Meeting Report

WHO-ILO Joint Effort on
Occupational Health and Safety in Africa

Occupational Health for workers in the informal sector.
16–20 October 2000
Pretoria South Africa

Report (G. Goldstein and G. Eijkemans)

Organisers
- WHO South Africa (Dr. Shasha)
- Ministry of Health South Africa (Mr. Sekobe)
- WHO/AFRO (Dr. Nitcheu, Mrs. Morfaw)
- Occupational and Environmental Health Programme WHO Geneva (Dr. Eijkemans)
Summary

The need to strengthen the field of occupational hazard prevention and control in Africa is urgent, as the current neglect carries a heavy burden of disease and disability. Safer and healthier work conditions can make an important contribution to poverty alleviation and sustainable development. Efficient application of available knowledge to practical solutions to overcome the “knowledge application gap” is more important than generating new theoretical knowledge.

In the majority of African countries, the informal sector of the economy is an employment refuge for workers who fall out from the formal sector, and provides a safety net for poor households’ income. Small enterprises and the informal sector are becoming the de facto mainstream, and the realm of employment for the majority of urban dwellers in developing countries. Occupational health services and supporting legislation require refocusing, revision and strengthening to respond to this reality. Often basic preventive measures including education and training for health and safety are overlooked. The informal sector includes many women and children; they are usually not covered by legislation, and do not have access to occupational health services.

The meeting was attended by national, regional and global experts and organizations, and it addressed 3 aspects of a new “African Initiative” in Occupational Health, that can build on existing experiences and projects, such as the PACE (Prevention And Control Exchange) project, the African Healthy City approach, the ILO WISE project, etc. The 3 aspects are:

1. Local demonstration projects.

Five cities in Anglophone Africa are planning projects for SSE, to be expanded to other cities and other language groups later. These cities are Johannesburg and Cape Town in South Africa, Dar es Salaam in Tanzania, Yaoundé in Cameroon and Harare in Zimbabwe. Delegates reviewed the situation analysis in each city, that is presented briefly in this report. A draft project workplan has been prepared, that is briefly described in this report. The meeting focused on city level planning, with seed money available from WHO for the first year of a five year project. The following issues were addressed:

- Scope
- Economic sector
- Long term plan
- Short term plan
- Resources
- Date of first city workshop
- Decision makers involved
- Coalition building
- Seed money: use
- Awareness, advocacy, access to solutions, surveillance and enforcement

The participants came with extensive local practical experience and the willingness to learn from the different experience of others. The workshop benefited from support and facilitation by colleagues from outside Africa, and from the involvement of the group from
Ghana, who are not directly involved in the 5 Cities Project. Draft workplans have been prepared and will be finalised within months (with collaboration with external partners).


The “African Initiative” brings together local, national and international/regional components to set a common agenda on improving health of workers in the African Region. It serves as a fund-raising platform for the projects and activities for occupational health in Africa. There will be a specific focus to address the knowledge-action gap in occupational health and safety (OHS) for small scale enterprises (SSE) and the informal sector, since the overwhelming majority of African workers can be found there.

The Initiative promotes policies for health at work, a healthy work environment, healthy work practices, occupational health services (including ergonomics, industrial hygiene, and safety), support services, occupational health standards, human resource development, collection of data as evidence for policy, information and awareness, strengthening of research, and collaboration with other services. Capacity building will involve the global occupational health network, GOHNET. There is an important new emphasis on advocacy and awareness raising to promote and protect the health of workers, especially in the informal sector. A classification of stakeholders in the initiative at local, national and international level has been prepared. At local level, these included workers; unions; associations; retrenched, boarded or retired workers; politicians and chiefs; healthy cities; traditional healers; employers; local departments of government; community based organisations on NGOs; medical aid schemes; professional bodies, and primary health care practitioners. At national level they considered government departments; universities and research organisations, unions and employers organisations, industry; and WHO. At international level, the key players were WHO and ILO, and WHO Collaborating Centers.

Locally the initiative supports projects such as the local demonstration city projects for SSE and the informal sector.

At national level there is the development of national action plans, providing a framework for needs assessment, prioritisation, action planning, resource management, implementation, monitoring and evaluation. The plans need to be monitored, evaluated and documented.

Regionally and internationally the initiative will raise the profile of occupational health and safety as a vital aspect of poverty alleviation and sustainable development in Africa, to support local initiatives as an integral part of development activities in many sectors. In November 2000 he initiative will be presented to the Southern African Development Community (SADC), comprising Angola, Botswana, DR Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe. [Mr Gopolang Sekobe (Director of Non Personal Health Services and Occupational Health, Department of Health, Pretoria), present throughout the meeting, is an strong supporter of the initiative and also a key office bearer in SADC].

The document for decision makers was provided to all participants before the start of the workshop. The document serves as a background document for the 5 Cities Project and the African Initiative.

Different groups worked on the different aspects of the document, such as policy framework/awareness-raising, practical solutions, social mobilisation, and workplace health promotion.

Participants made useful suggestions for improving the document. Decision makers do not read long documents; the finished document needs to be shorter, clear and with powerful examples. At present the document is international and contains insufficient regional context, expressing general principles regarding occupational health and the informal sector. For use in Africa, for example at the SADC meeting in November 2000, the document needs effective examples of problems and solutions from Africa.

Background information

There is a world-wide need to strengthen the field of occupational hazard prevention and control, concerning more efficient application of available knowledge to practical solutions, overcoming the “knowledge application gap”; this is more important than generating new theoretical knowledge. To make a difference, action should be taken before impairment, disease, disability or death occurs. International collaboration can strengthen national capabilities. Sharing of knowledge and experiences helps avoid duplication of efforts and waste of resources.

Rapid changes have occurred in the last decades in the work-force and in working conditions. Most workers in Africa are working in SSE’s and in the informal sector, generally without and form of preventive or health promoting actions, nor legal protection. At the same time, many children and women have been incorporated in the workforce, and these group of vulnerable workers is large and growing.

In this context, WHO’s Occupational Health programme works in the area of Workers’ Health promotion and protection, for the most vulnerable groups of workers in Africa: workers of the informal sector, women and children. The Cities project proposed by WHO aims at pulling together several resources in the different countries. It builds on existing experiences and projects, such as the African Healthy City approach, the PACE (Prevention And Control Exchange) project, the ILO WISE project, etc.

In the first instance, five cities in Anglophone Africa are identified for the development of materials and the model, to be expanded to other cities and other language groups later. These cities are Johannesburg and Cape Town in South Africa, Dar es Salaam in Tanzania, Yaoundé in Cameroon and Harare in Zimbabwe. After a first identification mission in April 2000 to South Africa and Zimbabwe, important partners and opportunities have been identified. In order to jumpstart the project, all stakeholders were involved in the planning meeting in South Africa in October 2000. In order to raise awareness in different countries in the world on the importance of improving the working conditions and health of workers in small scale enterprises and the informal sector, WHO is preparing a document for decision makers.
This planning meeting in South Africa, with participants from South Africa (Cape Town, Johannesburg,) Zimbabwe (Harare, including AFRO), and Tanzania (Dar es Salaam), Cameroon (Yaoundé) and external partners had the following objectives:

**Objectives:**

- Plan the first phase activities in 5 cities in Africa on Occupational Health for Workers in the informal sector (Johannesburg, Capetown, Harare, Yaoundé and Dar es Salaam)

**Expected outcomes:**

- General project implementation workplan and guidelines for specific city workplans

At this same meeting, the African Initiative on Occupational Health was explored and discussed, and the document for decision makers on SSE was reviewed.

THE MINUTES OF THE MEETING

**Monday 16th October**

**Welcome**

Welcomes were given by Gerry Eijkemans, WHO Pretoria; Dr Rees, South African Ministry of Health; and Dr Shasha, WHO Pretoria. There were then short statements of support from the 3 major NGOs working with WHO in occupational health; Pat Scott, International Ergonomics Association; Richard Ennals, International Commission on Occupational Health; Vernon Rose, International Occupational Hygiene Association. Mr Oti, WHO Pretoria, gave logistic information.

**Presentation of Participants**

Each participant gave a brief introduction. **Gerry Eijkemans** and **Greg Goldstein** are from WHO Geneva, and there was a team from WHO AFRO. There were leading experts from South African universities, government organisations, research groups, provinces, local authorities, and trade unions. **Kaj Elgstrand** from the National Institute for Working Life in Sweden is leading courses in Africa, and planning new collaborations. **Hannu Riiipinen** attended from the Finnish National Institute for Occupational Health, with longstanding research programmes in Africa. **Sandra Anderson** works with the UNAIDS programme, noting the enormous risks in the informal sector, with South African colleagues. **Paul Swuste** is from Delft University, working on PACE with WHO. **Dr Heitbrink** is from NIOSH. Maikel van Niftrik, a Dutch intern student is working in South Africa with WHO. Accra metropolitan authority and the Ministry of Health in Ghana were represented, and work on the Healthy Cities project in Accra. Medical research, occupational and environmental health from Tanzania has contributed to the Healthy Cities project, for which the informal sector is of central importance. **Urban Svedburg** is a Swedish occupational hygienist, is exploring collaboration between African Countries and Central America in Occupational Health. The Assistant Director of Health for Harare and the Ministry of Health in Zimbabwe were present, involved in Healthy Cities. Town planning and medical experts from Cameroun. The Johannesburg Healthy Cities project was represented. The US Industrial Hygienists Association were represented by Elias Okoro. Mrs Boshigo Matlou was participating for ILO. Richard Ennals (ICOH) has been the rapporteur for the meeting, and this document is based on his excellent minutes.
Presentation of workshop objectives

Gerry Eijkemans gave an overview of the WHO Africa programme. The African work has developed based on a large network of collaborating institutions, together with WHO. She emphasised globalisation and international links. There is growing inequity; although wages have risen over the last 20 years in East Asia, they have fallen in sub-Saharan Africa. The informal sector is growing fast, with precarious working conditions, with particular hazards for women and children. 60% of the working population in Africa are in the informal sector. Worldwide, there are 250 million child workers. There are over 1m work-related deaths per year, and overall costs of 4% of the world’s GDP. Occupation is a major risk factor, in terms of deaths and disability adjusted life years. She welcomed the forthcoming SADC meeting on occupational health. She analysed work-related mortality, and the economic impact. In the developing world, the burden is borne by workers and their families, and calculations are difficult. She discussed the global common “Occupational Health for All” agenda, and the work of collaborating centres. WHO works with partners, including governments, universities, NGOs and trade unions and other UN agencies.

The global strategy has 10 objectives: policies for health at work, healthy work environment, healthy work practices, occupational health services (including ergonomics, industrial hygiene, and safety, and not just medicine), support services, occupational health standards, human resource development, data information and awareness, strengthening of research, collaboration with other services. WHO has concentrated on the areas of evidence for policies, workers health promotion and protection and infrastructure and capacity building. It is also supporting the development of national action plans. Capacity building is vital, involving GOHNET, the global occupational health network: details were available at the meeting. The third area concerns the health promotion and protection of workers, including Healthy Cities and the informal sector. Africa is the first continent for this work.

She gave an overview of the conference programme, the development of a vision, and technical means of implementation. The outcomes will help develop plans for the occupational health activities of the 5 Healthy Cities projects. There will also be work on the common agenda for Africa (the African Initiative), and the draft document for decision makers.

Presentation: WHO Occupational Health Programme

Greg Goldstein (WHO Occupational Health programme in Geneva) argued that occupational health needs a stronger role in public health. He discussed benefits of a healthy workplace, which seem obvious yet the subject is not given the necessary resources. He argued that the occupational environment is central, with hazards that spill over into the general environment. When considering the workplace environment, we need to see links of health with physical, economic and social environments. Settings that support health include home, school, markets and workplace. Workplace health promotion and advocacy are particularly important. He summarised the general conclusions as presented in the draft document, and emphasised the need for higher profile. It is not effectively on the public health, development or political agendas. Thus the need for advocacy, and workplace health promotion. He drew in particular on WHP
work in Europe, with awards, networks and advocacy. This brings in a wider range of expertise, including political science.

He set out the case for advocacy, and discussed the river fencing and rescuing problem, as presented in the draft document. There can be resistance to what seem to be practical improvement messages. We need to change the way we do business, and become flexible, responsive, imaginative and newsworthy. Health stories often appear in the media, not recommending attention to good practice, but accounts of disasters. Following disasters, there is an opportunity for media inputs, and political agenda setting, leading to social change. He then illustrated the arguments of the gun control lobby in Australia, who succeeded in implementing legislative measures by having a package of measures ready, that were introduced following a massacre.

He encouraged the conference to produce workplans on common issues, enabling progress to a common goal of changing the status of occupational health, attracting the necessary resources.

**Presentation WHO/AFRO:**
**Occupational Health Programme and Healthy Cities Programme**

The WHO AFRO OCH focal point, Dr Nitcheu introduced the occupational health programme. The work has just been moved to the division concerned with health and sustainable development. The technical support functions of the regional office for Africa were set out. They have helped formulate national policies and programmes, supported development of legislation, provided training and information. Constraints have included a lack of evidence based data, lack of human resources, and lack of commitment. Next steps include raising awareness, providing tools and guidelines, supporting data collection, developing health and safety modules, and supporting training. This means collaboration with governments, agencies and NGOs.

WHO AFRO Healthy Cities focal point Mrs Elizabeth Morfaw introduced the Healthy Cities programme. Healthy Cities is an international initiative, started by WHO in Europe in 1986, and taken up by WHO AFRO in 1995, with over 1000 cities involved worldwide, placing health high on development agendas of cities. It helps municipal governments to provide environments conducive to health. It uses the settings approach, stresses inter-sector collaboration, recognises the need to change attitudes and living conditions. Leadership normally comes from the cities, with a health emphasis. This places emphasis on unhealthy living conditions, such as misery, poverty, overcrowding, food insecurity, makeshift housing, unsafe drinking water: all rampant in the African informal sector. Health conditions in settings may be studied, including how they are created by development activities of individuals and groups. This includes commercial activities. Living conditions affect health where health leadership is lacking, health is not high on the agenda, and health is not seen as important day to day. Health problems are created by unhealthy living conditions, reflecting deteriorating services, malnutrition, and mental problems.

Healthy cities are important for positive attitudes in human attitude and improvement in social conditions, and not just a matter of medical technology. Health comes from proactive care, with people making health themselves, and with health as a core element of development. Healthy cities projects have unique characteristics: defining a healthy city, the settings approach, city health profile, plan of action, networking and
infrastructure. The projects have beginnings, but no end. Examples of settings were given, with special qualities of efficiency and resources. Each setting has a unique set of authorities, frequent interactions, a range of social purposes, and patterns of formal and informal interaction. City health profiles and plans of action were introduced, which requires baseline data on sustainability, livelihood, physical and emotional health. These lead to profiles of the city health status, selecting environmental health priorities, developing health plans of action, projects and tools for research, monitoring and evaluation. The end product is important. Networking is an important characteristic: a source of enthusiasm, exchanging technological knowledge, and developing resources. The implementation infrastructure is led by local government, with health sector support, citizens groups and others. Local government is important, as they control the economic and political infrastructure, and their approval is necessary. They can give new focus to health services, apply development policies that focus on health, help develop local capacities, mobilise local resources, and develop need-based services in the local setting. How can this be done and maintained? There is a 20 steps process, adapted in South East Asia from original WHO guidelines, now being modified for use in Africa. Getting started includes analysis, study of healthy cities, base line data, and choice of location. Getting organised includes steering, reviewing, developing goals, planning, allocating roles. Taking action means moving from knowledge to action. There is immense potential for the informal sector.

Experience Johannesburg

A number of forces are driving environmental quality and health status in Johannesburg. They have lacked occupational health experts and champions. They face accelerated urbanisation (after the end of apartheid), major poverty and inequity, a level of scientific and technological development, and economic development, complicated by globalisation and international crises. There are resulting pressures on people and the environment, with pollution of surface water and air. Sulphur dioxide and nitrogen dioxide levels are high, in areas of informal sector activity. Soil is contaminated, with sprawling squatter settlements and overcrowding. There are economic refugees working in these settings.

The project was formed in 1992, looking at schools, homes, environments, foods and marketplaces. There was political and administrative support, and involvement of stakeholders. There was no specific focus on occupational health, but the need was increasingly felt, especially in the informal sector. The project management was set out, with management by the council, an activating committee, and working groups. The project was started at a time of rapid political change from apartheid to democracy. It was decided to mainstream a number of initiatives. The project was based in environmental health, but there have been changing balances between issues of policy and planning, addressing community participation at the critical period at the end of apartheid. It was difficult to be both decentralised and coherent metro-wide. There was insufficient co-ordination between projects with similar objectives (Healthy Cities, Sustainable Cities, Agenda 21, Safe Cities, Integrated Development Planning).

Healthy homes project activity initiated in high rise blocks, where there was concern about unsafe social and occupational activities. Buildings, such as an electricity generating centre, were being converted for housing use, and for informal sector working. Conditions were poor, with no sanitation or facilities. Waste was delivered for
sorting for resale. People knew that there were dangers. Children were involved in the work. An informal slaughterhouse was set up in a bedroom, but environmental health officers were threatened when they intervened. Sheep were kept in small backyards. Soweto houses are often involved in the informal sector, with women in particular involved in a wide range of activities. There were numerous dangerous exposures. There was clearly a need for occupational health interventions.

The healthy environments programme discovered children exposed to lead, with 80% with blood levels exceeding international guidelines. In Cape Town the figure can be 92-100%. Newspaper sellers have high blood lead levels. Food sellers need to be monitored. Domestic workers and asbestos workers give cause for concern. There is a real need for a comprehensive review of risks to workers in the informal sector.

Discussion

- There was discussion of the sources of lead in the informal sector: these include lead solder, batteries, lead paint, and motor vehicles (lead-free petrol only takes 10-12% of the market).
- What have been the results of the city project? The account had been of observations: the issue of blood lead is being taken up.
- The Healthy Cities project in Johannesburg was based on a core of enthusiasts, and when they left, momentum flagged. The political transformation process has made it hard for projects to keep going. A clear identity is needed.
- The consultation process appeared not to have included battery manufacturers. The project was driven by priorities such as children’s blood lead levels. The data that emerged provides the basis for future work.
- What development indicators were developed? More work needs to be done.
- Who paid for the workers on the team? They were project staff members.
- The project is not ongoing: though it formally continues, it has been decentralised. It needs to be resurrected.
- Could the pictures showing problems associated with occupational health in the informal sector be used as the basis for a book?
- There is a need for studies. Occupational health has not had high priority in South Africa, with budgets allocated to other topics. Who do we expect to fund necessary work? Healthy Cities projects depend on local commitment, if they are to be sustainable. One outcome of the project is to work differently, which does not always cost large sums of money. One strategy is to avoid large injections of funding, staying small.
- There was discussion of a blasting incident in a Pretoria suburb last week. The incident involved explosives and cyanide, that were stored at a small scale enterprise in the suburb. The example shows that small scale enterprises are crossing socio-economic boundaries. This is an example of an incident that can be used for advocacy. The public interest in the matter can be used to put occupational health and safety issues in SSE in the news and on the political agenda.

Involving the police can complicate problems from the perspective of the community. It is better to help the people concerned to improve their arrangements, with community support, rather than driving them underground. How can this be done? Education and awareness are important.
Tuesday 17th

Experience Dar es Salaam

The presentation was supported by a paper, which was distributed. Tanzania was located geographically, and described in outline: the population is 30 million. Only 10% of the workforce are in the formal sector, while 90% are in the informal sector, with conditions hazardous to health. The sector is increasing due to unemployment. The Ministry of Health has prepared national guidelines, for implementation by local government.

Dar es Salaam has 3 million residents, growing by 7-10% per year. The informal sector grew due to the failure of the formal sector to provide employment. Only 376,000 are in the formal sector, with 1 million in the informal sector. The sector has grown due to migration to cities, and a slump in the economy. Dar es Salaam offers better living and working conditions. Public corporations have been privatised and downsized. There is a lack of employment opportunities for school and college leavers. Informal sector workers face a range of health hazards, requiring identification of groups and provision of basic training, with external partners. New markets have been built, and human resources departments have been strengthened at municipal level. Vocational guidance has led to moving people to industrial production centres. A small business handbook has been published. New open markets are to be developed. Hygiene is to be improved in food markets. The WHO Healthy Cities project has supported improvements of Buguruni market. Revolving soft funds have been made available for improvements in the informal sector. A community bank is being established. Standards are being set out for petty traders. Auxiliary police are used for law enforcement. Studies of noise level show 80.04 dB in five areas. Chemical exposure in small industries has been studied. 55% were using chemicals, and 65% of those handling chemicals did not know how to keep themselves safe. The effects included respiratory problems, skin and eyes. 52% had hearing loss from noise, and 75% suffered respiratory diseases from dust.

Dar es Salaam faces problems with occupational health, due to a lack of trained staff, monitoring equipment, health seeking attitudes and transport for staff. Future plans deal with housekeeping, safe work procedures, policy statements, colour codes and welfare facilities. Hazards are to be monitored, with health surveillance and medical examination.

The Healthy Cities Project in Dar es Salaam was started in 1996, aiming to improve the health of urban dwellers, concentrating on market places and street vendors. Support came from the Netherlands. Awareness and community mobilisation were key methods. The idea of setting is vital, dealing with food markets, primary schools, and unplanned high density settlements. The presentation concentrated on markets and street food vendors, which are widely used. Conditions are not hygienic, with lack of protection against wind, and high temperatures. Food markets tend to arise spontaneously, without planning and support infrastructure, leading to health hazards. Children are exposed to threat, whether working or accompanying their mothers. The healthy market food concept was introduced, with inter-sector collaboration and community involvement in awareness raising. A task force conducted detailed analysis of the situation, leading to an action plan, with short and long term priorities. The plan is being used by vendors and planners, and some priority actions have been addressed, including a healthy market
day. Best performers received prizes. Cholera tends to attract blame for street food vendors, so a food safety campaign was implemented, with improvement of sanitation. A monitoring system has been established, with detailed analysis of microbial contamination. The key management tool for the campaign was the task force, which is multisectoral and interdisciplinary, with local, national and international involvement. The partnership approach has involved a number of agencies. Community involvement has been vital, identifying priorities and securing participation.

Achievements so far have included mobilisation at grass roots level, showing effectiveness and benefits for health when partners work together. There is increased demand for training on food safety. Community involvement was a challenge. Involvement of senior decision makers is vital. Overcoming local boundaries, and mistrust between sectors, takes time and effort. Sustaining commitment is difficult, but vital.

Discussion

• The whole issue of food handling was raised, and it appears to start from the consumer perspective, rather than food processing. This concerns biological hazards and infections. Those who prepare food are also consumers. The construction of sunshades is now being encouraged, to protect those preparing food.
• From South Africa it was noted that the Tanzanian informal sector seemed to be well understood. How was this achieved? There is interest in gaining basis information about the informal sector. Is the methodology published? Reports are available.

Experience Cape Town

Cape Town has two worlds living next to each other. There is a sprawling metropolis, with inequities, disparities and a bleak future. The economy has grown, with diverse sectors such as tourism. There is a strong IT and communications infrastructure. There is a critical skills gap. Only 15% have matriculation or higher qualifications. The informal sector is expanding, covering 15% of the population at this stage. The local population will soon double, and will be younger and sicker. HIV / AIDS and TB are major threats to young people, and add to orphans and criminality. The Western Cape has the highest rates of murder and theft, and second highest in fraud and assault. Service infrastructure levels are good, and the target of equity remains. Households lacking key facilities are black, in informal townships. There is a need for housing, affordable transport, but there are major problems, requiring the wake-up call of the Healthy Cities project. Young people are at considerable danger, including a 50% chance of contracting AIDS.

The Healthy Cities project started in 1996 with World Health Day; Agenda 21 had attracted attention to the sustainability agenda, and enthusiasm was developed. Local contacts formed a base, and international links were helpful. Seminars and networks were established, with local lobbying. Donor funding was sought without success. Local municipalities offered support, to start demonstration projects, and a co-ordinator was funded by local government. Success requires political decision making, joint action between sectors, and active community participation. Healthy Cities were seen as a means of changing bureaucracies. Interdisciplinary involvement was vital. There are different fora, and there was loosely structured ferment, with the objective of a co-ordinated interactive network. There were intersectoral committees. As yet there has
been little trade union input. Technical committees were formed to support projects. There is a co-ordinator, but no staff at present. Advocacy has been in terms of the deprivation trap, with poverty, deprivation, isolation, and physical weakness. Upstream thinking is needed. Healthy Cities work is about mobilising, advocacy, promoting innovation, increasing awareness, encouraging participation, and improving public policy. He outlined the health promoting settings in the Cape area, in schools, markets, neighbourhoods and workplaces. Community involvement is vital, with organisational development, building local infrastructures. Public participation brings knowledge that experts do not have, and increases what is generally known.

Healthy Cities concerns a social approach to health, involving multi-disciplines and multi-sectors. TB, for example, is a major concern, and needs to involve social services, as a disease of poverty, affected by water and sanitation. Healthy Cities should be a change agent in the Cape Town area, opening a door in the wall.

Projects have looked at collaboration, training and advocacy. Infectious diseases are being looked at from an inter-sectoral approach, for example worm infestation in the informal sector. The typical medical approach was accompanied by an environmental study with schools, of the factors associated with worms. This included informal meat trading and slaughtering, and problems of inadequate sanitation. Practical initiatives have followed. The curriculum has been augmented with new material on health promotion. There are projects concerning informal food trading, air pollution from diesel emissions and burning of tyres, accessible transport.

At present Healthy Cities projects work separately, and do not link. Local authorities in Cape Town follow health and safety legislation. Compliance with regulations is required. The Department of Labour is developing policies and guidelines for the informal sector. There are issues such as recycling, where local residents search dumps, and sell the material. The family will live and work with the refuse for the day. This means obligations being placed on the owner of the landfill site. Engineering companies pick up workers on the street, and may know little about them, causing problems if there are injuries. How is the informal sector to be engaged and taken forward? How can the sector be influenced? They are not registered, controlled or organised. Information is hard to find. The local council is seeking to provide improved services.

Discussion

- The ILO convention on child labour was cited, and it was urged that child labour by contractors should be discouraged. This is part of the strategy.
- There was discussion of policy processes. Globalisation discourages regulation and protection. Free trade zones open up further dangers of exploitation. What balance can there be with programmes such as Healthy Cities? It is important to set baseline standards from which to start.
- What mechanisms and partners are taking shape in Cape Town? Negotiation and discussion is not reaching people on the ground. Labour procurement policies are changing.
Experience Harare

The City of Harare was introduced in general terms, with a population of 1.5 million. There is rapid urbanisation, straining service provision in cities, stretching sewage, water services and waste collection. The rural area has suffered drought, and the infrastructure of cities has seemed attractive by contrast. The local authority is controlled by the urban councils act, including the election of an executive mayor. Environmental health services are provided for the city, including occupational health and safety, and industrial hygiene, including the informal sector.

In the 1990s, with economic changes, many people lost their jobs and moved to the informal sector, to earn a living. This means numerous small businesses, based in backyards rather than in designated placed. The council policy covers home industry, enabling people to use their skills to earn a living. Those supported by the scheme have bought premises and employ others. Identification of home industries requires a participatory approach, involving ward councillors and the community. City planners draw up site plans, with zoning schemes, and identified candidate sites, for which plans are circulated, and the relevant authorities take action. Home industry was defined as a large piece of land divided into small work areas, enabling work to be done, such as spray-painting and welding, away from home. Home industries need water supplies and toilet facilities, power and electricity, waste collection, roads and other services. Some of these services are difficult to provide, but basic facilities are a prerequisite. Management of home industries is through community services, supported by environmental health officers. A fee is levied from all operators, to sustain provision of services, including staff. In Harare there are over 40 home industry sites, with operators in numerous sectors. Private sector participation is important, assisting in development. Major companies such as British American Tobacco have expressed interest in developing sites.

A SWOT analysis of the Harare experience was presented. **Strengths** were that home industries provide an environment for developing occupational health practice and principles. Infrastructure and community involvement have been enhanced. Participation by industry and other interested organisations has been important. **Weaknesses** are many: workers are not covered by occupational health or social legislation. They do not have access to occupational health services. There is no state intervention in disputes, no official interventions. The state cannot intervene at present in working conditions in the informal sector. There are no local or national statistics concerning occupational health, but the groundwork has been done. **Opportunities** include an environment for reduction of risks, such as identification and elimination of toxic products, zoning of dangerous work. Medical surveillance is made easier. **Threats** include bureaucracy, raised expectations. Councillors can be over-zealous!

Illustrations were shown of a home industry site, and processing of the contents of drums, cleaned and shaped for new purposes such as door frames, spray painted without protection. Vehicles collect the material, and the products are on sale. Kitchen arrangements and refuse were shown. Paint pigments are available to tint paint, without protection. Upholstery can be of high quality, after training. Vehicle repairs and spraying is done without protection. Wire mesh is manufactured. Concrete walls are made using moulds. Fibreglass repair work is unprotected, with some good results. Refuse disposal presents problems, with recycling companies active.
Discussion

- There have been problems in Ghana with relocation of the informal sector, as people tend to move back. They find competing with similar activities difficult. This is hard to manage. Selection of the sites in Harare does not involve the industries concerned. People operate from their homes, and this led to an education programme concerning effects on families, and provision of services elsewhere. Industries work well together, sharing equipment.
- Materials used can cause problems: for example the importation of toxic waste. How are legal matters handled? Zimbabwe has paint manufacturing companies, and has signed conventions against importation of toxic waste. There was an incident of electric transformers being sold to scrap metal dealers during the UDI phase. These contained PCBs, handled and scraped by informal industries in homes. Each part of the transformer is used.
- The same problems seem to be raised, and we need solutions. Spray painting, moulding and repairs have been shown. What remedies have been recommended? This is what is now being addressed. Local funds have been used. With the drums, the workers were not aware of the risks of burning. Health surveillance needs to be introduced. To date only waste management and toilets have been monitored.
- Social factors are important. Work in Durban with street traders has dealt with theft and fires. If the entire system is not controlled, individuals are at risk. There tend to be systems of vigilantes, or informal security companies. There can also be mutual support and borrowing. Are banks flexible in supporting such workers? This is problematic. Banks are reluctant to loan without collateral.

Experience Yaoundé

An introduction to Cameroon preceded the account of Yaoundé, the capital. Demographic growth is 6%, and the capital has 1.3 million inhabitants. Unemployment and poverty have increased, civil service salaries have fallen, public enterprises have closed, training is inadequate, there is urban insecurity and poor living conditions. The informal sector has been defined as units of production without accounting, training or formal activity, with sole proprietor, and an absence of legal forms. The location is near markets and main roads, with numerous sectors, giving incomes to 60% of households. Clothes, hardware and manufacture, audio-visual and artisanal activities are widespread. The main participants are former civil servants, school leavers and the unemployed. Finance is from savings, informal trust and savings associations, and from relatives. The sector is organised, for example, through an association of women. They provide 41% of the GNP, reduce unemployment, absorb 33% of the active population, balance the social sector, and meet household needs. There are weaknesses: lack of information and education, no involvement in decision making, problems of competing with the formal sector. Funds are limited, interest rates are high, loans are not repaid, taxes are not paid. Living conditions and roads deteriorate. There are no specific sites.

In 1998 the government tried to address the insanitary conditions, involving the local administration. Waste contains organic substances, and contracts were agreed for collection. A new intervention strategy is being prepared, with preliminary studies. Economic difficulties require detailed research. The aim is to develop collective initiatives, with clear objectives and improved living conditions. There are now
opportunities, based on Healthy Cities and a policy of reducing poverty. This will include regulation, taxation, education and awareness raising.

Discussion

- Health aspects were not emphasised in the account. Health aspects of the informal sector are regarded as part of public health.
- The organisations in the informal sector were interesting. Will the present structures be used? Are there more such organisations? There is a lack of networking at present. The studies have been global, rather than concentrating on the informal sector. More needs to be known about financial arrangements, and the organisation of imports and exports, as neighbouring countries are closely involved.
- Who are the experts on the informal sector? This is the mainstream. The authorities are marginal. The informal sector includes the middle class and former civil servants. The field needs to be recharacterised. The sector is not disorganised, but is being addressed in a clumsy way. We need to inform systems, not just the sector.
- This initiative is a promising entry point. It is a question of dialogue: we are learning to accept, and learn from, the informal sector. Changing orientation is needed.

Presentation of Healthy Cities project framework

WHO AFRO re-emphasised the structure and basis of the Healthy Cities Programme, Baseline data is needed, with identified settings. This needs to be comprehensive, based on all parameters affecting health. Details of proposed indicators have been circulated. Guidelines are being developed, with expert support. Mortality and morbidity need to be monitored. City Environmental Health profiles are prepared using the prescribed indicator information, with current data. This results in a profile chart, against a variety of indicators, which clarifies the areas of health problems. This gives direction to programmes, and means of assessing progress. AFRO is keen to support city projects, and WHO has a plan of work to mobilise resources. Plans of action are needed, to be considered at a series of three workshops. Additional information is available.

Presentation PACE experience

Gerry Eijkmans explained the relation between PACE and the current project. PACE has been mainly a framework for development of a group structure and materials, and the next phase is the application of the network’s experiences and the developed materials to improve working conditions in the SSE in the cities. ILO projects such as WISE and SEED are also important as examples for the city project.

Paul Swuste is from Delft University Safety Science Group. He introduced PACE, products to date, and the future. Prevention And Control Exchange is a programme in industrial hygiene that addressed the knowledge application gap:

The Prevention and Control Exchange (PACE) initiative promotes the application of existing knowledge into pragmatic prevention and control solutions, integrated into adequate and sustainable programmes, emphasizing anticipated preventive action,
source control, safe work practices, workers participation and integration with environmental protection.

The outputs from this initiative, disseminated worldwide, will certainly contribute to the strengthening of national capabilities for the protection and promotion of workers’ health and the protection of the environment, as well as to sustainable development.

PACE activities

• Promotion of Political Will

An advocacy document on PACE aiming at decision-makers at different levels - “Prevention and Control Exchange (PACE) - a document for decision-makers” was prepared by OCH, and widely circulated having been received with much enthusiasm by a number of institutions and occupational health professionals around the world. Furthermore, articles about PACE have been published in Australia, Brazil, France, Germany, Netherlands, Poland, Sweden, Thailand, UK and the USA, thus giving wide dissemination to the PACE initiative. A Summary paper (Swuste, Goelzer and Corn) is on the Web at: http://www.occuphealth.fi/e/info/anl/195/swuste.htm

Educational materials

• Airborne Contaminants


• Videos: Two videos demonstrating the usefulness and relative efficiency of different control measures have already been produced (by the National Institute for Working Life, Sweden, jointly with WHO), utilizing the visualization technique “Picture Mix Exposure – PIMEX”.

• Document: “Occupational Exposure to Noise: Evaluation, Prevention and Control” (in English; being published shortly in Germany, for WHO).

Training Activities

Several technical cooperation activities, concerning the development of human resources specifically in the field of hazard prevention and control, have been carried out in Brasil and Mexico.

Prevention and Control Exchange (PACE): Hazard Prevention and Control in Small-scale Enterprises

Through PACE, it is expected not only to promote applied research on pragmatic control solutions, applicable to small industries, but also to identify and disseminate
already existing case studies, many of which are not published because they are not sophisticated enough for the specialized literature (hence not given due dissemination). Such knowledge may be even “life-saving” in certain situations. One very suitable group of measures (which protects at the same time workers and the environment) is the substitution/modification of materials, equipment and processes, or much better, the design (and selection) of safer and less polluting processes (“cleaner processes”).

The practice of occupational health and hygiene has to be adapted to the reality of SSE. For example, in most cases, risk assessment cannot be approached in the classical manner. In certain cases, a qualitative assessment may be the only solution and methodologies such as the Banding Approach, developed by the HSE (UK), must be further developed and applied. As to prevention, there are many well intentioned but ineffective efforts because recommended measures are not adapted to the actual context.

The activities develop through PACE so far are an important starting point for the 5 cities project in Africa.

**Short presentation on intermediate group results**

Three groups concentrated on cities, while two addressed a 20 year vision for the African initiative. The presentations, after three hours of work, stimulated considerable debate and discussion.

**Group 1**

Legislation should be enabling and user-friendly. The formulation process should be participatory, resulting in transparent legislation in layman’s language. The key is to protect the health of workers, and the benefits to all parties should be emphasised, together with the link to poverty reduction. Legislation should be specific to activities, and cost-effectiveness should be considered. Labour laws should protect basic humane conditions. Awareness should be raised through participation, the involvement of indigenous associations, and by an ongoing process, involving all levels. Responsibility should be all-encompassing, from individuals to international organisations. The Ministry of Health would take an overall lead, but with an intersectoral approach with other ministries. Environmental Health Officers and Ministries of Health and Labour would be involved with delivery. Human resources would include EHOs, inspectors, doctors and nurses, with an emphasis on capacity building. As for finances, ministries, departments and agencies should all be involved, with a foundation of public sector resources and support from WHO. It is vital to put these issues on the political agenda.

**Group 2**

The vision was of occupational health and safety for all, with a social security net. Legislation should facilitate and strengthen the informal sector, so that they could help themselves. They should be represented at local and national levels. Responsibilities were defined as internal and external, with structural responsibilities for government, local organisations and health personnel. Functional roles include collecting information, providing services and informing / educating / communicating. Externally there are roles
for WHO, ILO and ICOH. Structurally there is a need for public private partnerships, involving local government and the informal sector. Services should be integrated, with easy access, and a core of basic services from government. Trade unions can play a leading role (as in the clothing industry in the Western Cape). New personnel need to be brought in, and existing staff need to be retrained, with a new level of OHS specialists. Funding needs to come from donors, local authorities, NGOs, government and external organisations. Key activities include audits, development of networking, advocacy, and the transfer of skills and technology from North to South. Awareness activities need to involve all players.

**Group 3**

Each group member had stated what they saw as the main problems in implementing OHS in SSEs, and then moved to a vision of a utopia where the problems were solved. In this utopia, all people in SSEs would be safe and healthy, a key element would be their demand for education, policies, structures and services. Legislation needs to encompass SSEs, with simplified language, and core values with minimum standards. Suppliers should face extended liabilities. Awareness should be aided by a public relations office, education programmes and a demand for change. The group saw SSE self-employed people as responsible for their own health and safety, with responsibilities shared with suppliers. OHS services should follow demands from workers. Human resources are largely local, with finance from local government and enhanced research. Projects should be managed, planned and evaluated.

**Group 4**

The group argued that small enterprises and the informal sector are becoming the de facto mainstream, and this needs to be recognised in legislation. Workers need ready access to information, and should join the tax system, paying tax and receiving services. Local responsibility and skills are vital, with a role to be played by standards, linking quality to environmental protection and health and safety. Specialist services and skills need to be available and shared at the international level, rather than requiring each nation to be self-sufficient. This means new roles for international agencies, as well as for national governments. There are arguments for major interventions, for example to address the implications of AIDS, rather than waiting for unfolding but partially predictable catastrophe. In the context of project planning, it is important for cities to establish their baseline positions. Networking should be encouraged, especially horizontally across Healthy Cities projects, linking professionals and informal sector workers, enabling them to learn from differences. Advocacy is vital at regional level (such as with SADEC and ECOWAS), and internationally. Virtual funding (thousands of US dollars) is not enough. Serious funding is now required (millions), preparing the way for very serious funding (billions) if the pivotal importance of occupational health and safety in Africa is to be recognised. A step towards common ground is to establish the headline status of the issue. Healthy Cities work plans provide an environment for detailed development, with evaluation by WHO and ILO.

**Group 5**

The group considered the case for an African initiative, now Africa is on the agenda, and there is a vision for the continent, an African renaissance. There are common problems, such as growing cities and informal sectors, and the activities of multinational
companies. The group suggested the name WOSH (*Work safety and health*), and argued for an African desk, co-ordinating efforts and information, developing a united front, providing a steering committee and guidelines. The initiative needs to start at national level, with political and financial commitments. Inspectorates need to be established, with training, research, and a system of "continental memory". The group emphasised the importance of HIV/AIDS, going beyond awareness to inclusion as a dimension in each programme, including support for mother to child transmission treatment, voluntary care and treatment, and medication. An additional contribution noted the importance of ergonomics. The development impasse must be overcome, the theoretical vacuum broken, the lost decade overcome, and innovative solutions found. This means global networks, local initiatives, participatory development and attention to the needs of workers. From involvement comes co-operative co-responsibility.

18th October

Following a day of intensive small group work, groups reported in consideration at city level:

**Awareness Raising and Advocacy**

The group had representation from Johannesburg, Cape Town, Dar es Salaam and Yaoundé, and the day was spent learning different experiences, which were then reported as "Tales of Five Cities". The overall goal was a sustainable base for the 5 cities project. This was considered in three phases. The initial challenge was to create a buzz, and place the project on the local agenda, and attract the attention of potential funders.

In the first phase, data needs to be collected by sector, using support from students and the Healthy Cities project, with support at national and international level, and from WHO. A standard set of questions should be developed, with a checklist, photographs, a collection of stories from the informal sector, and statistics. The 5 cities should start to join forces, with city meetings, network meetings and a website.

In the second phase money should be collected by selling the project. This means working with financial, human and technical resources from partners such as ICOH, BBC, WorldSpace, universities, WHO AFRO, the informal sector, journalists and CEWC.

In the third phase, publicity needs to be developed, for example with the BBC on television, with Africa-wide radio in association with WorldSpace, and in newspapers through collaborative working with journalists. Educational materials are needed at all levels, within the project and among potential sponsors. Meetings need to involve all actors.

**Stakeholder Analysis and Coalition Building**

The group made an exhaustive classification of stakeholders at local, national and international level. At local level, these included workers; unions; associations; retrenched, boarded or retired workers; politicians and chiefs; healthy cities; traditional
healers; employers; local departments of government; community based organisations on NGOs; medical aid schemes; professional bodies, and primary health care practitioners. At national level they considered government departments; universities and research organisations; and WHO. At international level, the key players were WHO and ILO. Taking employers, for example, they are interested in productivity, which is increased by healthier employees. They want the lowest possible cost, and to avoid legal problems. They are required to obey the law, and they want information and co-operation.

They considered the arguments for joining coalitions. They could provide a coherent approach, access to resources and networking, with useful databases and websites. Peer group co-operation is a way of avoiding duplication, benefiting from research done by others. They can identify key players, and empower participating groups. Team building can be done through conferences, workshops, liaison, joint projects, and outcome based projects such as, in South Africa, BOSBERAAD, INDABA and KOPANO.

They identified the key leadership figures, and the causes they champion. The President offers influence, and with Ministers of Health and Labour, favour the interests of workers. Professional bodies represent specialist interests. Trade Unions defend the safety and health of workers, while provincial and local governments are concerned with implementing policy and regulations. Tertiary education institutions provide education, training and research, while international organisations provide liaison, networking and databases.

**Access to Solutions and Structure**

The group set out an outline structure for the 5 city projects, supported at international level by WHO, ILO and the three specialist NGOs, ICOH, IEA and IOHA, working through the national health departments in the 4 countries. Via district and city health authorities, we reach the level of Healthy Cities projects, each with a director, Environmental Health Officer, Occupational Nurse, and NGO or CBO representation. In each country the National Centre for Occupational Health would provide technical support. There should be an overall pilot project team, bringing together the 5 directors, 4 national centres, WHO, ILO, and the international NGOs.

The objectives are to facilitate recognition of the work of SSEs in the informal sector, and to sensitise SSEs with regard to OHS. EHOs need to be enabled to anticipate, recognise, and control problems, collecting information on injuries and accidents. This means developing a database. The outcomes should include a safer, healthier workplace, leading to enhanced productivity and profit. This requires an informed SSE sector, informed health personnel, with a new database, research projects and networks of partnerships. A pilot report will be an extremely important outcome, together, it is hoped, with environmental improvements, and improvements in living and working conditions.

Activities include training and retraining, research, development of guidelines, surveillance, lobbying and advocacy, and networking. Deliverables should include training for the 5 cities, guidelines, training materials, and networking. There should be a cycle of initial training, implementation, sharing of experience and measurement, and
reconvening for a final report and planning session. Overall co-ordination should be from WHO, with networking at each level. There should be gains for the informal sector, such as an insurance scheme with benefits for participants.

Evaluation and Surveillance

The group welcomed the support of participants from outside Africa. They started by considering the virtual project, which is easier to evaluate than the real thing, considering approaches to evaluation, appropriate indicators, ways of using information to improve practice, and areas where legislation might be appropriate.

The objective was to advance the promotion of OHS, integrating with general approaches to surveillance and evaluation. The outcome should be improved decision-making, and data for stakeholders. Activities would involve a system, whether new or existing. Information dissemination and involvement of stakeholders, including the Ministry of Labour, is vital. Specialists need to be identified, and financial plans developed. Data collection should include voluntary monitors, associations, sentinel clinics, and active involvement of the informal sector. Indicators would include training and its impact, hazards and controls, awareness levels, the range of resources involved, and knowledge of the informal sector by those in authority. Feedback needs to improve practice, with practical guidelines, and incentives such as tax breaks or assistance with levy payments.

Legislation raises complex issues, such as registration, rights of access for inspectors, statutory reports by general practitioners, and penalties for dangerous practices. Cities would need to make regular reports.

Discussion

- Who would provide the necessary training? It was recognised that there are training needs within the 5 cities in the project, and a need for education and awareness on a wider scale, in order to raise the profile of the issues and attract funding.
- Impacts on WOSH were discussed. Would sanitation or risks at work be given priority? How can reporting practices be improved?
- What should be the scope of each project, and how would commitment of EHOs be secured, given that they are hard pressed? Should OSH be linked to other issues such as HIV / AIDS? It was suggested that the pilot projects would concentrate on particular economic sectors. The informal sector needs to be helped to recognise that the intention is to help, not to inspect and punish. In many cases EHOs are working with the informal sector. Better recognition of occupational diseases would help improve the manageability of health care services. The self-reliant tradition of the informal sector was noted, and the important role of local organisations. A great deal could be learned through pilot projects.

The African Initiative

The last group took a continental level perspective, identifying the international actors, presenting a systematic approach to actions, and then dealing with funding. It was vital that the international actors, such as WHO and ILO, should join forces with greater effect. WHO is launching the African Initiative, with support from collaborating centres
such as in Finland and Sweden. ILO provides workshops, training and conventions. The role of OAU needs to be developed: they are addressing AIDS, seen as leadership's greatest challenge, and need to be helped to see the importance of OHS to health and the economy. UNAIDS plays a valuable role, mainstreaming AIDS across all programmes, and including occupational health. It provides a focus for WHO and ILO, mobilises governments, and supports advocacy with tailored materials. IPAAA helps organise work against AIDS in Africa. The three international NGOs: ICOH, IEA and IOHA, all offer networking, research and information. The International Office for Migration provides valuable advocacy support. OATUU is active in OHS and the Environment, and contributes to debates at SADC. Both SADC and ECOWAS bring a growing regional dimension to policy in Labour and Health.

The strategy is to join forces more effectively, assembling baseline data at all levels, developing advocacy, including addressing needs of OAU. Guidelines should be provided for the development of National Action Plans, covering needs assessment, prioritisation, action planning, resource management, implementation, monitoring and evaluation. The plans need to be monitored, evaluated and documented. This should result in "Health and Safety for all Workers in Africa: WOSH" or "The African Workers Safety and Health Initiative: WOSH".

The group further considered the need for a collaborating centre in Africa, approaches to training and networking, graphical ways of documenting good and bad practice, and, importantly, inexpensive solutions. Education should use all media, and good practice guides on the model of a recent UNAIDS publication. There should be 2 or 3 African liaison offices, catering for the different language communities. HIV / AIDS should be mainstreamed, and an emphasis should be placed on the OHS dimension of major infrastructure projects. Funding might come from sources such as the African Development Bank, World Bank, Turner Foundation, Fogherty Foundation, Gates Foundation, national aid and development agencies such as DFID and SIDA, as well as UN agencies.

David Rees argued that there is a need for focus, and for sharing solutions. Paul Swust pointed to small effective tools produced on PACE, benefiting from support of a larger framework. Kaj Elgstrand emphasised the importance of WHO and ILO joining forces. There was discussion of how to get people together, how to secure involvement, how to kick-start the process. Within a broad framework there could be detailed themes. A strong document should be taken to the UNAIDS conference in Ethiopia.

It was emphasized that a common agenda is needed, with work on the informal sector as the start of the African Initiative. The different agendas of the partners need to be known, supporting a practical project focus. The African initiative will be the umbrella for the different, coordinated projects and activities. The development of a website is a priority for the project, and Pat Scott is exploring the possibilities to set one up.

The issue of African collaborating centres in occupational health to support the work of the Africa Initiative was discussed with the participants, both in plenary and in individual sessions. The role of the collaborating centres will be vital in supporting the activities at various levels (local, national and international). A number of participants have expressed strong interest in following up these initial discussions, with a view to an application for collaborating centre status for their organization. The revised guidelines
for collaborating centres are being circulated to these participants, and further discussions and a visit to these centres are planned.

Thursday 19th

Plan of Action and Guidelines

The meeting dealt with city level planning, with seed money of $10,000 per city available from WHO for the first year of a five year project. The earlier issues now were applied to each city, with its own plan. The following issues, discussed in earlier sessions, were addressed:

- Scope
- Economic sector
- Long term plan
- Short term plan
- Resources
- Date of first city workshop
- Decision makers involved
- Coalition building
- Seed money: use
- Awareness, advocacy, access to solutions, surveillance and enforcement

Johannesburg

Scope: increasing awareness of OHS in the informal sector, providing healthy environment in and around Johannesburg in informal sector
Economic sector: following data collection, but e.g. food traders, waste sorters, light industries such as welding and painting
Long term plan: objective is policy and legislation, identifying stakeholders, holding meetings and workshops, data collection, analysis, solution; categorising informal sector; mobilisation of resources; health promotion: personal hygiene, environment, safety, outreach, awareness
Short term plan: starts personal hygiene, food safety, family health, health promotion,
Resources: multi-sectoral task teams, with Teknicons, universities, advisers; private and public sector finance
Seed money: used on research workshops and training
Date of first city workshop: 3rd week of January 2001
Decision makers involved: Departments of Health and Industry, NGOs, informal sector organisations
Coalition building: led by task team
Seed money: used on research workshops and training

Discussion

- Occupational hygiene was taken as long term. Only hazards of material processes are apparently addressed in the short term.
• The task team are seen as key stakeholders, with their leadership structures. Government will co-ordinate, led from the Ministry of Health.
• It seems ambitious. The project activity serves wider government objectives of poverty alleviation, and a wider view of public health.
• Who will lead the project? The 1997 Commission on Occupational Health gave responsibility for OHS in the informal sector to the Department of Health.

Cape Town

Scope: to develop a database and implement OSH for SSEs and the informal sector, contributing to safer working conditions and reduced risk,
Economic sector: in a specific geographical area, driven by the focus of the area.
Short term plan: Objectives, activities and outcomes were spelt out for the first year, with cost centres. This gives a base for action, reports and stories. An ACCESS database will then be linked to a website.
Long term plan: the data collection lays the foundation, consulting WHO for other material. Using the information, there will then be awareness, training material: starting with SSEs and health personnel; and advocacy. Training will build, motivating partners. Increased awareness and space recognition. Monitoring and evaluation will link with the other cities (which will require funding). Reporting to stakeholders, compiling and distributing reports, raising profile of OHS, quarterly. Research will be developed to reduce risk, again involving students. There is a project cycle, driven from advocacy, assessment, action and evaluation. Training would lead to qualifications.
Resources: university department as the core, with the database in place after 3-6 months; also using 300 students, as part of their projects.
Date of first city workshop: 3rd week of November 2000.
Decision makers involved, coalition building: Teknicon and universities, local government, environmental and occupational health, research council and local NGOs and CBOs, unions, Department of Labour and Health. (also involved in monitoring and evaluation).
Seed money: assigned to the cost centres listed above.

Discussion

• The starting point is a pilot database in one area with a population of 50,000, logging hazards as they arise. This is likely to cover the spectrum of industries, and may need prioritisation, such as by hazards, if it is to be manageable. The focus will be on high risk.
• The first workshop will identify the area, in terms of demographic representativity, poverty etc.
• The emphasis is on training, rather than on making improvements; student interventions can flow from research: action for change.
• Cape Town is more oriented to occupational health, and Johannesburg to public health. Separating the elements can be hard. More work has already been done in Cape Town.
• There were discussions of who picks up which costs, for example for joint activities across the cities. WHO will play a role in subsequent meetings; the seed money is
for use by cities. The project steering group should link the cities, as previously set out. Training can be put out to tender where required. This worked well in the Healthy Cities project in Dar es Salaam.

Dar es Salaam

Scope: improve working and living conditions in SSEs  
Economic sector: workshops of painters, mechanics, carpenters; starting with two clusters, each with 100-300 workshops, in one municipality.  
Long Term plan: Extension to other municipalities is planned. Layout; basic sanitation to 80 or 50%; access to safe drinking water, toilet and drainage, acceptable solid waste removal; ensuring good housekeeping; improved transport; reduced specific risks for accidents and diseases, including HIV / AIDS. Indicators still need to be refined. More needs to be known about the people concerned.  
Short term plan; starting with workshop, raising awareness, establishing task group, agreeing work plan; data collection by inspectors and planners; outcome is registration of workshops, with improvements in each of the key areas. Each activity area then needs a plan, from April 2001, led by city health officers and labour inspectors. The plan needs to be approved, implemented and monitored. Documentation is needed throughout, with a final project report. Evaluation will determine whether the project is to be expanded, again by the city authorities. Monitoring and surveillance of health and safety risks is required across the programme, led by the project team, resulting in improved conditions.  
Resources: leadership from city authorities.  
Date of first city workshop: December 2000.  
Decision makers involved: City Commission, city health and labour officers, planners.  
Coalition building: Cities are to take on the idea of making the environment healthier, setting up a multi-sectoral task force.  
Seed money: to cover performance incentives package, training and awareness, training posts, mobilise resources from other sectors.

Discussion

• How were the industries identified? There is enough knowledge to indicate that there are known risks, which need attention. Involvement of municipality representatives at the advocacy meeting will be important.
• The first meeting in December is important. What are the expectations? There are about to be national elections, and in December new leaders can be invited.

Yaoundé

Scope: occupational health services for informal sector as  
Economic sector: metal and automotive mechanics.  
Long term plan: improving health and work practices; reducing hazards and pollution; resulting in reduced hazards and pollution.  
Short term plan: organise seminar to inform and mobilise authorities, and leaders of workers, developing educational materials based on pilot
Resources: ministries of health and labour, municipalities, WHO, universities and experts; financial resources: seed money to be matched by municipality

Date of first city workshop: April 2001, following earlier relevant mobilisation activities

Decision makers involved: ministers, government delegates, mayors, traditional chiefs and NGO leaders

Coalition building: steering committee is needed

Seed money: to finance the workshop, with preliminary study, training materials and piloting.

Discussion

- How confident are the group of receiving matching money: effective advocacy will do the job, partly due to involvement in the Healthy Cities project.
- Is the choice of sector based on existing data? It is known that there are problem, but more data is needed. They may be other problem: these are major problems to start with: studies will reveal more.
- It is a good idea to start with a case study group, with a plan to broaden later. The approach could be critical: it might be that the approach stays at case study level. The advocacy meeting will represent a broad range of interest, and mayors may wish to set up similar projects.
- Do ministers take decisions for the city? As the capital city, ministers are involved in Yaoundé.

Harare

Scope and economic sector: consultation is needed; this is a draft. Focus is on objectionable smells, occupational health exposures (e.g. spray painting), industrial solid wastes (scrap metal and car shells), and lack of awareness of OHS. The goal is to improve OH and sanitation in Mbare home industries.

Long term plan: Data collection, additional toilets, awareness creation, training (with provision of protective equipment), industrial solid waste removal, networking, monitoring and evaluation, construction of a furnace and paint spraying booth (not in the pilot). Practical offers of help were made. For each activity, responsibilities were assigned, over specified periods, with stated outcomes and handover procedures, adding to public awareness. Monitoring, evaluation and documentation will be thorough.

Short term plan: For each activity, planning and initial work (apart from the last).

Resources: offers of support from the USA; local health staff, community and project team, additional funds will be sought to match the seed funds

Date of first city workshop: January 2001

Decision makers involved: city authorities, government ministers, community

Coalition building: through careful launching, involving the community in data gathering

Seed money: allocated to the activities set out above, with 50% on training.

Discussion

- Should the project provide personal protective equipment? It may be better to raise awareness. It is a matter of making a start, and demonstrating.
- Sustainability is important: how is this to be done. Is the community being involved in the right way? What else are they expected to do? The full package will be printed,
and addresses these issues. The project team has core responsibilities, which include training supervisors. The project is to be handed over to the community. Details have been discussed. The question is about local financial resources for sustainability.

- The city of Harare has designated areas and core facilities, with responsible staff. Numbers of users have increased, placing facilities under pressure. Development involves community involvement.
- Personal protective equipment is not an attractive solution; the first measure should be to prevent the risk; if that fails, then control must be tried in other ways; then personal protective equipment is needed.
- Involving the people in improvement and construction perhaps sounds inconsistent with the mayor handing over the facilities.

Friday 20th

Revision of Document for Decision makers

The document for Decision makers on improving occupational health in small-scale enterprises in the informal sector was provided to all participants before the start of the workshop. The document serves as a background document for the 5 Cities Project and the African Initiative. Different groups worked on the different aspects of the document, such as policy framework/awareness-raising, practical solutions, social mobilisation, and workplace health promotion. Participants made useful suggestions for improving the document.

Decision makers do not read long documents; the finished document needs to be shorter, clear and with powerful examples. At present the document is international and independent of regional context, expressing general principles regarding occupational health and the informal sector. For use in Africa, for example at the SADC meeting in November 2000, the document needs effective examples of problems and solutions from Africa.
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