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OSH NEEDS IN DEVELOPING COUNTRIES

Contents

Introduction.....	page 1
Argentina; <i>Antonio Werner</i>	3
Brazil; <i>René Mendes</i>	7
Chile; <i>Gustavo Molina</i>	11
China; <i>Min Zhang</i>	15
Colombia; <i>Patricia Canney</i>	20
Costa Rica; <i>Catharina Wesseling</i>	25
Ecuador; <i>Raúl Harari</i>	29
Egypt; <i>Bahira Lotfy</i>	34
Ghana; <i>Edith Clarke</i>	39
India; <i>Shyam Pingle</i>	43
Iran; <i>Alireza Dehdashti</i>	48
Kenya; <i>Franklin Muchiri</i>	52
Morocco; <i>Abdeljalil El Kholti</i>	56
Nicaragua; <i>Aurora Aragon</i>	60
Russia; <i>Mikhail Mikheev & Nikolay Shlyakhetskiy</i>	64
South Africa; <i>Shahieda Adams & Rodney Ehrlich</i>	69
South Korea; <i>Chang Bum Byun & Domyung Paek</i>	74
Tanzania; <i>Vera Ngowi</i>	78
Thailand; <i>Somkiat Siriruttanapruk</i>	82
Turkey; <i>Yücel Demiral</i>	86
Vietnam; <i>Nguyen Bich Diep</i>	91
Summary and reflections; <i>Tom Dwyer, Kaj Elgstrand & Nils F Petersson</i>	97
Guidelines for the articles.....	107

Dear Readers of *OSH & Development*,

This issue intends to give you a status report on occupational safety and health (OSH) in developing countries. A description is given about the OSH panorama, policy and legislation, organisation, and current and future OSH needs for each of the 21 countries represented. The guidelines followed by the authors are attached (see page 107).

Abdeljalil El Kholti, (author of the article on Morocco), came up with the idea for this review of OSH in developing countries. The review was originally intended for inclusion in the textbook *OSH for Development* (edited by Elgstrand & Petersson, Stockholm 2009), but this was not possible due to time constraints. We are pleased to be able to publish this special edition.

At the end of each article there is a short CV of the author, and some basic facts about the featured country. The health indicators used for these profiles (life expectancy at birth, infant mortality rate, malaria mortality rate & HIV prevalence rate) are taken from WHO's "World Health Statistics", 2009. Other basic facts included are taken from the CIA World Factbook, January 2010.

The special issue finishes with a summary of the 21 articles and some concluding reflections (see pages 97-105). This summary has been reviewed by the authors of the 21 country articles, but the three authors (Dwyer, Elgstrand & Petersson) are of course ultimately responsible for the opinions in the text.

This issue is no.10 of *OSH & Development*. The earlier nine volumes were published annually from 1998-2008. The first eight volumes were published by the Swedish National Institute for Working Life. Volumes no. 9 and 10 have been published by the Royal Institute of Technology, Stockholm, with economic support by the Swedish Council for Working Life and Social Research (FAS). All ten volumes have been published in collaboration with the Swedish Association of Occupational and Environmental Health & Development (UFA), and with ICOHs Scientific Committee on Occupational Health and Development (SCOHDev). There are ongoing discussions about future publication of the journal *OSH & Development* between the current Swedish editors, the Indian Association of Occupational Health, and the Centre for International Health at Ludwig-Maximilians-University, Munich.

Stockholm, 6 April 2010,
Kaj Elgstrand
 Editor

SOUTH AFRICA

Shahieda Adams & Rodney Ehrlich

OSH panorama

The economically active population number approximately 13 million. Unemployment is high at 24%, with 4 million unemployed. There is also a large informal sector accounting for 30% of the economically active population. The past decade has witnessed a contraction of mining and agriculture, historically major employment sectors, whilst non-manufacturing sectors have grown. Within the formal sector, the non-industrial sectors of trade, community and social services and finance now account for 69% of employment.

Only 32% of workers were unionised in 2006, with the highest rate (76%) being in mining and the lowest among domestic workers (2%) and agricultural and forestry workers (8%). Currently, the largest three trade union federations in South Africa have a combined membership of just under 3 million.

South Africa has separate occupational health and safety (OHS) systems for mining and non-mining sectors. OHS surveillance relies on statutory reporting of compensation claims, although it is likely that there is a high degree of underreporting of occupational disease and injuries. This is less of a problem in the mining sector owing to greater regulation and the mandatory provision of occupational health services

In the mining sector an injury rate of 4.1 per million hours worked was reported in 2006 (gold mining accounted for 56% of all such reported injuries). During the same year a fatality rate of 0.20 per million hours worked was reported for the mining sector, 202 deaths. In recognition that safety standards in South African mines are still not in line with international standards, the Mine Health and Safety Council has set the goal of achieving international safety benchmarks by 2013 in all underground metalliferous mines. In the non-mining sector a total of 219,399 occupational injuries were reported in 2006. This represents a reported injury rate of 42 per 1,000 workers registered with the compensation fund.

In the non-mining sector, occupational diseases account for only one percent of all claims certified. On average three to five thousand occupational disease claims were reported annually to the compensation fund between 2001 and 2006. The most common were noise-induced hearing loss, post-traumatic stress disorder, tuberculosis in health care workers, occupational skin disease and pneumoconioses. Occupational lung disease and noise-induced hearing loss account for most occupational diseases reported in the mining sector.

Legislation, policy and organisation

Multiple statutes provide for OHS in the different sectors. Tripartite advisory boards involving state official and representatives of business and labour operate under these statutes.

Enforcement is currently the responsibility of two different inspectorates. The Department of Labour is responsible for OHS enforcement outside the mining sector and the Department of

Minerals and Energy within the mining industry. Resources for enforcement of occupational health legislation are limited and unevenly distributed. As a result little capacity exists for effective accident investigation, workplace risk assessments and oversight over occupational health services. This is compounded by the lack of a national consistent reporting system for accidents and occupational disease.

OHS research is concentrated in the parastatal National Institute of Occupational Health and a number of university departments of public health. The only sustained source of major research funding is derived from a levy on the mining industry. This underwrites the tripartite Mine Health and Safety Council which solicits research into mining safety and health.

Information on employer provided workplace based health services outside the mines is scarce. Previous studies have found such services in 11-18% of workplaces. Employees in sectors such as agriculture and government have little or no access to occupational health services. The National Health Act refers to the delivery of occupational health services as a function of the provincial departments of health. However, this is ill defined. Outside of specialised occupational medicine referral clinics in a few of the provinces, occupational health is not part of the services provided to users of the public sector health system, although 80 percent of the population is dependent on this system for health care. Integration of occupational health and primary care for clients of public sector health services has been tried in some places, but without success.

In the professional OHS workforce, there are approximately 1,000 occupational health nurses, 470 occupational medicine practitioners and 130 occupational hygienists, almost all in the private sector. Most occupational medicine services are provided by general practitioners with a postgraduate diploma. A recent advance has been the establishment of occupational medicine as a medical specialty in its own right, requiring four years of postgraduate study.

Current and future needs

Overcoming fragmentation in occupational health and safety OHS legislation

A national strategy focusing on strategic targets for prevention of occupational injury and disease is desperately needed. A National Occupational Health and Safety Bill was promulgated in 2005 to provide for the establishment of a single National Health and Safety Authority, with the aim of achieving integration in prevention and compensation activities. If promulgated, this legislation could have a positive impact via improved enforcement capacity, uniform standard setting, improved information systems and research capacity, and an enhanced unified compensation system. However, there has been very little progress towards promulgation.

The South African trade union movement is strong but has not been effective in these national health and safety endeavors. This is paradoxical as the Congress of South African Trade Unions, the largest federation, is part of the governing alliance.

Surveillance and research

South Africa currently does not have a nationally coordinated surveillance system for occupational injuries or diseases. It is therefore impossible to assess the full extent and impact

of occupational injury and disease and the impact of any policy intervention. The development of a national reporting system that builds on existing databases is therefore a priority. Further, the lack of a national OHS research strategy and of significant funding for research outside of the mining industry remains a deficiency.

Achieving equity in workers' compensation

The government sponsored Commission into a Comprehensive System of Social Security identified the problem of exclusion of workers in large labour sectors such as domestic workers, informal sector employees and self-employed persons from the compensation system. Any new compensation system would need to broaden coverage to include such workers. Another source of historical inequity is the specialised legislation covering mining related lung diseases which offers fewer benefits than those given for the same diseases acquired in non-mining industries.

Rehabilitation of injured and disabled workers

The lack of compulsory rehabilitation or vocational training programmes to assist injured or disabled workers to return to work results in a huge loss to the economy; there is also a high probability of unemployment following significant injuries or occupational disease. The burden of occupational disability is shifted from employers to workers and their families and onto social security. The no-fault principle on which the compensation system is based shields employers from the full cost of occupational injuries and diseases and also proscribes workers' recourse to civil litigation. An actuarial assessment of the entire compensation system is required to assess the feasibility of increasing employer premiums, both to improve employee disability benefits and to allow for the funding of compulsory occupational rehabilitation programmes.

HIV/AIDS and tuberculosis

The scale of the HIV/AIDS epidemic has led to the development of workplace-based HIV education and prevention programmes such as voluntary counselling and testing, mainly in larger companies. Some of these companies finance anti-retroviral treatment or even provide treatment through their own medical services. However, the stigma attached to being identified as HIV positive and the fear for job security are likely to remain barriers to workers' use of workplace-based health services for HIV/AIDS treatment.

The HIV/AIDS epidemic has also fuelled a secondary tuberculosis (TB) epidemic. One of the consequences has been a rising risk of tuberculosis among health care workers, including drug resistant tuberculosis. This had led to renewed interest in screening of health workers for tuberculosis disease through novel methods and in improving access for TB and HIV care in this high-risk group.

The impact of the dual epidemic has been particularly severe on the gold mining industry since silica dust, silicosis and migrant labour patterns had already resulted in very high rates of TB. This epidemic has occurred despite the intensive tuberculosis screening and treatment services provided by mining companies. Improved TB control in the mining sector thus needs

stricter dust control in mining operations and extension of TB programmes to include rural areas where labour is recruited.

Informal and casual labour

Little is known about the OHS needs of the shifting population in the informal sector. A striking example is informal gold mining where mercury is used for small scale extraction or where dormant underground shafts are worked. A White Paper on the Transformation of the Health System proposed that the Department of Health provide occupational health services to the neglected and/or marginal sectors such as small and medium enterprises, the public sector, workers in the informal sector and the recently unemployed. However, this has not happened.

The provision of labour to the formal sector through labour brokers has grown very rapidly, fuelled by efforts by business to achieve labour flexibility and reduce labour costs. Although covered by OHS legislation, such workers are likely to fall outside the safety net of such legislation. Currently there are moves to restrict and even ban labour brokerage; however, pressure to weaken labour regulations is likely to remain. There is a concurrent initiative to extend medical care access to the whole population via mandatory national health insurance payments. Paradoxically this may weaken occupational health services as companies perceive such payments as a way to discharge their responsibility for health services to their employees, including preventive services.

Basic facts on South Africa

Size of area	1,219,000 sq km
Population	49 million
Capital	Johannesburg
Main religions	Christian (47%), Pentecostal/Charismatic (8%), Catholic (7%), Methodist (7%), Dutch Reformed (7%), none (15%)
Literacy	86% of the population age 15 and over can read and write
GDP per capita (PPP)	US\$ 10,100
Gini index	65
Life expectancy at birth	male 52 years, female 55 years
Infant mortality rate	46 deaths before age 1 year/1,000 live births
Malaria, mortality rate	less than 1 per 100,000 population
HIV, prevalence rate	16,293 per 100,000 adult population

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