Materials and methods Health and Hygiene audit of 115 canteens of IndianOil establishments was carried out to assess the health and hygiene of canteens/kitchens in our organisation. Based on the audit observations and recommendations, a common checklist for good kitchen practices and Kitchen Audit Checklist for calculating hygiene index was firmed up and circulated across the Corporation. It was advised that the Hygiene Index of all Canteens/Kitchens of IOCL establishments must be maintained as per the checklist provided and must be reviewed and updated quarterly by the Canteen Committee of respective location. The Hygiene Index must be prominently displayed at all locations as per sample provided. It was also advised that the checklist points for good kitchen practices must be implemented at all locations for improving the overall cleanliness and hygiene of our canteens and kitchens. Quarterly Review Report with updated Hygiene Index need to be sent to Corporate HSE for review. The action plan for liquidation of the recommendation is be prepared by respective location.

Result This Project made employees calorie conscious and benefitted all of them who consume from the produce of these facility and helped the supervisors to maintain high standards of hygiene at their respective workplaces.

Discussion It is important to check the kitchen practices like cooking, food handling from hygiene and nutrition point of view. Hence in the interest of the employee's health there should be a periodic nutritional audit, hygiene audit of these canteen and kitchens along with the training for cooks/service boys at the kitchen and pantry.

508 VARIABILITY IN OCCUPATIONAL NOISE EXPOSURE LEVELS IN METAL INDUSTRIES IN TANZANIA

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Introduction Machines and processes in the metal industry produce noise levels that are harmful to the human ear if not properly controlled. Empirical studies are lacking to document noise exposure which is one of the stepping stones towards development and enforcement of policies, and standards on noise control in developing countries, including Tanzania where this is lacking.

Methods The study was conducted from June 2016 to June 2017. Full-shift noise measurements (LAeq) were taken by personal dosimeters (Brüel and Kjaer type 4448) in four metal factories in Tanzania (Factory A; 47 measurements, B; 47, C; 34 and D; 40). Workers were randomly selected from payroll and shift list and assigned into job groups; Melters, moulders, firemen, tongsmen, roughing, cutters and pushers.

Results Personal noise exposure varied both within and between factories. The average noise exposure was 91.6 dB(A) in factory A, 96.7 dB(A) in factory B, 93.7 dB(A) in factory C and 89.9 dB(A) in factory D. The moulders had the lowest noise exposure (87.3 dB(A)), followed by melters (89.9 dB(A)), pushers (91.6 dB(A)), tongsmen (93.7 dB(A)), roughing (94.2 dB(A)), firemen (94.5 dB(A)) and cutters/bundlers (98.1 dB(A)).

Discussion To our knowledge this is the first study in East Africa to document personal noise exposure levels in metal industries. The noise exposure exceeded the occupational exposure limit used by OSHA, Tanzania. This study is expected to serve as an important input towards the development of the country's own regulations regarding noise exposure at the workplace.

529 A COMPARATIVE CASE STUDY TO UNDERSTAND THE ENABLING FACTORS AND BARRIERS TO IMPLEMENTING HEALTHWISE IN SELECTED HOSPITALS IN SOUTHERN AFRICA

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Introduction HealthWISE is a participatory, quality improvement tool, jointly developed by the International Labour Organisation and the World Health Organisation, to improve the occupational health and safety (OHS) of health workers. Its implementation in practice has been inadequately studied. We therefore conducted a three-country comparative case study in selected hospitals in Mozambique, South Africa and Zimbabwe to better understand the enabling factors and barriers to its implementation.

Methods Pilot implementation of three HealthWISE modules was observed, including planning meetings, Training-of-Trainers (ToT) workshops, action plan development, and check-in visits. Field notes, videotapes of the ToT workshops, monthly reports, and questionnaires supported the analysis. The Promoting Action on Research Implementation in Health Services (PARIHS) framework, which describes successful implementation as a function of evidence, context and facilitation, structured the examination of enabling factors and barriers.

Result Hospitals and participants were selected by local co-investigators and partners. Implementation began with three-day ToT workshops, where 78 participants were trained across the three countries. Action plans detailed activities related to building capacity and raising awareness about OHS. Check-in visits highlighted some misunderstandings related to the roles of the research team and participants in implementation activities.

While evidence to support OHS improvements is strong, implementation was constrained by context-related factors such as the steps in obtaining approvals for the research and determining funding flows. The ILO-NIOH-UBC partnership was key in moving activities forward.

Discussion Key steps prior to implementation included strengthening partnerships with stakeholders, and engaging with team members and participants to better understand OHS issues and priorities. Key steps in implementation included training to build local capacity and to empower participants with knowledge and skills to recognise and creatively address workplace issues, and supporting the development of individual hospital action plans that reflected workplace priorities while recognising resource constraints. Administrative hurdles took time to address.