Table 4 shows that 15% of the ‘Very small’ companies in Uganda are providing VCT services while Table 3 shows that actually, only 13% of the total number of employees lying in this size category have access to VCT. Another comparison of data from both tables shows that 50% of the ‘Large’ sized companies are providing ART services (Table 4) whereas 75% of the total number of employees in the same size category (Table 3) has access to ART services.

Table 3 therefore, is a more true representation of the percent of total employment having access to company provided health benefits. Based on our survey, 4/5 formal sector employees in Uganda have access to company sponsored care for malaria and TB. 3/5 have access to HIV testing and AIDS treatment, while only 1/3 receive company supported ANC services.

The ownership of companies providing the most services has not changed a lot since the 2003 survey. Just 8% of the Ugandan owned companies have HIV policies and 19% offer regular HIV/AIDS education. As can be evidenced in Table 5 below, the joint venture ships and multinationals consistently provided the largest amount of health services to their employees. The Ugandan individual proprietors and Ugandan parastatals extended the least benefits.

**Table 5: Service Provision by Ownership**

Ownership <sup>10</sup>	HIV Prevention	VCT	ART	Malaria treatment	TB treatment	ANC
Multinational (n=37)	49% (18)	32% (12)	24% (9)	51% (19)	30% (11)	38% (14)
Joint venture (n=14)	79% (11)	50% (7)	43% (6)	93% (13)	71% (10)	50% (7)
Ugandan proprietor (n=26)	35% (9)	15% (4)	23% (6)	39% (10)	23% (6)	19% (5)
Ugandan Parastatal (n=5)	100% (5)	20% (1)	20% (1)	60% (3)	60% (3)	20% (1)

When compared to the 2003 survey, there is a noticeable decline in the amount of health services being provided by the parastatals. In 2003, all the surveyed parastatals were offered VCT and ART services. The number of parastatals now offering VCT has gone down to 40% while that offering ART is even lower, at 20%. The companies included in the two samples are not the same, but it seems likely that Uganda parastatals have decided to refer employees to Government health clinics now that ART is widely available for free at these sites. The rationale may be that the patients will be treated, and these firms may be less sensitive to the time lost by employees sent for public treatment.

The Ugandan owned companies realized the least change in the amount of health services they were providing between 2003 and 2009. Currently, only 9% have HIV policies (compared to 8% in 2003), 23%

<sup>9</sup> n = number of companies

<sup>10</sup> n = number of companies



are offering ART (compared to 18% in 2003) and 15% are extending VCT services to employees (compared to 23% in 2003).

### C. Changes from 2003 Survey

This 2009 survey reveals that at present, 24% of employers have an HIV/AIDS policy (up from 16% in 2003), 53% have HIV/AIDS workplace Prevention programs (up from 43% in 2003), 33% provide support for HIV Counseling and Testing (up from 27% in 2003) and 29% offer ART to their employees (down from 32% in 2003). The percent of employers providing Malaria treatment, TB treatment and ANC services currently stands at 61%, 39% and 39% respectively. These services were not measured in the 2003 survey.

**Table 6: Comparison of Corporate Benefits Offered (2003 and 2009)**

Ownership <sup>11</sup>	HIV Policy		HIV Prevention		VCT		ART		Malaria	TB	ANC
	2003	2009	2003	2009	2003	2009	2003	2009	2009		
Multinational (9,37)	33%	27%	78%	30%	33%	38%	56%	30%	51%	30%	38%
Joint venture (4,14)	0%	43%	25%	50%	0%	50%	0%	43%	93%	71%	50%
Ugandan proprietor (22,26)	9%	8%	32%	19%	23%	15%	18%	23%	39%	23%	19%
Ugandan Parastatals (2,5)	50%	40%	50%	60%	100%	40%	100%	20%	60%	60%	20%
<b>Total</b>	<b>16%</b>	<b>24%</b>	<b>43%</b>	<b>53%</b>	<b>27%</b>	<b>33%</b>	<b>32%</b>	<b>29%</b>	<b>61%</b>	<b>39%</b>	<b>39%</b>

With the exception of ART, the table above shows that the level of corporate health benefits has increased somewhat over the past five years-- reflecting an increasing trend of private sector involvement in health service provision in Uganda. Overall, an upward trend was noted in the number of companies that have HIV/AIDS policies, HIV Prevention programs and VCT services.

The percent of firms offering ART fell among both parastatals and multinationals; however, the 2003 study deliberately included a sample of parastatals and multinationals known to be offering or considering offering ART. There could be various reasons for this reduction. In 2003, ARVs were a privilege limited only to those few that could afford them. For many employees, company sponsored ART programs were the sole source of antiretroviral drugs. Over the past 5 years, the situation has gradually changed. With the inception of the Global Fund in Uganda (2001) and USAID PEPFAR program (2004) that focused on increasing the number of clients on ART, antiretroviral drugs became more accessible. The number of service outlets providing ARVs likewise increased and people are now able to access them from many public health centers - free of charge.

To further increase ARV availability, the GOU lessened its restrictions on the type of private for-profit health facilities that could access and distribute these free drugs. The introduction of generic ARVs on the local market has further increased the affordability and availability of these drugs. Due to this increase in availability and fall in price, it seems likely that proportionately more people are now accessing ARVs through sources other than employer health programs. Even with the presence of a corporate clinic providing ART, employees may opt to receive their treatment elsewhere. Reasons may range from proximity of alternative ARV service outlets to a perception of increased confidentiality when one receives these drugs elsewhere.

<sup>11</sup> (Number of companies in 2003, Number of companies in 2009)



## D. Employee Attrition

For all the companies that provided attrition data, graphs were plotted to show the following attrition rates: “Workers lost due to Deaths and Medical Retirement as a fraction of Total employment”, “Workers lost due to Chronic Disease Deaths and Medical Retirement as a fraction of Total employment” and “Workers lost due to Chronic Disease Deaths and Medical Retirement as a fraction of Total attrition”.

Many of the smaller sized companies (<100 employees) interviewed reported no workers lost in the previous years. This may have been because they had no records to show worker deaths and workers simply fell off the payroll after they stopped coming to work.

For the companies that had better data, worker mortality in the last year for which they provided it varied from 0% to 10% of total work force attrition. The highest percentage losses were realized at the smaller sized firms, where one or two deaths represented a significant fraction of the total loss. At larger employers, annual deaths were less than 1% of the work force, ranging from 0% to 0.94% of the total turnover.

It may well be that the bigger companies tend to provide more services for their employees as opposed to the smaller sized firms and hence realize lower worker-mortality related attrition rates.

The companies that lie at the extreme ends of these ranges are perhaps illustrative: the total employment of the company with the lowest employee percentage loss due to chronic disease deaths and medical retirement, at 0.2%, was 4,760 employees, while the total employment at the company with the highest employee percentage loss due to chronic disease deaths and medical retirement, at 20%, was 5 employees.

### DIFFERENCES IN ATTRITION RATES BY COMPANY SIZE

**Figure 4: Multi-year plot showing illness related attrition rates for each company by year. (Workers Lost due to Death and Medical Retirement as a fraction of full time employment)**

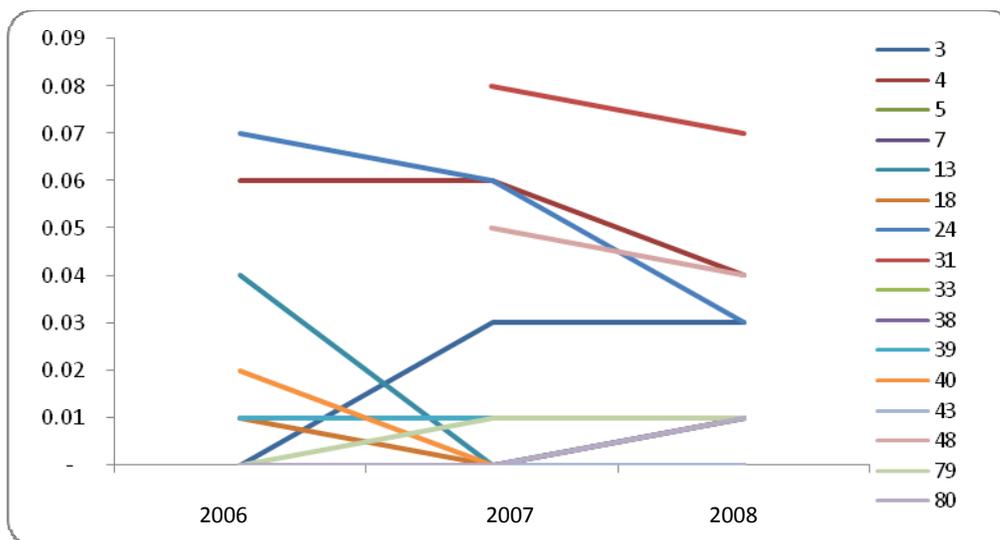
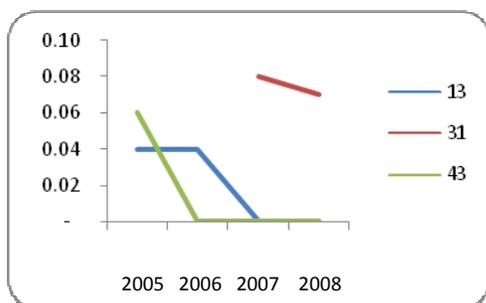


Figure 4 above shows the percent of total attrition for companies that reported data attributable to deaths and medical retirement in the last 3 years for which this data was available. Each colored line represents a different company while, for purposes of confidentiality, each company has been labeled with a number.

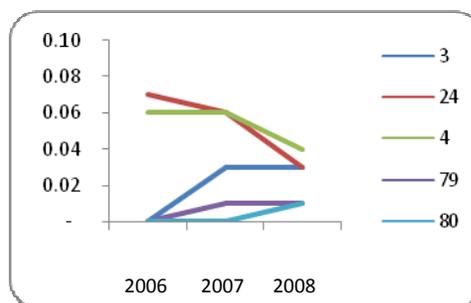


Numbers range from 1 to 82 representing the 82 surveyed companies. Figure 4 shows a consistent downward trend of attrition for almost all companies for the period 2006 through 2008. This trend supports the notion that with increased ART availability, fewer people are being medically retired from work or dying off due to chronic disease (that includes HIV/AIDS). They are thus being retained for longer periods than was previously possible and companies are experiencing lower attrition rates (attributable to deaths and medical retirement).

**Figure 5: Attrition Rates by Size — VERY SMALL sized companies**



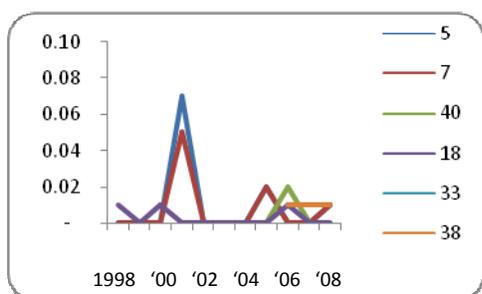
**Figure 6: Attrition Rates by Size — SMALL sized companies**



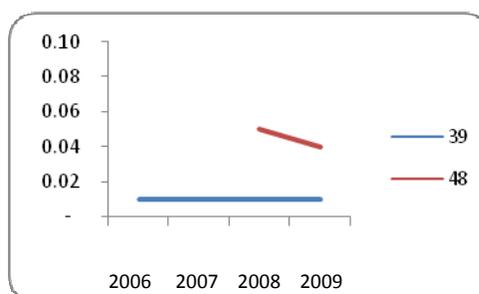
This downward trend of attrition is apparent in the small and large sized companies in Figures 5, 6 and 8. In Figure 7, a spike in the number of workers lost (due to deaths and medical retirement) between 2000 and 2002 is clearly noticeable at two companies. This may be due to those infected with HIV in earlier years dying off around this time – just before ARVs started becoming widely available.

At the two large sized companies in Figure 8, the attrition rate is static at one and is reducing at another. As earlier noted, the large sized companies tend to offer better medical benefits to their employees than their smaller sized counterparts. Some of them, especially those in agribusiness, might have reported lower attrition rates because of the migratory nature of their workers. Workers with a serious illness might have returned to their home and died after leaving the payroll.

**Figure 7: Attrition Rates by Size — MEDIUM sized companies**



**Figure 8: Attrition Rates by Size — LARGE sized companies**



In Figure 8, company 39, which experienced a flat-line death rate since 2006, is one of the few that has been offering ART benefits since 2003. This flat line supports the view that companies offering ART will experience lower attrition rates.



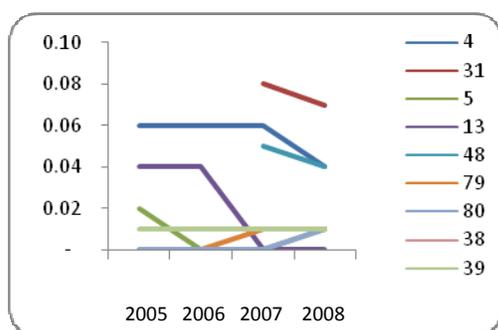
### DIFFERENCES IN ATTRITION RATES BY COMPANY OWNERSHIP

The downward trend in company turnover was most evident among those companies owned by multinationals (Figure 9). As observed in Table 5, the majority of these companies offer the full range of medical benefits to their employees i.e. VCT, ART, Malaria treatment, TB treatment and Antenatal care services.

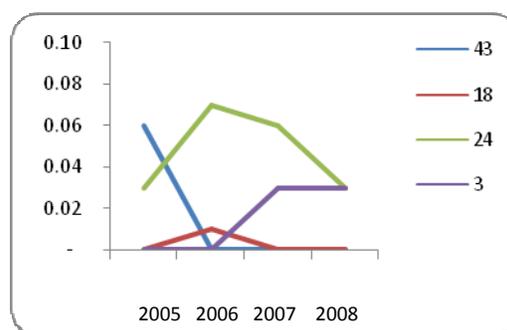
The declining trend in attrition rates for the multinationals supports the conclusion that the companies providing the highest amounts of services to employees will experience the lowest turnover rates.

Whereas the data for the "Individually owned" Ugandan companies showed a slight increase in attrition rates for some companies, it did not provide any conclusive evidence to support the claim that these companies in general experienced higher attrition rates due to their inferior worker benefits.

**Figure 9: Attrition Rates by ownership — MULTINATIONALS**



**Figure 10: Attrition Rates by ownership — UGANDAN OWNED Companies**



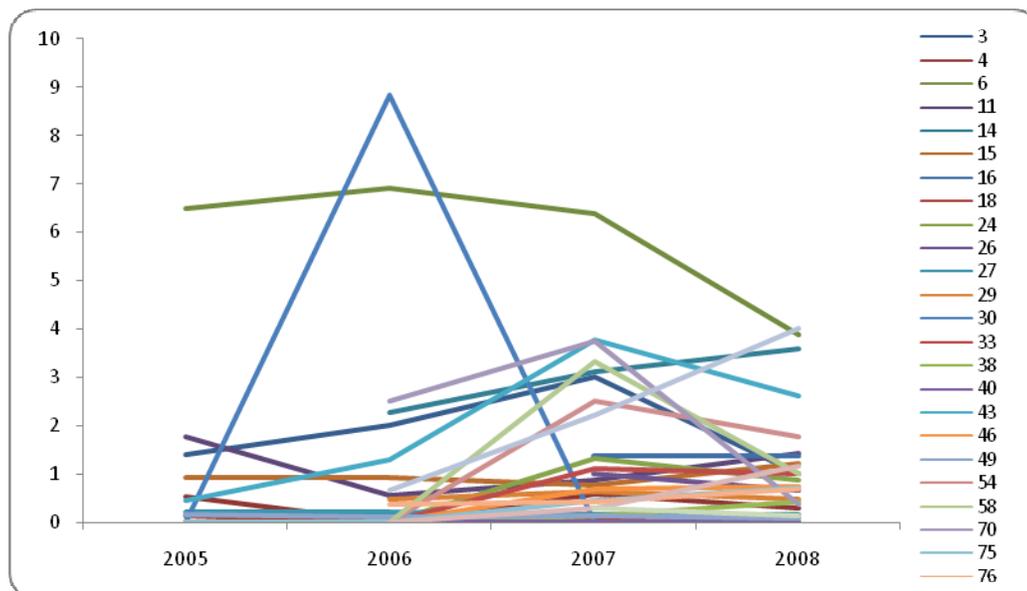
### SICK LEAVE DAYS PER EMPLOYEE PER YEAR IN EACH YEAR

The numbers of sick leave days reported by most companies (Figure 11) increased between 2006 and 2007. This increase in sick leave days can be attributed to the heavy rains and flash floods that occurred during this period<sup>12</sup>. Higher incidences of malaria, cholera and diarrhea were reported in 2007 because of the large stagnant pools of water left behind by these floods. Sick leave data for the same companies shows a significant decline from 2008 onwards.

<sup>12</sup> <http://uk.amref.org/news/floods-in-uganda-increase-malaria-and-cholera-outbreaks/>



**Figure 11: Graph Showing Sick Leave Days per Employee per year for each Company that Reported Sick Leave Data**



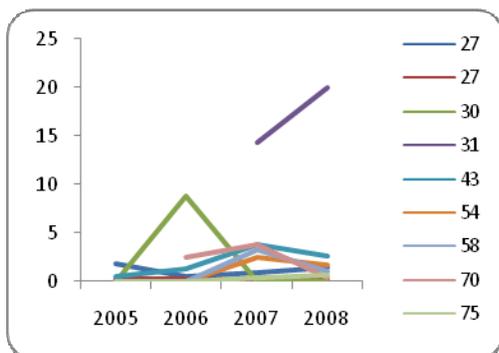
Another factor that could have contributed to this decline in attrition is the provision of ART. 50% of the 24 firms that provided ART benefits to workers started extending these between the years of 2005 and 2007. The declining trend of sick leave days observed after 2007 may partly be due to this.



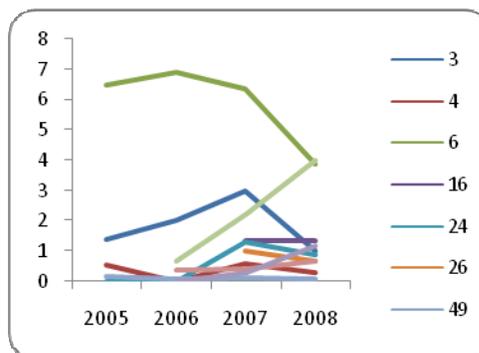
## DIFFERENCES IN SICK LEAVE DAYS PER EMPLOYEE BY COMPANY SIZE

There is no pattern obvious when the trends in sick leave are differentiated by company size, other than the spike in 2007.

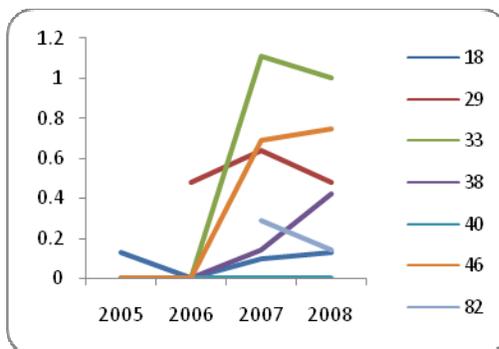
**Figure 12: Sick Leave Days per Employee — VERY SMALL sized Companies**



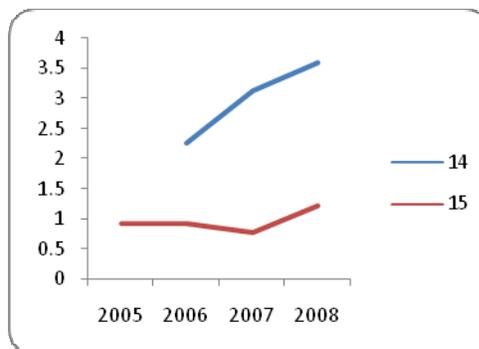
**Figure 13: Sick Leave Days per Employee — SMALL sized Companies**



**Figure 14: Sick Leave Days per Employee — MEDIUM sized Companies**



**Figure 15: Sick Leave Days per Employee — LARGE sized Companies**



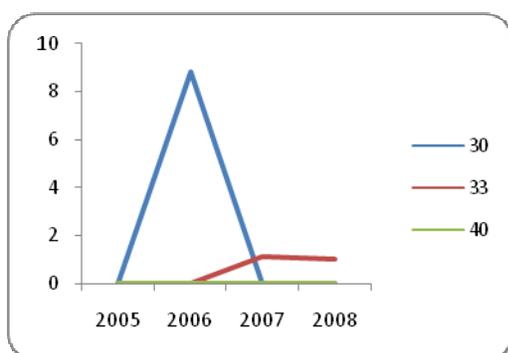


### DIFFERENCES IN SICK LEAVE DAYS PER EMPLOYEE BY OWNERSHIP TYPE

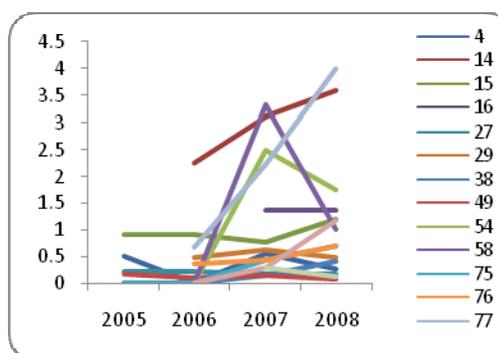
In Figure 18, the individually owned Ugandan companies, which were the least likely to provide ART benefits themselves, show a declining trend of sick leave days. This downward trend is probably due to their employees accessing the free government provided ARVs even though ART was not available through the company.

For the other types of company ownerships, other than the spike in 2007, there is no pattern obvious for the sick leave trends.

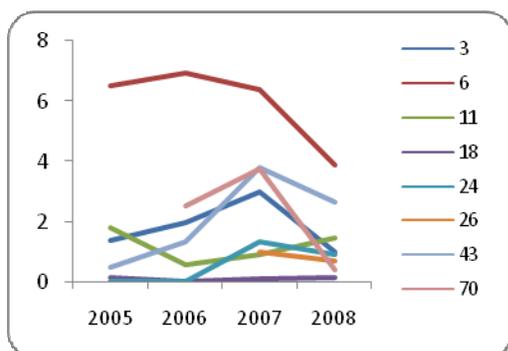
**Figure 16: Sick Leave Days per Employee — JOINT VENTURE Companies**



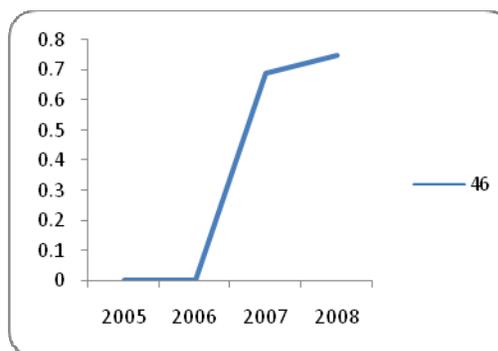
**Figure 17: Sick Leave Days per Employee — MULTINATIONAL Companies**



**Figure 18: Sick Leave Days per Employee — UGANDAN OWNED Companies**



**Figure 19: Sick Leave Days per Employee — UGANDAN PARASTATALS**





## VI. ANALYSIS OF THE RELATIONSHIP BETWEEN COMPANY PROVIDED SERVICES, ATTRITION AND SICK LEAVE

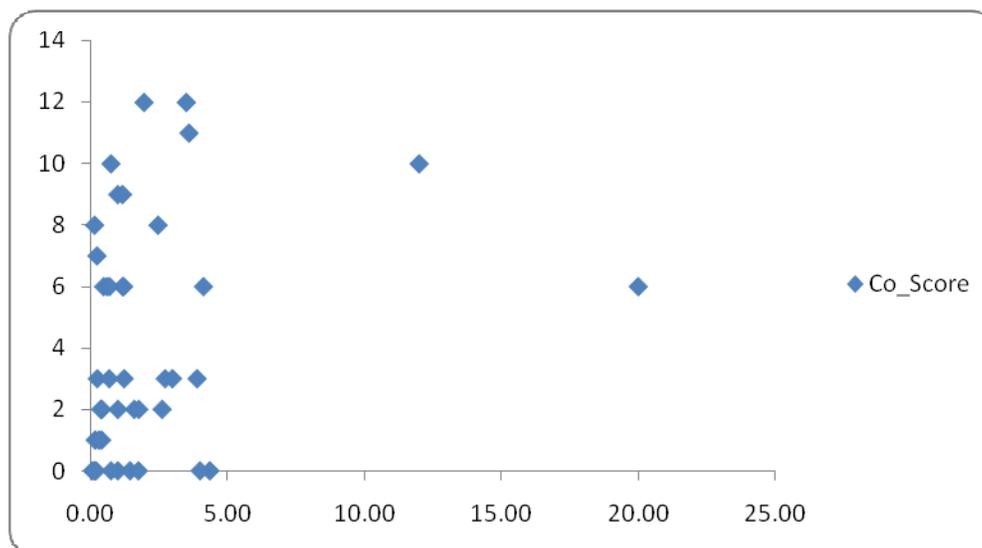
To determine if there was a relationship between the extent of company sponsored health services and improved outcomes (lower attrition and use of sick leave), the services provided by each company were plotted against predefined employee health indicators. For each company in the most recent reporting year, a score that shows the comprehensiveness of health services offered was created. Points were awarded as shown below. A service was free if it was provided in the onsite clinic, as a standard health insurance benefit, or through direct reimbursement of treatment costs to the employees/health facility:

Employee Health Indicator	Company Score
Company has HIV policy	1 point
Company provides workplace IEC on HIV	1 point
Company supports a peer education program on HIV for employees	1 point
Company provides VCT free to regular employees (via health insurance, direct reimbursement or on-site testing)	1 point
Company provides free ART for regular employees	1 point
Company provides malaria education at work	1 point
Company provides free treatment of malaria for employees	1 point
Company provides free bed nets for employees	1 point
Company provides free TB treatment for employees, or provides DOTS for employees initially referred to government clinics	2 points
Company provides free ANC for employees	1 point
Company provides free deliveries for employees	1 point
<b>Total Possible Points</b>	<b>12 points</b>



### A. Plots of outcome measures against service score for all companies providing data for the most recent years

Figure 20: Average Sick Leave Days Taken per Employee Plotted against the 'Company Score'



In figures 20 and 21, the average sick leave and attrition levels due to chronic disease deaths and medical retirement plotted against the company 'score' show that "worse" outcomes can occur in both high-scoring and low-scoring companies. While many firms with a high "service score" have good outcomes, this is not universally the case.

In part, this may be explained by the fact that firms that provide good services keep good data, or they have more benevolent personnel policies which allow sick workers to take more leave or stay in employment longer, perhaps until they die.





The Independent Variables								
	Coefficients	Standard Err.	t Stat	P-value	Lower 95%	Upper 95%	Lower 95.0%	Upper 95.0%
Intercept	0.139	0.022	6.453	0.000	0.094	0.184	0.094	0.184
Medical Score	-0.003	0.003	-1.045	0.308	-0.010	0.003	-0.010	0.003
Size	-0.053	0.010	-5.272	0.000	-0.074	-0.032	-0.074	-0.032
Ownership	-0.070	0.017	-4.049	0.001	-0.105	-0.034	-0.105	-0.034
ARVs Onsite	0.048	0.028	1.684	0.108	-0.011	0.107	-0.011	0.107
TB Onsite	0.040	0.027	1.465	0.158	-0.017	0.097	-0.017	0.097
Malaria Tx Onsite	<b>0.059</b>	<b>0.023</b>	<b>2.600</b>	<b>0.017</b>	<b>0.012</b>	<b>0.107</b>	<b>0.012</b>	<b>0.107</b>

This model significantly predicts the outcome--Percent of Employees Lost to Death or Medical Retirement in the Last Year--( $p < 0.000$ ) and accounts for 74% of the variability in the outcome. In this model, Size and Ownership are both significantly associated with a decrease in the outcome ( $-0.053$ ,  $p < 0.000$ ;  $-0.07$ ,  $p = 0.001$  respectively). Large size and multinational/parastatal ownership are associated with lower attrition.

Malaria Treatment Onsite is significantly associated with a 0.059 incremental increase in the outcome when controlling for the other variables ( $p = 0.017$ ).

ARVs Onsite and TB Onsite are not significantly associated with the outcome in the presence of the other variables but are included because they are potential confounders and have a positive linear impact on the outcome.

It can be deduced that the larger size and multinational/parastatal ownership are associated with lower employee attrition. These two factors are also associated with higher levels of employer provided/financed medical services. However, the medical score (comprehensiveness of medical service) by itself is not associated with lower attrition rates. Possibly, sick employees remain in employment to receive the more generous services.

Another possibility is that companies with work forces at greater risk are more likely to offer services (their results would be worse without them). It is also possible that companies with more services also have more benevolent personnel policies--permitting larger amounts of sick leave and allowing employees to remain in employment until death.

### Model Predicting Average Number of days of sick leave per employee in the most recent year

Regression Statistics	
Multiple R	0.981
R Square	0.963
Adjusted R Square	0.932
Standard Error	1.486
Observations	27

### Analysis of Variance



	df	SS	MS	F	Significance F
Regression	12	812.428	67.702	30.643	0.000
Residual	14	30.932	2.209		
Total	26	843.360			

The Independent Variables								
	Coefficients	Standard Err.	t Stat	P-value	Lower 95%	Upper 95%	Lower 95.0%	Upper 95.0%
Intercept	0.575	0.881	0.653	0.524	-1.314	2.464	-1.314	2.464
Medical Score	0.447	0.153	2.925	0.011	0.119	0.774	0.119	0.774
Size	0.261	0.447	0.584	0.569	-0.698	1.221	-0.698	1.221
Ownership	-0.595	1.028	-0.578	0.572	-2.800	1.611	-2.800	1.611
VCT Onsite	-8.340	3.742	-2.229	0.043	-16.366	-0.315	-16.366	-0.315
ARVs Onsite	11.764	12.017	0.979	0.344	-14.009	37.538	-14.009	37.538
Malaria Tx Onsite	5.317	1.211	4.390	0.001	2.720	7.915	2.720	7.915
Bed nets Onsite	-6.756	2.124	-3.180	0.007	-11.312	-2.199	-11.312	-2.199
TB Onsite	-23.017	6.388	-3.603	0.003	-36.719	-9.315	-36.719	-9.315
CB DOTS Onsite	16.499	4.595	3.590	0.003	6.643	26.355	6.643	26.355
ANC Onsite	5.972	3.702	1.613	0.129	-1.968	13.913	-1.968	13.913
FP Advice Onsite	5.905	2.313	2.552	0.023	0.943	10.867	0.943	10.867
FP Supplies Onsite	1.657	2.473	0.670	0.514	-3.646	6.960	-3.646	6.960
Intercept	0.575	0.881	0.653	0.524	-1.314	2.464	-1.314	2.464

This model significantly predicts the average amount of sick leave per employee accounting for 96.3% of the variability in the outcome ( $p < 0.000$ ).

The Independent Variables; Medical Score (0.447,  $p = 0.011$ ), Malaria Treatment Onsite (5.317,  $p = 0.001$ ), CB DOTS Onsite (16.499,  $p = 0.003$ ), and FP Advice Onsite (5.905,  $p = 0.023$ ) were all significantly associated with a linear increase in the outcome (sick leave days per employee). This means that the provision of these services is associated with an increase in sick leave days.

VCT Onsite (-8.34,  $p = 0.043$ ), Bed nets Onsite (-6.756,  $p = 0.007$ ), and TB Onsite (-23.017,  $p = 0.003$ ) were all associated with a linear decrease in the outcome. The provision of VCT onsite, TB onsite, and bed nets for employees is associated with fewer sick leave days. Likely, having TB on site avoids a TB positive employee going off for DOTS, so then they would not ask for sick leave days. With VCT on site, employees would not have to seek for these services elsewhere and hence spend less time away from the company. Perhaps having ready availability of HIV testing at the work site may get employees into treatment earlier--at public or private clinics--before they begin to lose time due to AIDS related infections.

A positive linear relationship for bed net provision may well mean that employees are not falling sick since the malaria is being prevented, whereas the negative linear trend observed with provision of malaria treatment suggests that people that already have an infection will probably lose some days due to illness. This desirable relationship does not hold for ART, but perhaps that is because sick people (who lose time) remain in employment because this is where they are treated.



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Simply providing a broad range of medical services has no statistically apparent relationship to the amount of absenteeism. However, when we break this down by service, we find that VCT on site, TB treatment on site and bed nets for employees are associated with a reduction in absenteeism. But providing ART is not.

Overall, there is no link between company service score and outcomes (attrition and sick leave). The link between the large sized companies and higher use of sick leave is probably because these firms have more generous policies or make an attempt to keep workers in service longer. Once we correct for size effects with the regression, there is no link between service score and use of sick leave.



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## VII. DISCUSSION (IMPORTANT LESSONS LEARNED)

Smaller firms were less likely to have outcome data due to their inferior record keeping practices and lack of designated human resource personnel to manage this data. The evidence also shows that these small firms still lag in providing medical services to employees. Some may occasionally provide compassionate leave to a sick employee but few report cases of chronic disease/death related attrition since workers simply fall off the payroll.

Most large firms provide AIDS benefits to their employees. This is either a result of realizing the negative impact of HIV/AIDS on staff, or because the firm is a subsidiary of a larger conglomerate that extends these benefits as a part of its policy.

Over the years, the AIDS benefits provided by employers have substantially increased: HIV policies, Prevention programs and VCT services are now being implemented by a larger number of companies than in 2003. ART benefits have slightly reduced from those offered 5 years ago, likely because of the increased availability of ARVs in the country. This has created more options for employees to access these drugs without employer assistance.

Probably thanks to the wider availability of ART, chronic disease related attrition shows a downward trend in those companies that had data. Although absenteeism spiked during the malaria epidemic of 2007, it improved again in the following year.

### **Limitations:**

During the analysis phase, many of the interviewed companies, especially the smaller sized firms, did not have sick leave and attrition data dating back more than two years. It was difficult to analyze trends at such firms.

Another challenge, particularly during the data collection process, was having an incomplete data sample frame. The companies interviewed were drawn from a combined database of FUE and UMA members. It is assumed that the majority of companies in Uganda are members of one association or the other, if not both. The database contained both 'active' and 'inactive' members of the two associations. Inactive members were companies that had ceased to subscribe to a particular association for one reason or the other while active members were those that had paid their subscription dues in the last one year. Since the list of active members was used, it limited our sample frame to only those companies that were actively paying dues at either association. The formal sector employers whose membership had lapsed, or which never joined the associations, may have different (and we would speculate inferior) personnel and medical care policies.



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## VIII. CONCLUSION

Ugandan employers vary in the extent of health services which they offer their employees. From our survey, we draw the following conclusions:

- Firms with a large work force, and multinational firms, are more likely to offer employees a broad range of health services.
- Because of their isolation, rural firms seem to be providing more services to their workers.
- Direct reimbursement is the dominant method of providing company sponsored health care.
- Insurance is an important factor in providing company sponsored health care since many of the smaller sized companies tend to prefer this mode.
- The construction and retail industries are least likely to offer good health benefits.
- ANC is the service of interest which companies are least likely to offer.
- Overall, the proportion of firms providing health services has risen somewhat since 2003. However, there has not been a large increase in the number of firms offering ART to their employees, probably because it is now free in the public sector.
- Where data is available, employee attrition has been falling in recent years, undoubtedly an indicator of stable AIDS infection rates and the increasing availability of ART.
- The available data do not support any conclusion that more generous health services result, by themselves, in lower attrition or sick leave. However, the sample of firms with sufficient data is small, and there are intrinsic differences in human resource policies which make it difficult to conduct a consistent analysis.



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## APPENDIX 1: DATA COLLECTION INSTRUMENT

### Basic Data about Responding Company/Institution

Company/Institution Name \_\_\_\_\_

1. Industry Sector
  - a. Agriculture (plantation) and forestry
  - b. Manufacturing
    - i. Agribusiness, food products
    - ii. Textile and garment
    - iii. Other
  - c. Mining, mineral extraction
  - d. Retail and wholesale trade
  - e. Hospitality
  - f. Services
    - i. Security
    - ii. Technical and Business Services
    - iii. Education and Health
    - iv. Other
  - g. Utilities (including communications)
  - h. Transport
  - i. Finance
  - j. Construction
2. Ownership
  - a. Multinational, wholly owned
  - b. Multinational, joint venture or franchise
  - c. Joint venture---Uganda and international investor
    - i. >50 Ugandan owned
    - ii. <50 Uganda owned
  - d. Uganda individual proprietor
  - e. Uganda parastatal
3. Relationship with Business PART/ HIPS (describe).
4. Date of survey
5. Source of data
  - a. Name
  - b. Title
  - c. Contact Information
  - d. Signature



**Medical Services Currently Provided by the Employer**

Benefit/ Service (The specific benefit/service offered by the company)	Narrative Question (The detailed question to be asked)	Response	On-site (Indicate if the service is provided onsite)	Off site Contract (Indicate if the service is provided offsite)	Insured Benefit (Indicate if the service is covered under an insurance scheme/plan)	Direct Reimbursement (Indicate if the service is received elsewhere and employees are reimbursed for expenses)	Currently Available to:				
							Regular Employees	Dependents Of Regular Employees	Casual Workers	Employees of Contractors	Community/ Out growers
<b>HIV/AIDS</b>											
Peer Education / Information Education Communication (IEC) materials	Does the company provide any IEC materials on HIV/AIDS Awareness & Prevention?	Yes (If 'Yes', proceed to next column)  No (If 'No', proceed to next row)									
	Does the Company provide peer education to its employees on AIDS prevention?	Yes  No									
HIV Policy	Does the Company have a written HIV/AIDS policy?	Y  N									



Benefit/Service	Narrative Question	Response	On-site	Off site Contract	Insured Benefit	Direct Reimbursement	Currently Available to:				
							Regular Employees	Dependents Of Regular Employees	Casual Workers	Employees of Contractors	Community/Out growers
Distribution Of Condoms	Does the Company provide condoms in the workplace?	Y N					a, b	a, b	a, b	a, b	a, b
Voluntary Counseling & Testing (VCT)	Does the company offer VCT services?	Y N					a, b	a, b	a, b	a, b	a, b
Opportunistic Infections (OI) Treatment	Does the company offer treatment of opportunistic infections? E.g. Herpes Zosta, some cancers and STI's	Y N					b	b	b	b	b
ART	Does the company provide ARVs?	Y N					a, b	a, b	a, b	a, b	a, b
<b>Malaria</b>											
Prevention/IEC	Does the Company provide any IEC materials on Malaria prevention?	Y N									
	Does the Company provide peer education to its employees on Malaria prevention?	Y N									
Treatment (Fansidar, Coartem, Artemether)	Does the company treat Malaria? If Yes, indicate which medications are used.	Y N					b	b	b	b	b
Bed nets	Does the Company avail Long Lasting Insecticide Treated bed nets?	Y N					b	b	b	b	b



Benefit/Service	Narrative Question	Response	On-site	Off site Contract	Insured Benefit	Direct Reimbursement	Currently Available to:				
							Regular Employees	Dependents Of Regular Employees	Casual Workers	Employees of Contractors	Community/Out growers
<b>TB</b>											
Treatment/Dx	Does the company provide TB Diagnostic and Treatment services?	Y N					b	b	b	b	b
Directly Observed Treatment Short course (DOTS)	Does the company provide Directly Observed Treatment Short course therapy?	Y N					b	b	b	b	b
Referral to Gov. Clinic	If TB is diagnosed /suspected, does the company refer TB cases to a government health center	Y N									
<b>Reproductive Health</b>											
Ante Natal Care (ANC)	Does the company provide Ante Natal Care services? Do these include IPT2 <sup>13</sup> for Malaria?	Y N					b	b	b	b	b
Attended Deliveries	Does the company provide delivery services?	Y N					b	b	b	b	b
Family Planning Advice	Does the company avail any Family Planning education/IEC materials?	Y N					b	b	b	b	b
Supplies	Does the company provide any family planning	Y					b	b	b	b	b

<sup>13</sup> IPT2 for Malaria is the Fansidar based treatment given to pregnant mothers during the first and second trimesters to prevent Malaria during pregnancy



	supplies? If 'Yes', indicate below:	N									
	i. Condoms						b	b	b	b	b
	ii. Contraceptives						b	b	b	b	b
	iii. Moon beads						b	b	b	b	b
	iv. LTFP methods e.g. IUD, Injectables, Tuba ligation, Vasectomy						b	b	b	b	b

**a** - Indicate date on which service (VCT, ART) first became available to this group

**b** - Indicate if service for this group is:

Free (B1)

Subsidized, but a user fee or copayment is charged (B2)

Charged at full price or provider's cost (B3)

Put "**No**" if service is not provided to this group



## Work Force Data

Date of End of Reporting Year \_\_\_\_\_

### Data for Year Ending in

Data requested	Question Narrative	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998
#FTE Workers At Year End	Number of Full time employees/ workers at the end of the given year											
Total Workers Lost in Year	What is the total annual staff turnover for this year for all causes including resignation, death, discharge and normal retirement? You can state as total number of employees or as a % of employees in a given year.											
Workers Lost Due to Death In Service <sup>14</sup>	Does the company keep data on employee deaths during service? If so, record and indicate no. of deaths for as many years back as possible.											
Deaths Due To Chronic Disease	How many of these deaths were due to chronic disease? E.g. Diabetes, Hypertension, AIDS, TB and cancer. (Ask if they know the exact cause of death for the workers in this group, and if so, ask for the number of AIDS and TB deaths)											
Other Deaths (violence, accidents, childbirth)	Indicate the number of deaths due to other causes like violence, accidents, childbirth, etc...											
Medical Retirement	Does the company keep data on retirement/discharge/resignation due to illness? If 'Yes', how many employees were retired due to medical problems?											
Retrenchment	How many workers were laid off?											
Other Attrition	Do you have any other workers you might have lost due to reasons other than those we've mentioned here?											

<sup>14</sup> Should equal to the total of the next two rows



Data requested	Question Narrative	2008	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998
Leave <sup>15</sup>												
Sick Leave @ Full Pay	How many sick leave days, at full pay, were availed to workers for this year in total?											
Sick Leave @ Partial Pay	How many sick leave days, at partial pay, were availed to workers in this year in total?											
Sick Leave @ No Pay	How many sick leave days, at no pay, were availed to workers in this year in total?											
Maternity Leave	How many days of maternity leave were given out to all female staff during this year?											
Compassionate Leave	How many days of compassionate leave were given out in this year in total?											
Other Leave	Please indicate other leave days that were taken but have not been included above.											

<sup>15</sup> For all data below, indicate average number of days per FTE worker. If not available, indicate total for company and we will compute average



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## APPENDIX 2: USER DEFINED FUNCTION TO CREATE LIST OF UNIQUE RANDOM NUMBERS

Function UniqueRandomNumbers(NumCount As Long, LLimit As Long, ULimit As Long) As Variant

' creates an array with NumCount unique long random numbers in the range LLimit - ULimit (including)

Dim RandColl As Collection, i As Long, varTemp() As Long

UniqueRandomNumbers = False

If NumCount < 1 Then Exit Function

If LLimit > ULimit Then Exit Function

If NumCount > (ULimit - LLimit + 1) Then Exit Function

Set RandColl = New Collection

Randomize

Do

On Error Resume Next

i = CLng(Rnd \* (ULimit - LLimit) + LLimit)

RandColl.Add i, CStr(i)

On Error GoTo 0

Loop Until RandColl.Count = NumCount

ReDim varTemp(1 To NumCount)

For i = 1 To NumCount

varTemp(i) = RandColl(i)

Next i

Set RandColl = Nothing

UniqueRandomNumbers = varTemp

Erase varTemp

End Function

' example use:

Sub TestUniqueRandomNumbers()

Dim varRandomNumberList As Variant

varRandomNumberList = UniqueRandomNumbers(50, 1, 100)

Range(Cells(3, 1), Cells(50 + 2, 1)).Value = \_

Application.Transpose(varRandomNumberList)

End Sub