WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

ORGANIZATION MONDIALE DE LA SANTE
BUREAU REGIONAL DE L'AFRIQUE

ORGANIZAÇÃO MUNDIAL DE SAÚDE
ESCRITÓRIO REGIONAL AFRICANO

REGIONAL COMMITTEE FOR AFRICA

AFR/RC54/13 Rev. 1
18 June 2004

Fifty-fourth session
Brazzaville, Republic of Congo, 30 August–3 September 2004

ORIGINAL: ENGLISH

Provisional agenda item 9.3

OCCUPATIONAL HEALTH AND SAFETY IN THE AFRICAN REGION: SITUATION ANALYSIS AND PERSPECTIVES

Report of the Regional Director

EXECUTIVE SUMMARY

1. It is estimated that every year over 1.1 million people worldwide die of occupational injuries and work-related diseases. In developing countries, the risks that foster ill-health are estimated to be 10 to 20 times higher than in developed countries.

2. The emergence of new technologies and the expansion of trade and financial regimes have transformed formal employment to the informal sector. In the future, self-employment and the informal sector are expected to be more important in both developing and industrialized countries. Workers in mining, forestry, construction and agriculture face increased risks. Many of them suffer occupational injuries and disease which lead to disability and premature death. In developing countries, only about 10% of workers have access to occupational health services.

3. Globally, efforts to improve workplace conditions were implemented as early as 1954, but it was only in 1979 that the World Health Organization and the International Labour Organization intensified their efforts. Notably, Resolution WHA32.14 on the Comprehensive Workers' Health Programme further developed occupational health, and Resolution WHA33.31 encouraged countries to integrate occupational health into primary health care services and to cover underserved populations. More recently, in 1996, the *Global strategy on occupational health for all* was developed by WHO collaborating centres.

4. In the African Region, WHO and ILO have recently pursued collaboration and cooperation in occupational health with various institutions. In 2002, *Health and environment: A strategy for the African Region* was adopted. This broad strategy enables countries to develop their own policies on health and environment, including occupational health and safety. In 2003, the regional directors of WHO and ILO signed a statement of intent to collaborate in occupational health and safety in Africa.

5. This document is meant to give guidance to policy-makers on how to raise the profile of occupational health. With relevant policies and actions, it is possible to improve the health, quality of life and socioeconomic status of the people in the Region.

6. The Regional Committee is therefore requested to review and adopt the orientations contained in this document, "Occupational health and safety: Situation analysis and perspective," to enable the Regional Office to support countries to improve the health and safety of working populations.

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INTRODUCTION

1. In 1950, the International Labour Organization (ILO) and the World Health Organization (WHO) defined occupational health as the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations. This is to be achieved by preventing ill-health, controlling risks, and adapting work to people and people to their jobs. Occupational health involves the action of occupational medicine, industrial hygiene, psychology, safety, physiotherapy, ergonomics and rehabilitation.

2. Occupational health and safety is a worldwide concern of workers and their families. The history of occupational health is a constant struggle between workers fighting for protection and preventative measures and employers seeking to deny or reduce their liability for work-related diseases and injuries.

3. People everywhere are exposed to almost limitless risks to their health, including both communicable and noncommunicable diseases. It is estimated that each year there are 160 million new cases and 1.1 million deaths associated with work-related diseases and injuries worldwide; this roughly equals the annual number of malaria deaths globally. The poor are especially at risk because their health is already compromised.[1]

4. Globally, efforts to improve workplace conditions were put in place as early as 1954, but it was only in 1979 that the World Health Organization and the International Labour Organization intensified their efforts. Notably, Resolution WHA32.14 on the Comprehensive Workers' Health Programme further developed occupational health, and Resolution WHA33.31 encouraged countries to integrate occupational health into primary health care services and to cover underserved populations. More recently, in 1996, the *Global strategy on occupational health for all* was adopted. The strategy seeks improvement in occupational health and safety through the application of health measures in some countries and encourages others to take positive steps to make such trends possible.

5. Various WHO documents, the Alma-Ata Declaration and the *Health-for-All policy for the 21st century in the African Region: Agenda 2020* stipulate the fundamental right of all people to the highest attainable standard of health, and it specifies the prevention of accidental injuries and the promotion of improved working conditions.[2] Occupational health practices constitute a set of key activities for the health and social dimensions of sustainable development that are likely to contribute to the achievement of the millennium development goals.

6. The most successful economies have demonstrated that workplaces designed according to principles of occupational health, safety and ergonomics are the most

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[1] WHO, The world health report, 2002: Reducing risks, promoting healthy life, Geneva, World Health Organization, 2002, p. 3.
[2] WHO, Global strategy on occupational health for all: The way to health at work, Geneva, World Health Organization, WHO/OCH/95.1, 1995.

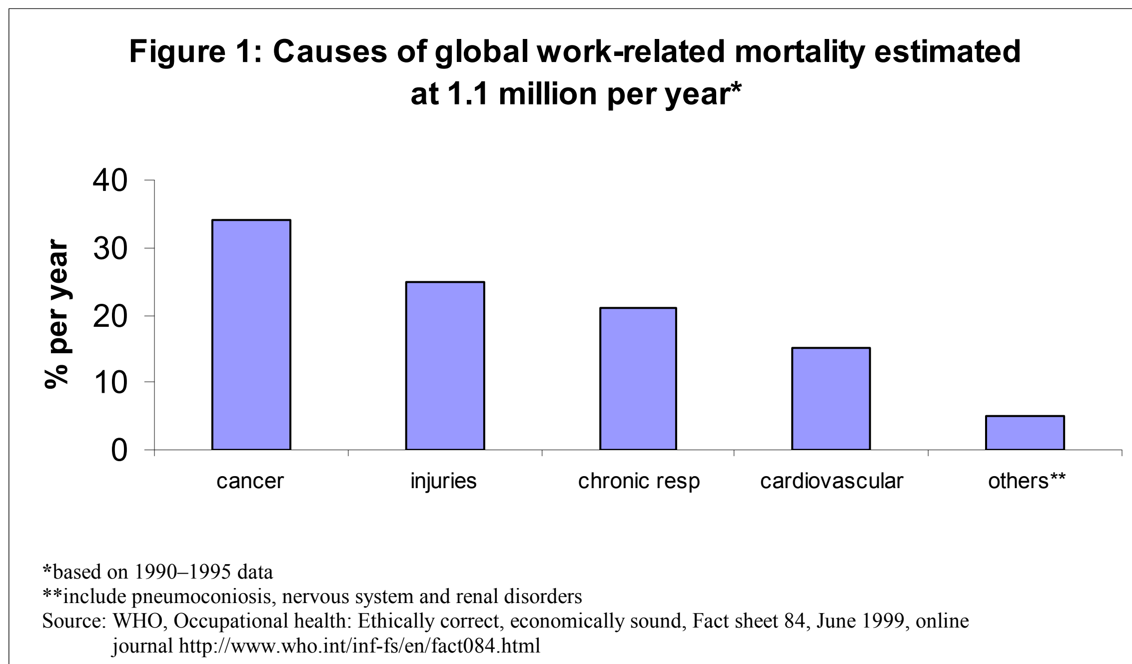
sustainable and productive. There is a need to advocate and systematically apply these principles in the African Region.

7. Since 2000, WHO and ILO have pursued collaboration and cooperation in occupational health with various institutions in the African Region. In 2002, *Health and environment: A strategy for the African Region* (AFR/RC52/10) was adopted to enable countries to develop their own policies on health and environment, including occupational health and safety. In 2003, the regional directors of WHO and ILO signed a statement of intent for collaboration in occupational health and safety in Africa. The two organizations agreed to collaborate and cooperate with governments, workers and employers to identify and address the needs of workers.

SITUATION ANALYSIS

8. In 1995, the world's workforce comprised about 2 400 million (45%) of the total population of the world and 58% of the population aged 10 years and above. Annually, 30% to 50% of workers report hazardous physical, chemical, biological and ergonomic exposures or workload. About 120 million occupational accidents with 200 000 fatalities occur annually, and 68 million to 157 million new cases of occupational disease may be caused by various exposures at work.[3]

Figure 1: Causes of global work-related mortality estimated at 1.1 million per year*



*based on 1990–1995 data
**include pneumoconiosis, nervous system and renal disorders
Source: WHO, Occupational health: Ethically correct, economically sound, Fact sheet 84, June 1999, online journal http://www.who.int/inf-fs/en/fact084.html

9. In addition to the already existing problems in occupational health and safety, there are specific issues related to women, children and the elderly at work. It is observed that conditions at work are not often favourable to women and children, although they

[3] WHO, Global strategy on occupational health for all: The way to health at work, Geneva, World Health Organization, WHO/OCH/95.1, 1995.

contribute appreciably to national economies. This is particularly so in agriculture where various chemical substances are used.

10. In the African Region, work-related threats to human health and life are becoming increasingly evident.[4] A study of workers in gold mining in an east African country reported abnormally high concentrations of total mercury in the urine samples of miners exposed to mercury vapour during burning of gold-mercury amalgams. In the same country, there were injury rates between 10 and 18 per 1 000 workers in mining, building and construction industries. In another east African country, there has been a rate of 7.6 clinical health complaints per worker per year from women working in manufacturing industries. In west Africa, a study revealed abnormal lead levels in blood and urine samples of smelters, automobile mechanics and petroleum retailers. Between 1990 and 1998, one southern African country reported 2 200 accidents and 16 deaths in agriculture and forestry. The cost of road injuries is estimated at 1% of gross national product in low-income countries.[5] Work injuries and fatalities caused by cumulative fatigue resulting from lack of sleep, night driving and shift work have also contributed to road traffic injuries.

11. In spite of all these work-related health findings, including psychosocial issues, only 5% to 10% of workers in developing countries and 20% to 50% of workers in developed countries have access to occupational health services.[6]

12. In 2001, a survey conducted by the WHO Regional Office in Africa[7] showed the lack of comprehensive occupational health services for workers in the Region in spite of various WHA resolutions. Of the countries surveyed, 63% conducted risk management; 41% provided information and education; 26% conducted pre-placement medical examinations; 33% provided clinical services for vaccinations, special examinations and treatment; 7% conducted research, provided examination for compensation, developed human resources, provided education and counseling on HIV/AIDs and use of tobacco, and collected data related to the health of workers.

13. Policies and legislation on occupational health and safety do indicate a commitment to workers' health. The regional survey showed that 48% of the countries have occupational health legislation and 37% have legislation pertaining to labour and health, but in both cases there is lack of adequate human resources to monitor applications.

14. The high incidence of endemic disease, conditions related to the use of tobacco and other harmful substances, and malnutrition as well as the absence of routine medical check-ups make workers more vulnerable to uncontrolled biological hazards. *The world health report 2002* shows that in the African Region, more than 40% of hepatitis B and

[4] For the following studies see the African newsletter on occupational health and safety, 10 (2), 1999, 11 (1, 2), 2001; and the East African medical journal, 73 (6), 1996.
[5] WHO, World report on road traffic injury prevention, Geneva, World Health Organization, 2004.
[6] WHO, Global strategy on occupational health for all: The way to health at work, Geneva, World Health Organization, WHO/OCH/95.1, 1995.
[7] DES/AFRO, Occupational health services in the African Region: Situation analysis, Brazzaville, Regional Office for Africa, Division of Health Environment and Sustainable Development, unpublished report, 2001.

hepatitis C cases and more than 3% of HIV infections are caused by risk at work. Some industries in some southern African countries report the negative impact of HIV/AIDS in workplaces.[8]

15. Activities are being undertaken by the Regional Office to address occupational health in the African Region. The Regional Office supports countries to develop legislation and policies on occupational health, a website is accessible to collaborators and an information strategy is available.

16. A network of collaborating centres in Africa is being established. In 2003, the World Health Organization and International Labour Organization successfully concluded a joint statement of intent on occupational health and safety in Africa. Through encouragement from the Regional Office, countries are cooperating among themselves in human resource development.

17. The Regional Office is also developing a mechanism for promotion and maintenance of high levels of health and safety for its own personnel and for others engaged within its area of control.

MAIN CHALLENGES

18. Considering the rampant poverty and poor performance of economies, the African Region is faced with a number of challenges. In the African region, the challenge is how to ensure that workers in the informal sector have adequate health education and are able to actively use such information.

19. Workers often face microbiological and occupationally-induced illnesses. Health workers are exposed to infectious agents; workers in agriculture and industry are exposed to injuries or illness from chemicals and machines; those in service industries and crowded cities suffer from fatigue and stress.

20. These problems are not only confined to the formal sector but to the rapidly growing informal sector as well. In Africa, the combination of old hazards, such as noise, heat and cold, are aggravated by new technologies. The growth of small and medium businesses and their contribution to socioeconomic growth require new approaches to occupational health services.

21. Child labour is now rampant in many countries. Child labour is associated with poverty, inadequate educational opportunities, lack of standards and failure to enforce relevant laws. Work that is harmless to adults can be extremely harmful to children. Work can endanger the physical, cognitive, emotional, social and moral development of children. Child labour is associated with risks of injury, poisonings, school drop-out or even death.

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[8] Decosas J, AIDS and development: What is the link, Development Express 7: 1–10, 1996, online journal http://www.acdi-cida.gc.ca/xpress/dex/dex9607.htm.

22. The health of women at work is worrisome as it has not been accorded the attention it deserves. Normal working conditions can be stressful for women workers, particularly during pregnancy.

23. The HIV/AIDS pandemic threatens the health and livelihood of the workforce and is already having an enormous impact on the productivity and economies of countries, businesses and families. This is particularly true of certain cadres of health professionals who are frequently in contact with blood and other body fluids. The challenge is to establish health and safety programmes in workplaces, especially health care settings.

24. Endemic diseases also affect workers and workplaces. In addition to occupationally-induced diseases, endemic diseases need to be managed properly at work.

25. The economic impact of health and safety programmes is obvious. The provision of health and safety programmes at work benefits workers, their families, employers and industry. Such programmes help to reduce the pressure on public health institutions.

PERSPECTIVES

26. The development of occupational health services and their integration with the primary health care approach present the health sector with opportunities to improve health in work settings.

27. The health sector, in particular ministries of health, should play a leading role in providing evidence to other sectors and stakeholders of the burden of diseases due to health risks in the workplace.

28. Because occupational health and safety affect numerous sectors, collaboration with the International Labour Organization is necessary; it is evident that concerted efforts are needed to pool resources and strengthen partnerships. Similar collaboration is needed with other sectors such as education, mining, environment, labour and social welfare.

29. The World Health Organization and International Labour Organization Joint Effort on Occupational Health and Safety in Africa (WHO/ILO AJE) aims at improving work conditions and environment in Africa, thus reducing the burden of occupational diseases and injuries through intensified coordination of occupational health and safety activities. It attempts to sustain and foster cooperation between the health and labour sectors for the benefit of workers in order to consolidate the mandates of each of the partners.[9]

30. The joint effort calls for collaboration in capacity building focused on human resource development; national policies, programmes and legislation; information, research and awareness raising. Promotion of occupational health and safety will focus attention on newly transferred technologies, hazardous occupations and vulnerable groups, including informal sector workers, women, children and the aged.

[9] Meeting report. WHO/ILO joint effort on occupational health and safety in Africa, Harare, 2001.

GUIDING PRINCIPLES

31. The guiding principles for addressing occupational health and safety in the African Region should take into consideration the various global and regional initiatives.

32. There should be compliance with international conventions and agreements, especially those concerning occupational health and safety, with greater emphasis on children, women and the elderly. Documents such as the Worst Forms of Child Labour Convention (1999) and the Fourth World Conference on Woman Beijing Declaration and Platform for Action (1995) should form the basis for proper formulation of national policies and implementation of occupational health and safety.

33. Intercountry cooperation should be encouraged to assist each other in human resource development. In most countries, occupational health is not allocated sufficient resources to carry out preventive, promotive and curative activities. There is a great need to develop and increase the number of adequate and relevant human resources to plan and implement sustainable occupational health programmes.

34. Scientific bodies should contribute to the development and implementation of occupational health and safety. Their involvement ensures continuous development of human resources, setting of research agenda and application of research results to policies and actions.

PRIORITY INTERVENTIONS

35. Given the extent and magnitude of the problems associated with occupational health and safety, there are numerous interventions that require commitment and action by governments and other partners.

36. Changes in employment trends away from the formal sector to subcontracting and the informal sector require that governments plan and provide comprehensive occupational health services to workplaces and within primary health care programmes.

37. There is need for development of relevant policies and legislation for occupational health and safety. Such developments require government commitment and the allocation of necessary resources for programme planning and implementation.

38. The research agenda should focus on improving efficiency, identifying ways to promote better health at workplaces and anticipating new problems.

39. Workplace policies and action plans, including health financing, have a positive effect on the health, safety and productivity of workers. It is necessary to include improved safety and health in the performance of management systems.

40. The avoidance of occupational hazards and adoption of appropriate working practices require the provision of relevant up-to-date information, tools, work aids and organizational structures. The employer should provide this environment.

41. The establishment of a registration system for occupational accidents, diseases and exposures will assist in the development of both preventive and curative strategies; these will also help to improve morale and productivity.

ROLES AND RESPONSIBILITIES

42. The responsibilities of various partners at country level include:

(a) Allocation of adequate resources for occupational health and safety, particularly for small businesses and the informal sector;

(b) Strengthening intersectoral collaboration and coordination among partners, with the health sector taking the leading role;

(c) Development and implementation of policies that encourage employers and workers to develop good and ethical health practices in the workplace;

(d) Review enforcement of legislation as well as regulation of norms, safety standards and laws governing work environment and work practices;

(e) Monitoring and follow-up of programmes concerning workers' health and safety, particularly for children and women.

43. On the international level, the World Health Organization should lead partners in the protection and maintenance of the health and safety of workers in the African Region. These roles and responsibilities include:

(a) Maintaining enough technical capacity and guidelines to support countries in developing policies and strategies;

(b) Coordination and guidance on setting priorities and using available local skills and expertise;

(c) Fund-raising to encourage and facilitate bilateral cooperation in order to share the scarce human resources available.

CONCLUSION

44. The availability of occupational health and safety services will prevent and reduce occupationally-induced diseases and conditions. By extending the public health agenda to the workplace, absenteeism due to general health problems will decrease and productivity will increase.

45. A well-established occupational health service will improve work safety and quality of life, reduce poverty and contribute to achieving the millennium development goals.

46. The Regional Committee is requested to consider and adopt the orientations contained in this document entitled “Occupational health and safety in the Africa Region: Situation analysis and perspectives”.