HEALTH IN THE WORKPLACE

IT'S EVERYBODY'S BUSINESS
INTRODUCTION

It is a fundamental policy of the World Council of Churches “to address spiritual and physical ill-health evidenced in unfulfilled lives and unjust socio-economic systems that perpetuate societal barriers in our world.” Unjust conditions in the workplace are often directly responsible for spiritual and physical ill-health.

Issues of occupational health and safety are not confined to developing countries. Indeed, recent findings of the Evangelical Church in Germany (EKD) Advisory Commission on Social Structures on “Work, Life and Health,” published in the EKD Bulletin (March 1991), reveal a full third of the German workforce as unable to work up until normal pension age for health reasons. The EKD Bulletin continues:

Work which places a considerable physical strain on people is still widespread in spite of the machines and technological improvements which have relieved or lightened their burden. A quarter of the workforce are exposed to noise; almost as many have to carry or lift heavy loads; about 21% have to suffer the effects of cold, moisture, heat, humidity, or draughts. The use of new technologies shifts strain to the psychological and social spheres. The number of hazardous working materials (solvents and lubricants, for example) is constantly increasing, [and the long-term effects of these] are often incalculable.

The theological section of the EKD report stressed that “toil” and hazards of the workplace are not some “unavoidable fate” for human beings, ordained by God and rooted in the order of creation. Quite the opposite: human beings have a responsibility to ensure the health and safety of their numbers in the workplace.

The government, the employer, and the workers themselves share this responsibility. Legislation on occupational health and safety are already in place. The problem is that the laws remain unimplemented, unenforced, and unimproved.

In the Philippines, for example, there are only 233 labour inspectors responsible for 357,187 firms nationwide. Many industries thus avoid inspection, and unsafe working conditions and many work-related illnesses and accidents go unreported. For many employers, profit takes precedence over the health and safety of their workers. During my visits to Filipino banana plantations, I have seen workers spraying the trees while using only handkerchiefs as masks, despite legislation in place to prevent this. During my recent visit to the Institute for Occupational Health and Safety Development (IOHSAD), Manila, Philippines, a staff member commented that it is only since watching televised reports on the Gulf War that many workers have realized what a proper gas mask is. Most do not realize that their work is making them sick.

In an effort to redress this situation, Contact presents in this issue what workers and churches have done and can do to support the workers in the workplace.

Erlinda Senturias
HEALTH IN THE WORKPLACE:
IT'S EVERYBODY'S BUSINESS

By Leah Wise, Executive Director of Southerners for Economic Justice, a regional advocacy group working in North Carolina, USA, and John Bookser-Feister. Mr Bookser-Feister and Ms Wise are also co-authors of the book Betrayal of Trust: Stories of Working North Carolinians (see page 5).

Industrial development and work-related illnesses can go hand-in-hand. In many cases industrial illnesses remain undetected because doctors do not make the connection between their patient’s condition and potential hazards in the workplace.

Bhopal and Chernobyl are dramatic examples of widespread health disasters wrought by manufacturer negligence. But most health care workers in the developing world have only to look to factories close by for violations of occupational safety and health provisions. What can health care workers do to stop injury in the workplace? Situations, of course, vary greatly from one country to another. Nonetheless, the combined advocacy of the medical community, the churches, the workers themselves, and other allies in local communities can act to make industries, even transnationals, accountable for their practices.

The goal of this advocacy is not only medical treatment for the victims of such workplace hazards as toxic exposure and repetitive motion trauma, but to eliminate the dangerous conditions in the workplace as a measure of prevention.

A case study: Schlage Lock Company
An example of this type of advocacy occurred in the southern United States in 1988-1989. The setting is northeastern North Carolina where, contrary to myths about America, people are coping with issues not unlike those in the developing world. The area never quite recovered from slavery. The majority of the region’s population is black, but government and politics are controlled by conservative whites.

Poverty and unemployment are extreme in parts of eastern North Carolina, and industrial development minimal. Labour unions are virtually nonexistent (the state workforce is about 95% non-union). Public officials fear industries may overlook their community if it is unionized, and workers fear factory shut-downs as the result of union activity.

To attract industry, local chambers of commerce, with substantial support from the state government’s industrial recruiting division, offer tax incentives, free land and infrastructure, and the promise of a “cheap and docile” workforce. The consequence often is an almost unregulated situation. Companies are permitted to require workers to work under dangerous conditions, and workers have no structure in place for holding employers accountable.

Eastern North Carolina is part of the region of 320 counties, stretching from southern Maryland to eastern Texas, called the Black Belt South. Historically, the Black Belt was the slavery-dependent plantation region of the Southeastern United States and today is still poor and underdeveloped. The majority of the population of the heart of this rural area is of African-American descent.

North Carolina’s Black Belt region has been placed in the worst 4% of 202 health service areas in the United States in terms of health status. Economic, social, environmental, political, occupational, and racial conditions all impact on people’s health.
HEALTH FACTS ON NORTH CAROLINA'S BLACK BELT

The Infant mortality rate, expressed in number of deaths per thousand live births, is considered one of the best indicators of the health status of a given population, since it reflects conditions of general health, nutrition, access to health care, quality of water and other socio-economic conditions. In 1988, North Carolina had the worst infant mortality rate of the country. Currently, the rate is the 4th highest. For African-Americans in North Carolina, the rate is 2.5 times higher than the overall state average.

The overall life expectancy in North Carolina is significantly lower for African Americans than for whites. Eastern North Carolina, where Black-Belt counties are concentrated, has the highest death rate in the state. African-American death rates in North Carolina exceed those of the white population by nearly 50%.

North Carolina has the highest percentage of people in the USA lacking indoor plumbing. One-third of poor households live in substandard housing.

North Carolina has the lowest wage for production workers in manufacturing in the USA, as well as the lowest percentage of unionized workers.

In 1988, 544 North Carolinian workers were injured or made ill each day by dangerous and unhealthy jobs. In 1989, 143 workers died as the result of accidents while at work, which does not include deaths as the result of long-term exposure to chemicals.

Only one out of 872 hazardous waste sites have been cleaned up in North Carolina. 75% of off-site hazardous waste sites in the South of the USA are in African-American communities.

The rural areas of North Carolina, especially in the Black Belt, know a lack of health care providers. For example, 20 counties in North Carolina have no doctors who deliver babies, and the doctor/patient ratio is five times lower in rural than in urban areas.

Trends in illiteracy are linked to other indicators of population status. 800,000 North Carolina adults are illiterate. One out of five could not read this page.

The above information was provided by the Community Health Collective, an organization addressing the health conditions of five of North Carolina's Black Belt counties by bringing community organizations together on specific projects. The Community Health Collective works in collaboration with the North Carolina Student Rural Health Coalition (see page 6 of this article).
Schlage Lock, a lock manufacturer, had operated its plant in Rocky Mount, North Carolina, USA since 1972. Schlage Lock is a subsidiary of the transnational Ingersoll-Rand Corporation. Schlage workers in Rocky Mount made door locks using a variety of metals and chemicals. The plant was profitable and was expanded in 1981 with the help of a county-sponsored industrial revenue bond worth US$5.5 million. In 1985, employment at the plant was at its highest with 700 workers. Women of colour made up at least two-thirds of the production workers.

In 1987, Schlage began transferring its operations to a region of northern Mexico, immediately across the US border from Texas, where production costs were kept low by minimal wage and minimal government regulation. Industrial development in the region received strong backing from the Mexican government. As workers back in North Carolina were laid off by Schlage, complaints of unfairness began to surface. Two of the women workers finally turned to the local church for help.

From paralysis to action: Schlage Workers for Justice

The pastor who first heard the workers' complaints believed that the women were being treated unfairly. Schlage was offering incentives, including a severance plan, for Rocky Mount management employees to keep the Rocky Mount plant operating until workers in Mexico were trained to make quality locks. Production workers in Rocky Mount, however, were to receive no severance benefits or pay incentives. The pastor to whom the women production workers turned put them in touch with a local community organization, the Black Workers for Justice. A key member of that organization, Philip White, was also a staff organizer for Southerners for Economic Justice (SEJ). A regional advocacy group, SEJ was working to organize dislocated workers in North Carolina. SEJ responded by contributing Mr White full-time to organize the Schlage workers.

As Mr White brought the women and their co-workers together, they began to talk about their jobs and some of the things they had witnessed over the years. There were stories of chemical exposure and illegal chemical dumping. More disturbing, the workers noticed that many of them had similar health problems, especially esophageal and respiratory troubles. The workers began to wonder aloud if there was any link between the deaths of seventeen co-workers (believed to be cancer-related) and toxic exposure.

The workers decided to form an organization and demand justice from the giant Ingersoll-Rand. They named their group Schlage Workers for Justice and elected a dynamic, biracial duo of women as its leaders. They took up daily picketing of the Schlage plant and the city
government building of Rocky Mount. One local development official became so enraged at their actions that he drove up and down the picket line, pointing his thumb down and sticking out his tongue. Government officials were generally unresponsive.

Advocacy organizations began to take a closer look at Schlage Lock. Research by an environmental group revealed that Schlage had been cited on several occasions for violations of state toxic disposal laws. Yet the citations had never appeared in the local press.

The workers' list of demands now grew to include health screening for all the Schlage workers before the company closed its doors. The workers also began to insist that Schlage clean up the mess it intended to leave behind.

The workers were persistent. Several months into their picketing, a group of them climbed into a van and drove 10 hours to Ingersoll-Rand's annual shareholder meeting in Morristown, New Jersey. They spoke to shareholders who were surprised to hear what was happening in North Carolina.

Still the Schlage Lock management refused to meet with the workers' group. Communication from the company came as announcements in the press.

The worker's allies: church and community organizations

The role of advocacy groups and the coalitional effort they mounted were critical to the success of the Schlage workers' struggle. A number of labour, academic, church, legal, environmental, and consumer advocacy groups became involved as the seriousness of the workers' situation became clear. In the centre of the effort was Southerners for Economic Justice (SEJ), a 12-year-old organization promoting workers' rights and encouraging churches to stand with the working poor. The advocates sought to bring as much public pressure as possible upon Schlage Lock to treat its workers, and the citizens of Rocky Mount who had financed its progress, with fairness.

Calling upon its contacts in the national industrial retention movement, SEJ was able to amass critical information within a few short weeks. With a copy of Ingersoll-Rand's annual stockholder report, it was able to corroborate the workers' claim that their plant was profitable. The report revealed a trend of record-breaking profits for the Door and Hardware Group, especially crediting the contribution of lock sales. SEJ brought in a Chicago-based labour research group to analyze the "social costs" of
the Schlage Lock plant closing. Their findings were sobering: over two years federal, state, and local governments would lose a minimum of US$10.5 million as a result of the closing. A “ripple effect” on suppliers would cause job loss for 632 non-Schlage workers. The lost personal income and buying power to the community would amount to US$20 million. The Schlage workers, if they successfully found replacement work, would likely receive lower wages and consequently have a lower standard of living. These findings were made available to the press to keep the pressure on Schlage to come to terms with the workers.

In the effort to win national exposure for the workers’ cause, SEJ brought the Schlage workers to a national gathering of plant closing activists. The conference broadened the workers’ outlook and generated information and support from many parts of the United States.

Meanwhile, efforts were made to involve the churches. This was an issue of justice that called for church involvement. At the outset of the campaign, a ministers’ breakfast was held with local black church leaders to express support for the Schlage workers. The Interfaith Center on Corporate Responsibility and the American Baptist Churches’ national staff offered guidance in planning for the Schlage workers’ delegation to attend the Ingersoll-Rand shareholders meeting.

SEJ also involved the Presbyterian Church, USA. SEJ Director, Leah Wise, brought the workers’ story to the quadrennial Women’s Economic Justice Conference of the church. That conference resulted in a resolution asking Ingersoll-Rand to meet with the workers and provide just payment, care, and benefits to those who would lose jobs; to clean the plant site; and to reconsider its decision to close the plant. The women sent postcards of concern to the Ingersoll-Rand headquarters as well.

When a prominent Presbyterian who headed the Rocky Mount chamber of commerce balked at the women’s resolution of support, an ad hoc synod committee was formed to investigate the Schlage Lock closing. The synod committee interviewed the workers, the advocates, and the company and ended up modifying and strengthening the original resolution.

Southerners for Economic Justice: exposing a “betrayal of trust”

Southerners for Economic Justice (SEJ), based in Durham, North Carolina, played a central role in organizing the Schlage workers and providing a critical link to allies and resources. The organization was founded in 1976, when textile workers of certain plants were seeking to unionize. SEJ was conceived to be an organization that could gather community and church support for workers’ efforts to defend themselves from corporate abuse.

In the years before the Schlage Lock plant closing was announced, SEJ conducted a project to document the amount of workplace injury taking place in the state of North Carolina. Its findings, published in the book Betrayal of Trust: Stories of Working North Carolinians were disturbing. People throughout the state were being injured and poisoned on the job, and then fired without just compensation. In the tense climate caused by high unemployment, those workers who were hurt at work and then made demands upon the company were often avoided by fellow employees, who feared for their own jobs.

The documentation project was inspired by two hardworking black women who, after sustaining injury at work, were fired and then denied compensation.
Mattie Brown worked at a ball-bearing plant, inspecting ball bearings at close range. In the course of her work, she breathed a chemical rustproofing coating in a room already cloudy with kerosene vapour (liquid kerosene was used to cool bearing parts). She was provided no protective equipment. When Mattie experienced symptoms of nausea and dizziness, she was told by her supervisor, “If you can’t take the heat, get out of the kitchen!” He accused her of imagining the symptoms. When she began to have fainting spells, the company denied that it had anything to do with her health problems. She was desperate for an income, so she kept working. She was removed unconscious from the plant five times. Finally, she was fired. There was no legal protection for her, lawyers said. In the end, Mattie was left with a permanent nerve disorder, allergies, and no income.

Later, at a hearing on economic issues sponsored by the local Roman Catholic diocese, Mattie told the story of women working in that plant who were still suffering. “There’s a lady there now,” she said. “She has a very dark black complexion—all the pigment in her hands has been eaten away. Her hands is raw. But she’s still got to work because she has children.”

A public hearing became the pinnacle event of the campaign and represented a model coalitional effort. The workers, joined by a host of experts, testified before a panel of community leaders about what had been happening at the plant. The panel’s members included ministers from several denominations and representatives from the medical, scientific, business, legal, and labour communities and local government. Thereafter, the panel constituted itself as the Citizens’ Commission on Plant Closings, with the task of making recommendations to the community based on the lessons from the Schlage Lock plant closing. One of the most disturbing reports at the hearing was the results of a health screening of 79 workers, conducted by a non-profit health-care agency, the North Carolina Student Health Organization: “Doctors found that 45% of those tested had respiratory problems, 27% had liver damage, and 21% suffered some nerve damage,” reported a spokesman. “Of the 79 workers tested,” he continued, “64% reported having frequent headaches.” Nosebleeds, skin rashes, and shortness of breath were also reported.

In spite of these widespread health problems, local health departments responsible for safeguarding the public’s health refused to become involved. Inadequate toxic waste disposal practices were also revealed at the hearing. An investigator from the Clean Water Fund of North Carolina discovered several citations against Schlage Lock that were never made public, nor enforced. Methylchloride (17 parts per billion) and toluene (110 parts per billion) had leaked from the Schlage Lock site to adjoining property.

Success at last

About six weeks after the public hearing, Schlage Lock announced a clean-up plan for the site and agreed to provide a severance payment to those workers who would participate in a “training programme.” The company also offered to conduct medical examinations of the workers and help in gaining worker’s compensation benefits from the state if they suffered disability. The plant would not remain open.

All the picketing, marches, rallies, documentation, briefings, press conferences, letters to the editors, phone calls, health screening, and other activities of the workers and their allies paid off. The Presbyterian Church, USA’s involvement may have provided the extra push that finally convinced Ingersoll-Rand to provide a settlement for the workers.

While the company never would meet with the workers, it responded readily to the Presbyterian committee. The involvement of a national institution defied the company’s desire to keep the closing a local matter.
Angela Summers

Angela Summers went to her pastor for help after being fired from Hanes Hosiery, a subsidiary of the Sara Lee transnational corporation. She had developed inflammation in a tendon (tendinitis) due to rapid repetitive movement necessary for her work (she sewed underwear for piece-rate as fast as she possibly could). At the time that she was assigned to this work, she was advised by a trainer to feed garments to her sewing machine using a series of specific wrist and arm motions. During the training, Angela heard a "pop" inside her wrist and felt soreness. She told her trainer, but was accused of "faking." Angela tells her story best:

"The next day I went to the company nurse. She treated me and told me not to go to a doctor. That night I hurt so bad that I went to the emergency room. They told me I had mild tendinitis. That year I was off a total of six weeks with tendinitis. I kept working because I had bills to pay. I made it through the week by working real fast on Monday, Tuesday, and Wednesday, because those last two days my wrist got real sore. I saved tickets from my work bundles on fast days and turned them in on Thursday and Friday when I needed to work slower. (The tickets, taken from bundles of garments, are used to keep track of how many bundles a worker should be paid for.) A lot of the girls saved tickets instead of turning them in right away, because, you know, some days you might not be feeling good or something and not be able to work so fast."

Angela suffered from her condition for months at work and was on sick leave several times, but her tendinitis persisted. Finally, ten minutes before her wrist was to be put in a cast by her doctor, the company accused her of attempting to steal two dollars by turning in tickets for work she had not done. Angela denied the accusations. She was fired.

Her pastor listened to her story and then called Southerners for Economic Justice. At the legal hearing that followed, Angela was confronted by a team of company managers and supervisors who produced two dollars worth of evidence against her. It was ruled that the Hanes company had operated within the law. There was nothing to be done. Angela was left with an injury and no income.

North Carolina has the highest percentage of women in the manufacturing workforce in the US (47%). Job competition means that women like Angela, above, who are fired or otherwise lose their jobs are easily replaced by others willing to take the health risks implied.
Community-based involvement is critical

The reason for sharing stories like those of Angela, Mattie, and the Schlage workers is to show how down-to-earth, practical involvement with workers and their problems is necessary to addressing health issues for the working public. Without an appreciation of the working person's situation, health-care workers will continue to fail to connect patients' symptoms with workplace hazards.

The experience of Schlage Workers for Justice demonstrates how crucial the church and advocacy groups were in seemingly hopeless situations. Had the Schlage workers not organized or located allies who could help them "work the system," it is likely that the plant would have closed quietly without much attention, stranding the workers and leaving the city with a contaminated site. The advocacy role that the Church can play is all the more critical in places where there is not a strong workers' organization or union.

The Church also provides workers with links to the outside world, which is especially important in isolated areas. Ingersoll-Rand, for example, would never have listened to a small group of workers from a plant they were about to abandon. Here the involvement of national church bodies seems to have made a critical difference. As a result, at the closing of the Rocky Mount plant the workers were in significantly better financial shape after Ingersoll-Rand granted them severance benefits.

Perhaps most importantly, the workers had gained a new outlook. One Schlage worker commented that he had never felt so alive as when he stood up against Schlage for his rights. Other workers shared his sentiments. Those looking for new jobs walked into interviews with open eyes—especially looking to avoid situations of toxic exposure.

Conclusion: workplace health is community health

The Southerners for Economic Justice's "Betrayal of Trust" project showed how tightly interwoven workplace issues are with community concerns. Corporations fence in their factories and encourage a feeling that rules are different on company property. Yet when a worker gets sick or injured at work, entire families are affected.

Mattie Brown and others like her brought home toxic substances in their clothing. Children's clothes were washed together in the same water as Mattie's. When Angela Summers' wrists made her life difficult, her church missed an important member of the choir. She was unable to contribute fully to her family and community.

People spend almost half of their lives in the workplace. Empowering people to understand and make good decisions about occupational health makes sense. Worker education and improvements in policies that regulate industries in the provision of healthy workplaces are two critical health issues of our day.

Photo: John Beekman-Fleiter
George Ardis, an injured worker. How can the trust that has been betrayed be restored?
IMPROVING THE HEALTH OF WORKING MOTHERS AND THEIR INFANTS

Many mothers with infants give up breastfeeding when they return to work after giving birth. This happens despite the general recognition that breastfeeding provides ideal nutrition for infants, reduces incidence and severity of infectious diseases in infants, contributes to women's health by reducing the risk of cancer and by increasing the space between pregnancies, provides social and economic benefits to the family and the nation, and promotes closeness between mother and child. There are many reasons why a working mother might give up, or never start, breastfeeding. The most obvious one is that working conditions do not allow her to breastfeed easily.

Contact recently interviewed Patricia Marin, a UNICEF staff member and pediatrician, on her experience in Brazil. In how, in one instance, working mothers were helped to be able to breastfeed their babies.

Contact: Could you first help us with a little background on your experience?

Dr Marin: Yes, this was about six or seven years ago when I was in Brazil coordinating the UNICEF breastfeeding programme. In 1980, the government of Brazil and UNICEF worked together to organize a national breastfeeding programme. The programme operated at many levels: international in regard to the International Code for the Marketing of Breast-milk Substitutes; national in regard to collaboration health professionals and their representative bodies; and local in regard to working mothers and mother support groups.

But what I want to stress is what happened in the area of working mothers.

In 1988, we did a study in the 27 states of Brazil to try to find out more about breastfeeding among working women. We focused mainly on the states in which we knew there were many factories employing women. The capital of the state of Santa Catalina, Florianopolis, had something like 87 factories. Santa Catalina is well known for its beautiful embroidery, and many women are employed in embroidery factories in Santa Catalina. In fact, there are some ten Brazilian states that depend largely on such handicrafts for their livelihood.

There are laws in Brazil governing conditions for working mothers in the factories. For example, a mother receives two months of maternity leave. Also according to law, each factory that employs more than 19 women of child-bearing age must provide a nursery.

While we were doing this study, we decided to speak with the governor of Santa Catalina about the condition of working mothers in the factories.

Contact: When you say "we," who exactly do you mean?

Dr Marin: I mean the mothers' support group working with the women employed in the embroidery factories, together with those of us doing the study. We called on the governor one day to discuss breastfeeding patterns among working women and to request his help. Our discussion focused on how many factories actually observed the law about providing a creche. (We knew that only 2% of the 87 factories in Florianopolis complied with the law.)

The governor became absolutely convinced that he could do something to help. The first step was to increase the fine paid by factory owners who did not observe the law. The fine was increased 1000 times! After this, the amount of money that the owner had to pay became painful. Before, they had preferred to pay the fine instead of create the creches. So after this fine increase, the situation changed completely. At the end of one and a half years, all 87 factories were monitored by government inspectors. The number of factories observing the law had increased to 90%!

Contact: What does this tell you in the end?

Dr Marin: In my work, an example like this shows that it is not enough just to train specialists in breastfeeding or create mother support groups or convince nutritionists not to distribute food to children under six months. There are many things that can be done to promote the health of working mothers and their children. Here, it made a difference for working mothers to deal with the governor and the factory owners. In this case, raising awareness at the policy-making level made a difference. Later this was followed-up in other states.
HELPING TO REALIZE A JUST, SAFE, AND HUMANE WORKPLACE FOR THE FILIPINO WORKER

By staff members of the Institute for Occupational Health and Safety Development (IOHSAD)*

IOHSAD: the institution
The Institute for Occupational Health and Safety Development (IOHSAD) is a non-profit independent organization primarily engaged in assisting Filipino workers to develop comprehensive and self-reliant occupational health and safety programmes. It is a resource center in the field of occupational health and safety. More specifically, it provides technical, material, and moral support in the field of occupational health and safety to the labour sector, e.g. health and safety committees of trade unions, workers' dependents, and health programmes in workers' communities.

The roots of IOHSAD go back to 1982, when it was known as the Factory-Based Primary Health Care Program for the Council of Primary Health Care (CPHC). Our work then entailed initiating health programmes in the workplace that focused on preventive health care.

The realities of workplace conditions, however, necessitated a redirection of our efforts. To respond to this reality, in March 1988, IOHSAD was established as a separate institution that would focus on providing for the occupational health and safety needs of the workers.

IOHSAD: its standpoint and objectives
IOHSAD believes that health is not merely a state of physical and mental well-being, rather it is a condition influenced by a complex interplay of economic, political, and socio-cultural factors.

The right to occupational health and safety is a basic human right of workers. It is closely related to the right to physical survival. The right to a healthy and safe working environment implies that workers have the right to know and act on existing and potential health and safety hazards in their workplaces.

Solutions to workers' health problems can be meaningful and lasting only if they proceed from a thorough analysis of workplace conditions and only if the workers themselves are actively involved in occupational health and safety (OHS) programmes.

IOHSAD's objectives are to
- increase the health awareness of both workers and health practitioners, particularly of health in relation to various factors, e.g. socio-economic and political,
- promote improvements in current health and safety conditions of Filipino workers,
- lobby for better laws and better enforcement of laws pertaining to OHS,
- popularize the theory and practice of comprehensive and self-reliant OHS programmes.

How IOHSAD works
To attain its goals, IOHSAD has established four major programmes, designed to make it
relevant and responsive to the OHS needs of workers. These programmes cover the areas of research, health care services, training, and information services.

During the past several years, IOHSAD has conducted baseline studies on the agricultural, mining, textile, semiconductor, beverage, and metal industries. Last year, the results of IOHSAD research provided valuable input into proposed legislation pertaining to OHS that was passed by the Philippine Senate.

IOHSAD maintains a clinic to provide affordable health care services for workers and their dependents. The purpose of the clinic is primarily to determine when illness in workers is work-related. Cases merit compensation are expedited with the help of IOHSAD coordination with the government agencies concerned. IOHSAD also maintains health programmes in workers' communities.

IOHSAD's work, however, focuses mainly on training and education. OHS seminars and health skills training programmes for workers are conducted in collaboration with labour federations or individual trade unions. Here workers undergo basic health orientation and learn about health hazards and the prevention of illnesses and accidents in the workplace. These workers then form health and safety committees (HSCs) in order to implement OHS programmes in their own factories. IOHSAD also conducts advanced health skills training and training of trainers for HSC members.

IOHSAD popularizes its research findings by producing, publishing, and disseminating information and educational materials to all interested parties, particularly trade unions, non-governmental organizations, people's organizations, policy-makers, and institutions active in similar or related concerns. It also provides unions with supporting documents that can help in bargaining for adequate OHS provisions.

Some encouraging gains

Over the past few years, the efforts of IOHSAD have begun to bear fruit. One significant result of these efforts has been the establishment of health and safety committees. These worker-led and administered committees work for the inclusion of health and safety provisions in the collective bargaining agreements between union and management. In such factories, the occupational health and safety concerns have been incorporated as an integral component of the union programme. Because workers are aware of occupational health and safety standards and their corresponding rights under these provisions, they are no longer easily silenced or forced to resign when they become victims of work-related accidents or occupational diseases.

Most of the HSC members who are trained by IOHSAD have a high rate of successfully negotiating the establishment of joint Union-Management Health and Safety Committees.

A workers' rally to demand occupational health and safety provisions in factories.
The mask this textile factory production worker is wearing does not adequately prevent the inhalation of cotton dust.

This sprayer on a banana plantation is wearing no protective gloves or mask.

This often paves the way for fruitful discussion during grievance meetings, where solutions to existing hazards are rationally discussed. These meetings generally result in better and safer working conditions.

In spite of these small initial gains, much remains to be done to significantly improve conditions in the workplace.

IOHSAD’s vision

IOHSAD’s vision is for its beneficiaries to eventually set up and manage comprehensive and self-reliant occupational health and safety programmes in their respective workplaces. IOHSAD believes that changing the conditions in the workplace and creating a safe and healthy working environment cannot—and should not—be left to the initiative of employers or to a government that gives low priority to the health and safety of workers. It is only through the persistent efforts of the workers to organize health and safety committees that they will truly attain not only better working conditions but also broader economic and political benefits.

IOHSAD believes that a just, safe, and humane workplace is vital evidence of genuine workers' empowerment. In the realization of this goal, we share what we know with the workers, even as we learn from them. We help them to establish comprehensive and self-reliant occupational health programmes until they can stand on their own. This, we think, is the best legacy IOHSAD could ever offer to the Filipino workers.
Leonardo

Leonardo, 31 years old, of Polomolok, South Cotabato, on the Philippine island of Mindanao, has been employed on a Dole pineapple plantation for seven years. In 1972, he had worked on a banana plantation, handling various chemicals. In 1978, he was hired by Dole, first as a harvester and then as a planter. In 1983, his work at Dole involved handling chemicals, including, according to Leonardo, Thiadan (an insecticide), Ditolatan (a fungicide), Benlate (a fungicide), and Basudin (an insecticide). WHO classifies Thiadan and Basudin as moderately hazardous chemicals. Leonardo’s only protection in his work was a long-sleeved shirt, short gloves, and a handkerchief or an old T-shirt used as a face mask. He was never given safety training.

In 1983, Leonardo noticed that he developed bruises easily, even with only slight pressure. He had frequent nosebleeds, was easily fatigued, and suffered general body weakness. He did not seek medical advice until he developed persistent gum bleeding. When his hemoglobin level was found to be low, he was given an anti-hemorrhagic. A few months later, he became markedly pale and weak. His hemoglobin level had dropped further. At the Dole Hospital, he received a blood transfusion and was discharged. A few months later, he again fell ill. His hemoglobin level had dropped yet further. He was given another blood transfusion and treated with steroids and an anti-hemorrhagic.

In June 1984, the physicians could not control the bleeding from his gums, so he was referred to the Medical Center of Manila. Laboratory analyses and two bone marrow biopsies revealed his illness to be acquired idiopathic aplastic anemia. The prognosis was “grave. . . with chance of recovery with appropriate care and support. . .”

Leonardo returned home with a letter from the hematologist who had diagnosed his illness, explaining the prognosis, requesting to see the patient every two to three months, and suggesting that Dole “transfer him to a more sedentary job away from chemicals for the time being.” A check-up three months later indicated a “recovering bone marrow.” Dole meanwhile transferred him to a job that did not involve the use of chemicals.

All of Leonardo’s medical expenses were paid by the company and through Medicare programme benefits. Expenses for the boat trip to and from Manila for diagnosis, however, were deducted from his salary. Leonardo also covered transportation costs for his last visit to Manila for a check-up. He was provided lodging by friends of his workers’ union, based in Manila. He did not return for follow-up.

Conclusion

Leonardo’s case is only one among many. The findings of the Health and Workers Group of the Council for Primary Health Care, Inc. reveal Dole to be violating most of the provisions of the Occupational Safety and Health Standards of the Philippine Labor Code relating to Personal Protective Equipment and Devices (provision 1080), Hazardous Materials (provision 1090), and Pesticides (provision 1954). Moreover, the Philippine government allows the use of pesticides banned or restricted in other countries on Philippine plantations controlled by multinationals or their local business partners.

A safety foreman of the Dole company, quoted by the Health and Workers Group, however, referred to his plantation as “. . . one of the safest, if not the safest in the area. Dolefil receives the safety award of the SOPI [Safety Organization of the Philippines, Inc.] almost every year.”

What can be done to prove workers’ claims in the face of corruption and direct opposition from those in positions of power? The first step is to organize. The Schlage Lock workers did it. The working women in Santa Catalina did it. And IOHSAD is doing it. Is there an occupational health and safety issue that you need to get organized about? Perhaps your church can help.
GUIDELINES TO MISSION HOSPITALS FOR IMPLEMENTATION OF RATIONAL DRUGS POLICY

Policies in support of the rational use of drugs are needed at all levels of health care management involved in drug selection, supply, or distribution. We share with you the following guidelines, developed by the Christian Medical Association of India (CMAI) and published in the Christian Medical Journal of India (January—March 1990). (See Contact No.107 for further information on essential drugs and rational drug use.)

1. Obtain sanction from the church medical board and governing body of the hospital for implementation of rational drug concept and policies.

2. Set up a formulary, pharmacy, and therapeutics committee (hereafter referred to as "The Committee").

3. The Committee should review the CMAI formulary and adapt it to local needs on the guidelines suggested. It should also review the formulary once every year and update it.

4. The Committee should lay down policies for selection of drugs, selection of supplier, placement of orders, use of generic names, etc.

5. Hospitals should be actively involved in updating knowledge through continuing education by organizing staff seminars, international meetings, workshops, and exchange of visits with other institutions, etc.

6. Institutions should train all levels of personnel (administrators, doctors, nurses, pharmacists, and other health workers) in rational therapeutics, either with local resources or through courses organized by CMAI or any other motivated agency.

7. Contact with representatives of drug companies should be limited to very few individuals.

8. Coercion of the hospital management into purchase of irrational medicines by employment of unethical means should be prevented.

9. Hospitals in the same region and/or under the same management should take advantage of low cost drug distribution units and explore possibilities for group purchasing.

10. Hospitals should implement standard procedures for procurement, storage, inventory control, distribution, and record-keeping.
ANNOUNCING... 
THE WORLD ALLIANCE FOR BREASTFEEDING ACTION (WABA)

For many years, the Christian Medical Commission has worked to promote, support, and protect breastfeeding, often in collaboration with other non-governmental organizations. In April of this year, CMC participated in the founding of the World Alliance for Breastfeeding Action (WABA), an alliance of international non-governmental organizations involved in advocacy for breastfeeding.

World leaders, at the World Summit for Children, held in New York, USA in September 1990, adopted goals for the year 2000 with the overall aim to end child deaths and child malnutrition. Statistics indicate that up to 4000 children a day are dying from intestinal diseases and forms of malnutrition that breastfeeding would have prevented.

The non-governmental community, through this new World Alliance for Breastfeeding Action, intends to work at national, regional, and international levels to reinstate exclusive breastfeeding as the norm and thus fulfill the Summit goals by helping to put an end to unnecessary deaths in infants. WABA will focus on the following areas of activity:

- social mobilization
- health worker training in breastfeeding management
- dissemination of information on breastfeeding
- compliance with the International Code of Marketing of Breast-milk Substitutes
- support to breastfeeding mothers
- research on breastfeeding
- health care practices
- breastfeeding women and work.

WABA is not intended to compete with NGOs already involved in this work but to facilitate coordination, exchange, and dissemination of information and the development of projects and strategies for the mobilization of resources, including technical expertise.

CMC anticipates fruitful collaboration with all of its WABA partners and will keep Contact readers informed of developments.

ON THE AGENDA

The Asian Health Institute, Aichi, Japan and Anitra Trust, Madras, India announce a Leadership Development Course for People’s Health in People’s Hands, to be held from 22 July through 13 September 1991.

Community-based health action (CBHA) is a potent strategy for change, and this approach in action since the 1970s in a handful of projects in Asia has yielded excitingly positive results. Designed to promote the CBHA movement, the course is meant primarily for non-doctors from existing programmes who are highly motivated and have a definite commitment to returning to their communities. They should have demonstrated leadership ability, have worked in a community-based programme for at least two years, and be able to read and write English.

For further information write to

ACHAN
61, Dr Radhakrishnan Road
Madras-600 004
India

An International Labour Organization study covering the years 1945 to 1989 indicates a two-thirds decline in women’s unemployment in Algeria and Cape Verde, and a 50% drop in Bangladesh, Bolivia, Honduras, and the Maldives. Why? It appears that women have simply not been counted, reports the magazine New Internationalist. They have not been counted despite the fact that in most of these countries women contribute substantially in the agricultural sector and in some countries do most of the agricultural work. In Algeria, working women are down from 37% to 1%. “But more than one million women work in agriculture in Algeria,” continues New Internationalist. “Unpaid workers on family farms have been excluded from the statistics” and are “increasingly invisible in 62 of the 83 countries surveyed . . . .” This can lead to women being neglected in development strategies.

World Development Forum (30.11.1990)
USEFUL PUBLICATIONS

English for the Workplace: ESL for Action. Problem Posing at Work by Elsa Roberts Auerbach and Nina Wallerstein

This English as a Second Language (ESL) series includes a student book and a teacher’s guide. Based on the problem-posing approach in the promotion of effective learning and critical thinking skills, the lessons are experience-centred and build on themes of the workplace. The student book explores daily life in the workplace and issues of immigrant workers: how they get a job, how they relate to co-workers and supervisors, how they face stress at work and health and safety problems, how as part of a minority (and often women) workers face special pressure on the job and at home. The book helps students to examine their roles in the workplace and stimulates them to write their own curriculum.

The teacher’s guide explores the different stages of the problem-posing approach and includes suggested activities on how to listen for critical issues (both in and out of the classroom), how to bring issues into the classroom through creating codes (discussion starters), how to use the problem-posing questioning strategy with codes to elicit dialogue, how to use codes to address potentially threatening or overwhelming problems raised by students, and how to encourage students to challenge the problems they face in their lives.

Information on how to obtain the series is available from the publisher at the following addresses:

Addison-Wesley Publishing Company, Inc.
1 Jacob Way
Reading, Massachusetts 01867
USA

and

Addison-Wesley Publishers Ltd.
Finchampstead Road
Wokingham
Berkshire RG11 2NZ
United Kingdom

Eye Care Programmes in Developing Countries by Harjinder S. Chana

Published by the Norwegian Association of the Blind and Partially-Sighted (NABP), this comprehensive resource manual deals with the principles, planning, implementation, and evaluation of eye-care programmes in developing countries. Based on the NABP’s field experience worldwide, the book stresses the community-based, participatory approach.

Available in English at US$30 to individuals in developed countries and NGOs and free of charge to individuals in developing countries at the following address:

Director
Norwegian Church Aid
P.O. Box 52802
Nairobi
Kenya

Bitter Facts About Drugs by Dr Syed Rizwanuddin Ahmad

This book takes a critical look at the range of drugs available in Pakistan. The author concludes that about 800 of the brand drugs (in an estimated 2000 dosage forms) widely sold in Pakistan are of questionable value or unsafe. Yet they account for 50% of the total drug sales in the country. The book includes a review of a large number of these drugs, classified in pharmacological groups with introductory pharmacological information on each group.

To promote its products, the pharmaceutical industry spends an estimated US$455 annually per physician in Pakistan. The author draws attention to this fact and appeals to all parties involved to accept their responsibility for developing a national drug policy and ensuring the rational use of drugs.

The book is available at US$25, including postage, from the distributor:

PACE Distribution Company
5th Floor, Press Trust House
I.I. Chundrigar Road
Karachi 74200
Pakistan
The rational use of drugs in the management of acute diarrhoea in children

There is no justification for continued production and sale of antidiarrhoeals for children, concludes a new World Health Organization (WHO) report on the subject. The report, which cites over 300 references, critically reviews the evidence on effectiveness and safety of the drugs most commonly used in cases of acute diarrhoea in children.

Approximately 4 million children under 5 years of age die each year as a result of diarrhoea. Over half of these deaths could be prevented by a simple, but highly effective therapy—oral rehydration therapy (ORT). As long as inappropriate drugs are marketed for the treatment of childhood diarrhoea, children who could be helped by ORT will receive useless and often harmful drugs instead. These drugs have an indirect as well as a direct toll on children’s lives: where resources are scarce, money spent on drugs is unavailable for food and other basic necessities.

Drug treatment is needed in only approximately 5% of cases of childhood diarrhoea—antibiotics for diarrhoea caused by dysentery or cholera, and antiparasitics for amoebiasis or giardiasis.

Following pressure from the medical profession and consumer organizations, specific products have already been withdrawn from the market. Gradual product-by-product withdrawal, however, is not enough. National regulatory authorities should adopt measures that fully reflect the conclusions of the WHO report. Informed consumers and health professionals can help see that this is done.

Copies of the report may be obtained at SF14 or SF9.60 in developing countries from WHO, at the following address:

Distribution and Sales
World Health Organization
Avenue Appia
1211 Geneva 27
Switzerland

Better Care of Mentally Disabled Children, published by the Voluntary Health Association of India (1989)

This booklet is addressed mainly to parents of mentally disabled children, but also to school teachers and health and social workers involved in their care. In simple language, it answers questions about mental disability in children. It dispels basic misconceptions about mental illness and suggests ways to help mentally disabled children learn to look after themselves (for example eat and drink without help; go to the toilet; dress and undress without help; and care for the teeth).

Although written for use in India, the booklet is relevant to such cases everywhere.

Available in English from
Voluntary Health Association of India
40, Institutional Area, Behind Qutab Hotel
New Delhi-110 016
India

PROTECTING INFANT HEALTH

A Health Workers' Guide to the International Code of Marketing of Breast Milk Substitutes

The 6th edition in English of Protecting Infant Health, produced by the International Baby Food Action Network (IBFAN) and the International Organization of Consumers Unions (IOCU), is now available. (Earlier editions are available in Arabic, French, Spanish, Thai, German, Portuguese, Bahasa Indonesia, and Chinese.) For information on how to obtain this highly useful guide, write to

IBFAN/IOCU
P.O. Box 1045
10830 Penang
Malaysia
CONTACT is the periodical bulletin of the Christian Medical Commission (CMC), a sub-unit of the World Council of Churches (WCC). It is published six times a year in English, French, and Spanish. Selected issues are also published in Portuguese in Geneva, Kiswahili in Kenya and Tanzania, and Arabic in Egypt. Present circulation exceeds 35,000.

CONTACT deals with varied aspects of the community's involvement in health and seeks to report topical, innovative, and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the first annual issue of each language version. Articles may be freely reproduced, providing that acknowledgement is made to CONTACT, the bi-monthly bulletin of the Christian Medical Commission of the World Council of Churches.

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(CCP: 12-572-3)