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Workers' Health in Africa

Meredeth Turshen

This article attempts to formulate questions about the political economy of occupational health in Africa and to construct a framework for theoretical analysis. In the article that follows this one, Peter Kamuzora reconsiders the questions in the Tanzanian context.

A survey of the scattered and scanty literature on current problems of occupational health in Africa shows that, because the sources are overwhelmingly based on the medical model, their use in constructing a macro-analysis would lead to the formulation of the wrong set of questions and answers. Most of the literature on occupational health in Africa focuses on diseases (for example, pneumoconiosis), which are causally linked to specific occupations (crushing phosphate) by way of the germ theory of disease (inhalation of dust causes tissue changes in the lungs). Generally, overviews of occupational diseases group conditions by economic sector (i.e. mining, agriculture, and industry). Using this sort of material, one arrives at formulations of the problem that pinpoint causation in the physical environment at work. Thus, in a recent WHO paper on worker's health in agriculture, problems like zoonotic diseases (anthrax, brucellosis) are attributed to work with animals, schistosomiasis to work in irrigated agriculture, and byssinosis to work in dusty environments in the cotton, sisal, flax, jute, and hemp industries.

Closely related to the literature on disease is the discussion of illness (e.g. pesticide poisoning), impairment (e.g. hearing loss), and injury (e.g. mining accidents). These conditions are generally attributed to the use of new technology (including the techniques of the green revolution), mechanisation, prolonged working hours, and over-exertion. These authors interpret the environment more broadly than does germ theory, and they implicate physical conditions other than disease agents or vectors in causation.

Another body of literature links the organisation of work (e.g. alternating shifts) to work-related diseases (e.g. chronic gastro-enteritis and duodenal ulcer). The shockingly few studies of the health of migrant workers fall into this category. Contributors to this body of literature introduce psychosocial concepts like stress and imply that disease is caused by multiple rather than single factors. Multifactorial causation is a more sophisticated epidemiological model than germ theory, but it is still dominated by the paradigm of clinical medicine.

Environmental considerations have broadened from the original narrow concern with the physical environment to a wider focus on work organisation and the psychosocial environment. But the question of industrial siting has yet to enter the African literature on occupational health despite the tragic accidents of Pemex in

Mexico City and Union Carbide at Bhopal, and the ongoing crisis of pollution at Cubatao in Brazil, which should draw attention to the need for a redefinition of the environment to include the slums surrounding the factory fence, plantation, or mine.

Solutions to occupational disease problems focus on medical intervention and the creation of occupational health services. This is the approach of the World Health Organization in what has been its least imaginative programme. The management of injuries and illnesses related to work organisation tends to be based on the discipline of ergonomics rather than medicine. Ergonomics, in its most conservative application, adapts the worker to the machine; in its most progressive application, it is a tool of worker self-management. In South Africa, it has been used to extract the maximum exertion from African workers. Preventive approaches also focus on the worker and the work environment, leading to solutions that require either building up workers to make them impervious to their environment (e.g. by improving nutritional status), or protecting them from it (e.g. by providing personal protective equipment and machine guards). Far too rarely is the problem engineered out of the environment.

A plethora of legislative acts has been adopted and state agencies created to administer and enforce the laws. WHO regularly publishes national legislation on health and safety in the International Digest of Health Legislation. The International Labour Organisation, since its inception in 1919, has adopted many health and safety conventions, but not all of them were ratified by member states and none can be enforced.

Perhaps the worst aspect of the approach that characterises this whole body of literature is the discouragement it engenders: what can be the solution to this long litany of occupational health problems, given the overwhelming general health problems and dearth of resources in Africa? Not surprisingly, African governments and international organisations assign last priority to problems of occupational health. How convenient for capital.

General Issues in the Political Economy of Occupational Health

The literature on occupational health in Africa pays no attention to the economic systems in which occupations are practised (e.g. whether capitalist or socialist labour relations), to the relationship between economic sectors (not only mining, agriculture and industry, but also between the formal and informal sectors), or to the insertion of the national economy in the international economic order. And, of course, the unpaid labour of women and children is simply ignored.

To raise questions in a useful way, it is necessary to situate occupational illness and disease in the theoretical context of the social relations of production and in the concrete setting of a national economy. The main determinants of occupational health problems and occupational health services (or preventive arrangements) are the level of development (that is, the forces of production) and the degree of socialisation of relations of production (of both capital and labour). Within this framework, women's occupational health represents a set of problems that appear to be conditioned by women's participation in the economy, polity, and society.

Countries can be categorised according to certain parameters that elaborate the broad concepts of forces of production and socialisation of labour and capital: useful parameters are, for example, the extent of nationalisation or socialisation of

land, mines, and industry; whether centrally planned or free market economy; extent of investment by and state control of multinational corporations; whether the state controls marketing for export and internal distribution; extent of worker self-management, percent of workforce organised, and autonomy of trade union movement; and whether a one-party or multiparty state. The economies of most countries are mixed (there are no pure socialist or *laissez-faire* capitalist examples); but it is important to situate them on a spectrum, and clearly there is a difference between, say, Algeria at one end and South Africa at the other.

The working hypotheses for this paper are: *one*, for historical and material reasons, African countries are developing along a continuum that began with pre-colonial agricultural and pastoral economies, which interacted in the colonial period with capitalist plantation agriculture and extractive industry, and are advancing unevenly toward manufacturing and heavy industry, and that the stage of development determines general health as well as occupational health problems; and *two*, that the degree of socialisation of capital and labour determines both the severity of occupational health problems and the adequacy of services and preventive arrangements.

A third hypothesis addresses women's occupational health problems: women's health and health care, including occupational health, although conditioned by the limits and possibilities of the economic formation in which women live and work, vary according to women's economic, social, and political participation. Women's participation can be measured in five areas of state policy: legislation, family policy, education and ideology, (waged) employment, and political representation. How women's interests are expressed in these five areas is predictive of whether women control definitions of health and illness, whether health care is adapted to their needs, and what access they have to health care.

The existence and extent of child labour and labour migration, and the type and severity of health problems afflicting migrants and children who work, appear to be determined by the forces of production and the socialisation of capital and labour. Because child health services are so often combined with services for women, the adequacy of health services and preventive arrangements for labouring children is likely to be determined by the participation of women in the economy, polity, and society. Health services for international migrants appear to be determined by the socialisation of labour and capital in the host country.

With these hypotheses in mind, I would like in the remainder of this article to raise questions for research; however, I believe that answers can be provided only by analyses at the national level or, in the case of migrant workers in Africa, at the regional level.

Question 1: What is the nature of occupational health?

Is occupational health the health of the working population? If so and if almost every African is a worker, why are only some conditions defined as occupational? Why is the ill health of farmers not defined as work-related until the problem occurs in commercial agriculture? Is there a correlation with women's role in subsistence farming?

Is the definition of occupational disease too narrow and is it controlled by capital rather than by labour? What is the effect on these definitions of insurance schemes and social security systems? What is the connection with a wage and the capitalist

free labour system? Is the relative lack of government and professional interest in occupational health related to low levels of development, to Africa's late entry in the world market system, or to the extreme exploitation of Africans?

Question 2: Are the problems of occupational health the same in subsistence farming, cash cropping, and plantation agriculture?

There is practically no literature on plantations in Africa, let alone any studies of occupational health; yet we know, primarily from plantation studies in Asia, that working and living conditions are exploitive and oppressive. Recently the World Development Movement published a pamphlet on the tea trade with case studies of Kenya and Malawi; the health conditions mentioned are not occupational but general — malnutrition (on the Brooke Bond estate in Kenya) and pneumonia (on the Ruo estate in Malawi).

Do subsistence farmers and peasants who raise cash crops ('smallholders') have more, fewer or the same health problems as plantation workers? If the problems are different, is it because work is organised differently? Some critics of the World Bank maintain that the purpose of Bank aid to smallholders is to complement International Monetary Fund assaults on social spending, since self-sufficient farmers have need of fewer social services.

What about occupational health on new agricultural schemes that blur old distinctions between public and private investment? For example, in Burkina Faso, a public agency (Amenagement des Valles des Volta, financed entirely by foreign capital) makes peasants responsible for growing their own food while maintaining control over the productive forces (land use, credit, fertiliser, machinery, etc.), resulting in the production of very cheap cotton for the European textile industry. These peasants are worse off than sharecroppers or wage labourers because they bear a major portion of production costs and risks but have no control over land use decisions nor any way to insulate their incomes against failure. The exploitation of women on this scheme is extreme, and the health of women in Burkina Faso is poor and deteriorating.

What about the health of workers in the fishing industry? Some intriguing articles have been published about the new organisation of work in fish harvesting and the conditions of women workers in fish processing in Senegal, suggesting that health problems are related to exploitation as much as to the specifics of the fishing industry.

Question 3. What is the relation of work organisation to occupational health?

In Africa, workers in industrial and mining jobs are sometimes referred to as a labour aristocracy because they are better paid than day labourers in agriculture, than workers in the informal sector, and the 20 to 50 per cent of Africans thought to be unemployed. Yet it would seem that work is organised and controlled more tightly in industry and mining.

The most progressive studies of occupational health coming out of Europe and North America suggest that the less control workers have over their work the more stressful it is and that, with increased responsibility in these circumstances, there is more stress-related disease and behaviour, both at work and at home. But these studies assume the context of capitalist labour relations in industrialised countries where, to varying degrees, workers are organised in trade unions and protected by

the state. The study findings may not be applicable to Africa — outside of South Africa. On the other hand, the differences between North and South may not matter in this instance.

Arrighi suggests that the type of state and the organisational form of trade unions are irrelevant to worker militancy. For him the determinant factor is the process of proletarianisation in which subsistence increasingly comes from wages, because the loss of alternatives to waged work weakens the workers' bargaining power, whereas the growing division of labour and the increasing mechanisation of labour processes strengthen the workers' position. This focus on the factory floor may be too narrow for the African context, where struggle also takes place in the community and is led by peasants as well as workers. But what, then, is the relation between work organisation, unionisation, state strength or sovereignty, and occupational health?

Question 4. What are the long-term health consequences of migrant labour, child labour, and the double burden of women's productive and reproductive work?

While an important and growing body of sociological literature exists on the impact of labour migration on the family, there is little specific information on the political economy of migrant health and few hints of synergies between psychological stress and physical hazards for the migrant or his family. Yet it is speculated that there is a specific link between macro-economic conditions, migration, and such diseases as tuberculosis and schistosomiasis. There may also be an important link to migrant deaths from homicide and suicide.

The problems of child labour have recently been addressed by the ILO and WHO. Because children are as often exploited by members of another generation as by members of another class, it is necessary to know the extent to which part of the product of workers as a whole (and, among them children) is expropriated by others. Some studies of child labour in Africa redefine the problem culturally as part of socialisation and therefore nonexistent. Yet a study by the Anti-Slavery Society suggests extreme exploitation of children in South Africa, and a WHO report of a conference in Nairobi describes graphically the dramatic health effects of child labour. Recently, *Le Monde Diplomatique* devoted an issue to child labour, children as victims of war, and the growing problem of abandoned children.

There is a specifically feminist literature on women and work in Africa, but occupational health problems as such have not yet been taken up. Some questions that need to be asked, within the theoretical framework of the subordination of women, are: what are the health impacts on women workers of their transition from subsistence farming to waged work and from rural to urban living? What new health problems for women and children are associated with combining waged work with reproduction? What is the role of trade unions in the fight for maternity rights, voluntary contraception, and child care? What about sexual harassment on the job and prostitution in the cities?

Question 5. What specific recommendations can be made to improve workers' health in Africa?

What occupational health standards can be recommended for workers with low levels of general health? Does the standard-setting approach even make sense in these circumstances? What synergies are there between new occupational hazards

and old problems of malnutrition and communicable diseases? Do chemical and other environmental hazards intensify in the fragile African ecology? If standards are adopted, who is to enforce them? the state, who is often the employer? multinational corporations? the workers?

Are insurance schemes and social security systems, which operate separate health services paid for by insured workers, a good way to provide occupational health services? Or do they postpone the development of a national health service by duplicating facilities and employing scarce trained personnel? What can be said of the exclusive health services of multinational corporations that are for their employees only.?

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