Global Challenges to Equity in Safety and Health at Work: Struggles for Fair Work in Southern Africa

RENE LOEWENSON*

ABSTRACT

Weaknesses in social protection and risk management systems within workplaces and in the wider public health environment and weak investment in health insurance and health services shift a significant share of the burden of production risks onto worker communities and under-funded public services. Inequality has been constructed by powerful economic and political interests and by weak policies for channelling the benefits of globalization to those most in need. Powerful drivers of inequity are not simply addressed through technical interventions—they demand political and economic action. This paper explores the knowledge and evidence needed to impact public policy and the approaches to building political momentum for that knowledge to be used.

Introduction

Equity Aspirations and Widening Inequality

Southern Africa has become synonymous with struggles against inequality. It is a region where people have carried out acts of enormous courage to challenge unfair differences in political and economic rights on the basis of race, class and ethnic group, and to obtain basic rights to vote, and secure jobs, own land, receive health care, and attend schools. And yet it remains

* Training and Research Support Center (TARSC), Harare, Zimbabwe.

Perspectives on Global Development and Technology, Volume 3, issue 1-2
© 2004 Koninklijke Brill NV, Leiden
a region of significant and often growing inequality. Disparities in the fulfillment of basic rights persist by race, rural/urban status, socioeconomic status, and gender and geographical region. Despite strong public policy and commitment to equity in the region, public resources still do not preferentially reach those with the greatest needs. This paper draws attention to the driving forces of this inequity and explores how the driving forces for equity may be better mobilized.

**Development and Deprivation in the Lives of Workers**

*Gaps Between Global Knowledge and Workplace Practice*

The first dimension of inequity lies in the gap between global knowledge and local practice in the work life of people, North and South. Workplaces in Southern Africa continue to experience work-related hazards that have long been controlled or even eliminated in high-income countries. The movement of capital, technology, and changes in work organization appears to have outpaced the systems for social protection of workers’ health. Agriculture, manufacturing, and mining sector work is associated with high rates of injury from mechanical, electrical, and physical hazards (Loewenson 1998). The expansion of chemical, electronic, and biotechnology industries and of the service and transport sectors has introduced new risks, widened the spread of work-related risks and their interaction with non-work factors in ill-health, including environmental pollution. Hence, in addition to old and prevalent problems of traumatic injury, respiratory disease, occupational dermatitis, and musculo-skeletal injury, workers also now suffer new stresses such as new asthmatic disorders, psychological stress, and ergonomic and visual effects of VDUs. Work is increasingly characterized by a high level of demand, with little control over the nature and content of the work, leading to digestive disorders, sleep difficulties, and musculoskeletal problems (Fuentes and Ehrenreich 1994; Kothari et al. 1996).

**Poverty and Poor Returns from Global Integration Undermine Workers’ Health**

Avoidable differences in the distribution of risks and ill-health due to work in the region are often attributed to poverty within production processes, particularly in small enterprises. Workers in small enterprises and in the “informal” economy experience high rates of exposure to work-related risks, with inadequate systems for protection. Informal employment has increased as formal sectors of the economy have failed to provide adequate incomes or employment to a rapidly growing labor force (Mhone 1996). Jobs in the informal economy are often of poor quality, provide low
incomes, and have low annual profits and start-up capital (USAID/Gemini 1991).

Risks in the sector include poor work organization, poor access to clean water and sanitation, ergonomic hazards, hazardous hand-tools, and exposure to dusts and chemicals. Informal workers in agriculture often apply chemicals manually, using old, poorly maintained equipment, with inadequate information to users on the risks. Workers are exposed to toxic chemicals that have been restricted or banned in the North, used in unsafe and poorly maintained application techniques—with lack of information and knowledge provided to the user—workers are also exposed to the risks of unsafe storage of chemicals and use of old chemical containers for food and water storage (Lakew and Mekonnen 1997; Loewenson and Nhachi 1996; London 1994). Hazards are poorly controlled. Even personnel protective equipment (PPE) is poorly provided and often poorly maintained where it is provided (Batino 1995; ILO 1990; Kogi 1985; Loewenson 1998). These risks spill into wider populations in home-based enterprises (Kogi 1985).

Workers in the informal sector suffer occupational injury and mortality rates similar to those of workers in the formal sector, but higher rates of occupational illness (Jinadu 1987; Loewenson 1998, 2000; Lukindo 1993; Tornberg et al. 1996). While their injuries have been found to lead to lost work time and thus to be compensable, almost none of such injuries, according to one survey in Zimbabwe, were reported or compensated (Loewenson 1998).

However, not all the differentials in occupational injury and illness can be traced to poor value added in production systems. There is in some cases an inverse relationship between returns to production and investments in safe work. Paradoxically, those workplaces most integrated into the global economy are sometimes those found to experience the highest level of risk. Export Processing Zones (EPZs) have highly liberalized tax and trade regimes to improve access to global markets for export goods. They have been associated with above average-rates of machine-related accidents, dusts, noise, poor ventilation, and toxic chemical exposure. They are also documented to expose workers to high levels of job stress. A combination of accidents, stress, and intense exposure to other common hazards is reported to arise out of unrealistic production quotas, productivity incentives, and inadequate controls on overtime, all of which create pressures for highly intense work. These stresses have been documented to produce cardiovascular and psychological disorders. It is often young women who work in low quality insecure jobs in EPZs, and they have been documented to experience additional reproductive health problems,
including miscarriage, problems with pregnancies, and poor fetal health (Fuentes and Ehrenreich 1994; ILO 1988b).

Workers who migrate to areas of higher employment do not reap returns in improved social protection. While migrancy is a longstanding feature of production systems in Southern Africa, increased trade and financial flows have added new waves of migrancy, including informal sector traders. Migrant workers experience chronic occupational disease that is poorly detected, leading to unemployment and disease burdens being borne in poor households or public health systems in countries that migrants come from and producing a number of problems in detection, reporting, and compensation of illness and injury. Studies in South Africa and Botswana have indicated, for example, that there are thousands of undetected or unreported cases of occupational lung diseases in former mine workers in the rural areas of Southern Africa (Dubovsky 1993; Steen et al. 1994; Trapido et al. 1996).

**Greater Exportable Surpluses, Greater Cost Burdens of Ill-Health Borne by Workers**

A further source of inequity arises in an unfair shift of the burden of injury and illness from production systems to poor workers and their families. Migrant workers with chronic occupational disease are generally absorbed back into poor rural communities, where their disease is managed in poor households and underfunded public health systems.

Shortfalls in workers’ protection and compensation in informal employment shifts the burden of social protection to the workers and their families. Poor households and communities thus provide the major source of relief in such cases. Many workers in the informal economy spend large amounts on health and education, but they do so through individual out-of-pocket payments and not through collectively pooled risk schemes. This may further reduce available resources to spend on technologies or other measures for workplace safety, and further increase risk of injury.

Occupational risks spill over to non-employed populations, through home-based enterprise, air and water pollution, and through the transmission of communicable disease (Packard 1989). Sexually transmitted infections and HIV, for example, have been found to be greater in communities along transport routes, or in communities surrounding major development projects. Enterprises that provide poor living environments, as have been found in the dormitory style hostels of EPZs or agroindustries, generate public health problems that are not adequately factored into health services provided (Kamel 1990a). Such morbidity is not usually classified as “occupational” but is certainly work related (Maganu 1988).
Not only are these burdens often not borne within production systems, but also occupational morbidity may be masked by background levels of ill-health attributable to poor diet, substandard housing, overcrowding, and adverse environmental conditions.

Few workers are covered by formal health insurance, leaving individuals and public health systems with inadequate funds for a reasonable quality of medical care. Compensation systems provide extremely low benefits after injury, and in the absence of formal health insurance, injury leading to job loss can lead to the collapse of household income. Informal social protection mechanisms (extended family, local community) have been stretched to extreme limits.

The burden of ill-health borne at the household level has been exacerbated by longstanding inequities in health and access to health care, with worsening inequalities under new market reforms (EQUINET 1998; EQUINET 2001). Hence, while poor health status in the region is higher in groups that have in the past been subject to racial discrimination, it is also increased in groups with recent experience of decreased employment opportunities and/or lack of employment rights (Gilson and McIntyre 2000).

The Driving Forces of Inequity

It has been argued that inequality is a natural consequence of economic and social life, and that equity is constructed by social action and public policy. However, it appears that within current processes of globalization, inequality is not simply happening but is being constructed by powerful economic and political interests and public policies that weaken the application of the benefits of globalization in those most who most need it.

Poor Application of Global Knowledge

Knowledge and information have spread rapidly within recent years, but application of both in Southern Africa is undermined by the low visibility or consideration of workers’ health when plans and decisions are made regarding production. Weak monitoring and regulatory systems imply that a significant share of occupational morbidity is not routinely reported, particularly chronic illness due to chemical, ergonomic, and psychosocial factors. Health problems may also be underreported due to fears of job insecurity and high labor turnover, factors that have become more pronounced under recent economic reforms. WHO/OGIEH (1996) estimates of the burden of occupational disease suggest that occupational
reporting systems in Southern Africa probably underestimate the real burden of occupational disease 50-fold (Loewenson 1998). ¹

Underdetection of occupational morbidity also implies that the burden of uncertainty over the adverse health risks of production processes is usually borne by exposed workers. In industrialized countries, standard setting in unclear situations may err on the side of controlling risks, but in poorer countries this often errs on the side of continued exposure. Unfortunately, these countries also have the least human, technical, and financial resources to carry out studies needed to demonstrate the risk, a situation exacerbated by the outflow of occupational health professionals.

Improved knowledge and practice in systems for protecting workers health is poorly applied due to economic signals that factor workers’ health as a cost rather than a contributor to production systems. Operators within the financially starved informal economy, for example, avoid regulation and try to diminish contact with administrative and enforcement systems to avoid spending on safety requirements. At the same time, they are poorly served by public information, insurance, or technical support services. With low levels of capital, informal operators may use poorly developed tools and techniques and may innovate shortcuts in production that, while necessary for economic survival, may pose serious hazards to workers. These conditions generate a number of deficits in the informal economy—a rights gap in relation to freedom of association, right to organize, and to collective bargaining; a social protection gap in terms of working conditions and social security; and gaps in labor law and its enforcement.

Again, the attempt to cut health and safety costs is not unique to sectors where productivity is low. Concessions given in EPZs to allow production without labor or health protection and without applying safety regulations signal the extent to which these inputs are regarded as “costs” to production. While ILO has carried out a significant amount of work to show the production returns from quality, secure jobs and investments in work environments and labor well-being, on the ground, these are areas commonly sacrificed by those seeking to attract investors or by companies themselves (ILO 2002).

Losing Sight of Workers’ Health in the Wider Resurgence of Disease

Work-related ill-health has become less visible in the wider resurgence of disease and reversal of health care gains in the region. Structural

¹The WHO estimate is made on the basis of evidence from countries with better reporting systems, and is compared against the real reported levels from occupational injury and disease reporting systems in Southern Africa.
adjustment and liberalization of economies in Sub-Saharan Africa at the end of the last century were associated with increased infant mortality, worsening nutritional status, reduced per capita expenditure on health, reduced real earnings of health workers, and massive attrition of health sector personnel (Anyinyam 1989; Cliff 1991; Commonwealth Secretariat 1989; Cornia et al. 1987; CWGH 1997; Kalumba 1991; Kanji 1991; Lesley et al. 1986; Loewenson and Chisvo 1994; Loxley 1990).

The most marked health problem in this respect has been the HIV/AIDS epidemic, with Southern Africa being the worst affected region in the world. With adult HIV prevalence rates of 25% and more, companies that had little investment in reducing occupational risks became concerned about mitigating the impacts of HIV/AIDS on production. Such impacts cost the company about US$200/employee annually, while insurers predicted collapse of benefit schemes due to AIDS. In fact, HIV/AIDS moved through all the current equity fault lines in Southern African social and economic systems and demonstrated clearly and rapidly the extent to which production sectors were geared to shift health risks and burdens from production to poor communities.

HIV first moved through skilled, mobile, educated, and urban groups in the region, but rapidly spread to rural, lower income groups, and from adults to adolescents. The epidemic moved from more socially and economically powerful adult males to poor and economically insecure females, particularly female adolescents (ILO 1995a, 1995b, 1995c). HIV transmission was highest where income and gender inequalities coincided with movement for trade, work, food, and social support—a common pattern in the region in areas of migrant employment, along transport routes, and in urban and peri-urban areas.

Despite the increased risk emanating from production-related activities, productive and formal sectors transferred, with relative efficiency, the negative impacts of HIV-related ill-health to the household level. Many companies, despite running ad hoc HIV awareness programs, screened employees for HIV before employment, or found ways of discharging HIV-infected employees. Death, disability, and medical insurance schemes excluded people with HIV or reduced benefits, reducing coverage and household savings and shifting the costs of unsecured risks to public and household budgets. Regulatory frameworks for demanding company liabilities had been significantly weakened by liberalized labor and tax regimes under market reforms. Even where new laws were passed, under pressure from unions, to prevent HIV discrimination in employment, they were poorly implemented or enforced.

Health services, facing increased burdens from non-working ill people, promoted home-based care approaches. These have often been inade-
quately supported, further stressing households, and particularly women caregivers. Worker households were largely unsupported by social security after job termination due to AIDS; these households spent four times their share of annual household income on AIDS-related health costs compared with households covered by social security (Hanson 1992). The impact of AIDS has thus been to shift burdens from formal to informal economies, to precipitate deeper poverty in poor households, and to facilitate the intergenerational transmission of poverty (Loewenson and Whiteside 1996).

**Negative Terms Reinforced by Macroeconomic Reforms and Trade Systems**

Globally, the incomes of a quarter of the world’s population declined towards the end of the last millennium, a large share of these concentrating in Sub-Saharan Africa (UNDP 1996). Globalization has produced mixed employment outcomes, particularly in the South. On the one hand, the global spread of human rights agendas, the enhancement of equity in employment law, and the widening of employment opportunities in nontraditional spheres of employment have brought more people into the workforce. New production technology and processes have generated new forms of employment. The gains, however, have not been felt across much of Southern Africa. For the large majority of Southern African workers, liberalized trade has been accompanied by a transfer of hazardous technologies and processes, an increase in assembly line, low quality jobs with minimal options for advancement and a growth in insecure, casual and small-scale informal employment (Fuentes and Ehrenreich 1994; ILO 1998b; ILO in SATUCC 1977; McConnell 1988; Pearce et al. 1994).

Women have been particularly affected by these employment patterns. They have taken on more jobs and work longer hours. Generally, they occupy low-skill, low-paying jobs, and casual or nonpermanent forms of employment and jobs where unionization rates are low (Fuentes and Ehrenreich 1994; Johal et al. 1993; Kothari et al. 1996; Smyre 1992). Such poor quality jobs do not usually enhance social protection, while the increase in out-contracted, casual, and home-based work disguises the employment relationship and shifts liability for working conditions to the worker. It is not simply poor growth that generates these conditions: UNDP data on development indicators in SADC countries show that, even in countries experiencing economic growth or greater prosperity, economic returns are not being translated adequately into human development (UNDP 1999).

Market reforms and poor economic performance have generally led to weakened public sector services and infrastructures, reduced real public spending on health and social protection, increased competition for scarce
health resources, and caused a plateau or at best reduced coverage and poorer quality of care, particularly at the primary care level (Lennock 1994; Loewenson and Chisvo 1994; Price 1997; Sahn and Bernier 1996; UNICEF MoHCW 1996).

Liberalization has enabled a wider spread of providers, with an inadequate state infrastructure to regulate quality or ensure equity in the growth of private providers. Cost escalation in the private sector has also led to a greater share of overall health resources going to a smaller and wealthier section of the population. This has exacerbated salary differentials between private and public sectors, leading to attrition of skilled health professionals from the public sector into the private sector. Declining real wages and social benefits for health professionals have also encouraged the attrition of skilled personnel to migrate to higher income countries, sometimes aided by active recruitment processes. New trade rules such as General Agreement on Trade in Service (GATS) threaten to further weaken the ability of the state to protect public sector employment or regulate private providers. The liberalized growth of private care under conditions of declining access to basic public services has led to parallel worlds, where those with wealth and connections have access to the highest technology, while many poor people cannot get or afford secure access to essential services or drugs (EQUINET 2001; Klugman and McIntyre 2000; Mutizwa, Mangisa, and Mbengwa 2000).

With few exceptions, health services in the region continue to be more accessible to social groups who experience lower levels of ill-health, even with respect to basic preventive and curative services for diseases that are more commonly experienced among the poor (World Bank 2000). It would thus appear that trends towards insecure, low-quality employment, reduced public sector capacity and professional attrition have not only increased inequalities in health, but have also enabled more powerful business, medical, and wealthy interest groups to exact health and social welfare concessions at the cost of poorer, less organized workers (Bennett et al. 1995; Kalumba 1997; Lafond 1991; Storey 1989; Van Rensburg and Fourie 1994).

Confronting Inequity: Turning Values into Practice

How can such trends towards inequality and poverty be addressed? Such powerful drivers of inequity are not likely to be simply addressed through technical interventions, nor through applying resources to social interventions targeted at specific problems or groups. They demand a deeper level of political and economic action.

Inequity assigns social value to what is considered to be unfair, avoidable, and unnecessary within the spectrum of inequalities. It is thus
not possible to confront inequity purely from a technical perspective: The decision on what is unfair is a social and political decision and often a site of struggle.

Further, experience of Southern Africa interventions in the late twentieth century indicates that it is difficult to sustain the implementation of equity-oriented social policies and gains when health inequalities arise from patterns of ownership of wealth, employment, trade, and political influence that are not adequately addressed. If improved equity in health demands engagement with the political and economic factors that generate unfair inequalities, then struggles around health at work are an ideal site for raising and confronting the decisions around production and employment that undermine health at national and global levels.

There are many ways of tapping this opportunity. This paper focuses on two such drivers for equity:

- The first relates to building the knowledge and evidence that can impact on public policy at global and national levels.
- The second relates to building the political momentum for that knowledge to be used.

Knowledge and Information as a Fundamental Basis for Any Policy Shift

Occupational health risks in Southern Africa, as in other parts of Africa, have always been poorly monitored, studied, and documented. Many occupational health studies have been directed at describing occupational risks and health outcomes in groups of workers, often documenting risk-disease relationships already well documented in industrialized countries, and in some cases long controlled or eliminated (Loewenson 1998b). There is still a serious gap in the evidence base for policies on safe work in Southern Africa.

Evidence is thus needed to raise the visibility of gaps in workers’ health, examine and critique the assumption that health improvements are a cost to production, and strengthen the arguments and mechanisms for improved monitoring and detection of the ill health arising from production. Information is needed on the extent to which production gains are translated into safe work investments and the manner in which shortfalls are mediated by insecure employment and wider inequalities in access to inputs to health and health care. The burden shift of injury and illness to households and poor communities needs to be made more visible, particularly where this shift is mediated by market reforms and weak public policy.
Producing this knowledge is not simple, given the manner in which economic trends have fragmented, disrupted, and moved vulnerable communities and undermined the technical and financial resources available.

**Political Momentum for Change**

Southern Africa is not unique in experiencing inequities in workers' health. Even within high-income countries, there are areas of employment and groups of workers that experience increased risk and poor social protection. This situation not only traces back to an absence of evidence, it also traces back to the interests and political momentum for applying knowledge in practice. Paradoxically, global knowledge is poorly applied in precisely those settings where risks are greatest.

Rather than reversing this trend, globalization has been associated with economic policies that intensify it. It is insufficient to make information on risk available to public authorities in Southern Africa. Liberalization and trade competition between poor states have been associated with deregulation of production and health laws and weakened public sector capacities, such as is described in this paper in EPZs and in declining public social protection systems. This deregulation weakens both the state systems and the strength of workers' organizations necessary to ensure that risks are recognized and standards enforced. States vulnerable to investor pressures and workers vulnerable to job insecurity and labor flexibility may themselves be unwilling to expose and deal with health problems (Packard 1989).

Confronting inequity cannot therefore be separated from the political struggle around policies and resources. As Sen (1999) puts it “Issues of social allocation of economic resources cannot be separated from the role of participatory politics and the reach of informed public discussion” (cited in WHO 1999). In workers' health, health and safety outcomes are associated with the social norms and networks within production systems, the basic rights workers have to collective organization and action, and the mechanisms for procedural justice and participation (Loewenson 1998b; Pearce et al. 1994; Wilkinson 1997).

The extent of political momentum for equity in health and safety at work is reflected therefore in the presence and application of legal frameworks of rights and obligations, in the public sector policies and capacities, in the norms that define the “safety culture” and in the effectiveness and authority of tripartite systems for reaching consensus on acceptable standards of work safety.

This site is currently one of struggle. Liberalization has been associated with deregulation of employment and health and safety laws, promotion of nontransparent self-regulation systems, often with absurdly low penalties
for breach of law relative to other production costs. Declining public sector capacities, patchy law enforcement, and rare invoking of criminal sanctions for breach of law signal weak public policies. As multilateral lending agencies (and bilateral aid agencies) have become more directly involved in political and economic decision-making processes, they too have influenced the extent of state regulation of and expenditure on employment-related issues like health and safety. There are exceptions to this influence in both Zimbabwe and South Africa, where, beyond efforts at safety promotion, the state has been willing to take strong measures to enforce laws and prosecute offences.

Behind this development is the pressure from workers themselves. If equity is socially defined, then those directly influenced by the conditions of work have an important role to play in shaping the values and norms that determine what is unfair and the attendant public policy choices.

The political momentum for occupational health is stronger where workers are well organized and more informed and able to control the work process. Job and income security, literacy, information rights and access, union access, collective bargaining rights and effective union representation organization are thus fundamental to equity in health and safety at work. Conversely, current trends towards output related pay, insecure and flexible contracts, restrictions to union access, migrant and out-contracted work and proscribed collective bargaining rights fundamentally undermine the social and political resources that enable workers to achieve improved health and safety (Dreze and Sen 1995; Navarro 2002; Sen 1992).

Southern African workers seeking to address the economic, investment, employment, and public policy measures that generate inequity in workers’ health quickly confront the extent to which these concepts are only partially defined, under globalization, by national policies and processes. Increasingly global institutions, policies and transnational investors and producers shape whether a worker in Malawi has a job, what type of job, and whether that worker will access medical care or drug treatments.

The success with which Southern African workers are able to resolve these problems nationally now depends on the extent to which inequity in health and safety is perceived to be a risk not only for the poor, or the unemployed, or the disabled in the South, but also for the rich, and for wider prosperity and health globally.

Linking Knowledge to Political Momentum

Much occupational health work disregards or underplays the social production of occupational health gains, compared to the role of technical knowledge and development. In Southern Africa, as in many other parts
of the world, production systems and social services have both undergone periods of radical transformation based on organized, social and political demand. As noted at the beginning of this paper, popular struggles lay behind the transformation of the state in most of the region. The central role of the state in responding to and consolidating law and services around that demand and the weak arrangements for sustaining public participation and accountability have masked the critical role that social norms and action play in shaping and realizing public policy. Whatever lies behind it, the gap between technical knowledge and organized demand, reflected in the gap between professionals and workers, undermines the ability of both to influence public policy.

In contrast, there have been unique moments in history when that gap has been closed, with significantly positive outcomes. For example, the use of participatory inquiry for occupational health in Italy in the 1970s brought together professionals and workers to identify risks and promote a healthy work life. This joint work created a widespread consciousness about the importance of work for health that influenced Italian public health policy and institutions in the 1970’s. It not only led to a large body of new scientific literature on work-health relationships, but brought about changes at the work-place through local action, gave unions and workers greater control over work environment decisions, motivated unions to develop their own occupational health institutions, and motivated changes in labor legislation. The combined effects of these changes contributed to a decline in work-related health problems and work accidents (Berlinguer 1979; Laurell 1984). Similarly in Zimbabwe and in South Africa, there were periods of participatory and joint work between professionals and unions that raised the profile of occupational health and safety, made visible occupational health problems, led to new areas of collective bargaining in occupational health and new legal rights and services (Loewenson 1998b; ZCTU 1992, 1994). These experiences signal the type of political and technical momentum needed to face the challenges highlighted earlier to equity in health and safety and work. Such links between technical and political elements of change have been achieved where there are strong alliances between professionals and workers.

Globalization, however, adds a new dimension to these old lessons. This paper has highlighted not only the inequalities North and South, but also the global source of many challenges to equity in the healthy work life among people in the South. Global institutions such the World Trade Organization (WTO) now set terms that limit the authority of governments at the national level, while transnational corporations have more power than many states.
With this imbalance between risk and resources, addressing inequity in health and safety depends on the extent to which it is perceived to be a risk not only in those exposed, but also for wider global security, prosperity, and health. Recurring episodes of financial collapse, poverty-induced conflict, warfare, and human rights abuses have raised some awareness in the North that markets have become too dominant in human life and that poverty is a risk not only for the poor, but also for wider global security. There is a growing understanding that global security and equity cannot be built on the significant burdens of deprivation borne by communities in the South, which includes workers in Africa. What is less well understood is that improving conditions in Southern Africa also depends on more deliberate policies for ensuring global equity.

The current level of engagement between South and North professionals, workers, researchers, and others who could give counsel on how to deal with risks in occupational health is, however, too low and too sporadic to outpace the prescriptions emerging from powerful political and economic actors. Globalization has produced powerful tools, new communication technologies, more widely connected social movements, and an increasingly global recognition of universal rights as fundamental to policy. The full potential of these tools is still to be realized in building concerted global action for the health of workers.

References


BELINGUER, GIOVANNI 1979 Una Riforma per la Salute. De Donato, Bari.


JOHAL, R., S. KEYVANSHAD AND D. LISKER 1993 “Zimbabwe Gender Issues” (Information Sheet No. 1.43). World Bank, Africa Region.


MHONE, GUY

MONGUTI, S.

MUTIZWA MANGISA, DOROTHY AND MBENGWE ALBERT

NAVARRO, VINCENT

NOWEIR, M.

PACKARD, RANDALL

PEARCE, NEILL AND E. MATOS
*Industrialisation and Health in Occupational Cancer in Developing Countries*. Lyon, France: IARC Publications.

PRICE, MAX

SAHN, D. AND R. BERNIER

SATUCC

SEKIMPI, DEO ET AL.

SEN, AMARTYA

SHUKLA, A., S. KUMAR AND F. ORY

STEEN, T. ET AL.

STOREY, P.

STRASSMAN, W.

TAQI, ALI
1996  “Globalization of Economic Relations: Implications for Occupational Safety and Health.” Presented at the XIV World Congress on Occupational Safety and Health, April 23, Madrid, Spain.

TORNBERG, V., V. FORASTIERI, P. RiwA AND D. SVAI

TRAPIDO, A. ET AL.
TRIPLE, A.G.

UNDP

UNICEF

USAID/GEMINI

VAN RENSBERG, H.C. AND A. FOURIE

VILEGAS, G.S.

WHITE, NEIL AND JONNY MYERS, N.D.
“Agricultural Respiratory Disease in Industrialising Countries.” Cape Town, South Africa: University of Cape Town. Mimeo.

WILKINSON, RICHARD G.

WORLD HEALTH ORGANIZATION/OGIEH

WORLD HEALTH ORGANIZATION (WHO)
1996 “Good Health is a Question of Priorities Not Income.” WHO Newsletter, 4.

ZIMBABWE CONGRESS OF TRADE UNIONS (ZCTU).