Do occupational health services really exist in Ghana?

A special focus on the agricultural and informal sectors

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Introduction

Ghana has a large informal sector which constitutes 70% of its 7.7 million workforce. This sector consists of varied small and micro scale industries. The largest proportion of the informal sector is made up of agricultural workers who constitute 60% of the country’s workforce and are mainly small holders. The only exception to this rule are workers employed by a few multinationals like Unilever and Firestore which own plantations. The contribution of agriculture to Gross Domestic Product (GDP) is 51%. A considerable proportion of informal sector workers are involved in mining, manufacturing including woodwork, cement block moulding as well as batik and tie and dye making. Others work as salesmen, artisans like automobile repairers and welders, while others provide services, such as in catering, transport and the beauty industry.

Numerous injuries and diseases are associated with work in the informal and agricultural sector, although as a result of underreporting and poor data collection, accurate statistics are scarce. Injuries occur commonly in farming, road transport, mining, quarrying and woodwork. The sector is also associated with a wide range of communicable diseases, including schistosomiasis, filariasis and malaria (e.g. high prevalence in irrigation agriculture) and HIV/AIDS which is particularly associated with mining and the transport sector. Non-communicable diseases widespread in the sector include Noise-Induced Hearing Loss (NIHL), pneumoconiosis like silicosis, chemical poisoning (from pesticides), stress, and occupational asthma.

With such varied industries associated with the potential for a wide range of illnesses and injuries, the need for comprehensive provision of occupational health services (OHS) could be deemed as paramount for the well-being of workers in the sector. The situation on the ground, however, suggests otherwise.

Legal basis and financing

Ghana has no national policy on occupational health services. A draft policy jointly developed by the Ministries of Labour, Health, and Mines and Energy as far back as 2000 is yet to be adopted.
There are two main statutes that have charted the course for the provision of services over the years. These are the Factories, Offices and Shops Act 1970, Act 328 and the Mining Regulations 1970 LI 665 which have driven the implementation in the Labour and mining sectors, respectively.

Other statutes that have a bearing on OHS are the Workmen’s Compensation Law 1987, Environmental Protection Agency Act 490, 1994, and the Ghana Health Service and Teaching Hospitals Act 526, 1999.

Section XV of the Labour Act 651, 2003, recently promulgated, covers Occupational Safety, Health and Environment. This is based on the tenets of ILO Conventions Nos. 155 and 161 which the country has not yet ratified.

There are several shortcomings of the legal provisions on OHS. The Factories’ Act and Mining Regulations which have for years provided guidance for implementation are very limited in coverage. While the Factories Act caters for factories, offices, shops, ports and construction, the mining regulations cater only for the mining sector. The vast majority of industries, including agriculture and most of the informal sector are therefore not specifically covered.

Secondly, the provisions are very limited in scope providing very inadequately for prevention. Preventive strategies like risk assessments, medical surveillance and control of hazards are not catered for. There is an overlap of some of the functions mandated by these pieces of legislation for different ministries. For example, both the EPA Act and Factories Act mandate entry into factory premises by inspectors from the EPA and Factories Inspectorate, respectively. There is also some disagreement between the Factories’ and Mines’ Inspectorates regarding the inspection of explosives’ stores, which both organizations have a mandate for.

There is a lack of specification of standards which should form the yardstick against which services are to be evaluated. Compensations as defined by the Workmen’s Compensation Law bear no relation to the level of risk to which workers are exposed.

The laws do not define funding mechanisms for OHS that should be applied both by government and the private sector. OHS programmes are therefore grossly underfunded, a reflection of the low priority accorded to it by the government.

The National Health Insurance Schemes (being put in place) though catering for curative care, explicitly exclude OHS provisions like rehabilitation and provision of prosthesis.

Providers, functions and staffing

The facilities for providing OHS in the informal sector consist predominantly of government, private and faith based health facilities in the communities. Since most people in this sector are self-employed, they pay a fee upfront for services rendered to them. Those workers in plantation agriculture are, however, catered for by their companies.
Services provided in comparison to those prescribed by the ILO Convention No. 161 on Occupational Health Services, are very limited, providing basic curative care and first aid. Primary medical care is therefore the norm. Comprehensive occupational health preventive activities are grossly lacking except in one multinational company (involved in plantation agriculture) where some provisions exist for medical surveillance, risk assessment, worker education and HIV/AIDS prevention programmes.

Not surprisingly, multidisciplinary OHS teams are also lacking. The key staff rendering OHS in the health facilities are the health care workers found typically in those institutions, i.e. doctors, nurses and paramedical staff. Those trained specifically in occupational health are very few, the whole public sector having only 4 physicians, one nurse and 34 factory inspectors. There is also an acute shortage of OHS training programmes. The School of Public Health is struggling to institute an occupational health programme.

In the light of the above, it is estimated that the proportion of workers who receive comprehensive OHS in the informal sector is likely to be constituted by not more than 1–2% of workers.

One could therefore conclude that although there are some OHS being provided in most of the informal and agricultural sectors, the scope of functions are very limited with by far only a small minority having access to comprehensive services.

**Planned Changes / Recommendations**

Although not specifically articulated by the government, the following proposals could constitute some avenues for improving the current situation of OHS:

1. A window of opportunity could be exploited by adopting the proposed OHS policy and building on section XV of the new Labour Act 651, 2003 which mandates occupational health and safety for all sectors of the economy which would include the informal and agricultural sectors. There is a need for the urgent promulgation of a legislative instrument (LI) to give meaning to this section of the Act and provide practical guidance for its implementation.

   The LI should include systems for standard setting, as well as criteria for accreditation and certification of bodies involved in the administration of OHS. It should also spell out funding mechanisms to support the implementation of OHS.

   In addition, it would be important to spell out explicitly within the policy and LI the need for provisions to cover the informal and agricultural sectors. It should also spell out the need to integrate primary medical care with other OHS preventive functions.

2. Since capacity building is such an important prerequisite for obtaining the right calibre of staff to man the services, resources should be made available for training at pre-service, in-service and post-basic training levels.

   The Ghana Health Service/Ministry of Health (GHS/MOH) is making some efforts to integrate OHS with primary health care (PHC) through the development
of a curriculum and handbook for primary health workers which will facilitate their training. These efforts need to be strengthened by increasing the resources available for them and expanding them to cater for the needs of pre-service and post-basic training institutions.

3. To ensure that employers begin to see expenditures on OHS as an investment rather than a drain of profits, mechanisms should be sought to provide some incentives to encourage them to contribute. In this regard, strategies such as advocacy to create awareness of the need, by tripartite partners, as well as tax breaks for companies who put money into OHS should be considered.

4. Although the national health insurance scheme is in its infancy, consideration should be given to integrating comprehensive occupational health service provisions with it in order for the full benefits to be realized for the working population.

**Needs for international assistance**

Areas in which international bodies could assist to strengthen OHS in Ghana include the following:

1. Strengthening of advocacy to sensitize Ghanaian leaders and those of other African countries to see occupational health and safety as an important component of the human dimension of sustainable development. One of the ways in which this could be achieved would be by integrating into the preconditions for development projects including development assistance, measures to ensure that an OHS component is built into plans much in the same way that the World Bank and some other agencies ensure that measures of environmental performance are incorporated into feasibility studies/environmental assessments of such projects and programmes.

2. Sensitization of governments towards the adoption of a common policy on OHS and its integration in development and poverty reduction efforts at the regional level e.g. within the context of The Economic Community of West African States, ECOWAS and The New Partnership for Africa’s Development, NEPAD, should be encouraged.

3. Assistance by multilateral agencies in terms of communication on the ILO/WHO strategy would help the political leaders to appreciate the need for intensive intersectoral collaboration to achieve the objective of attaining basic occupational health services.

4. Technical support from external partners for capacity building efforts for country nationals would help to strengthen the human capacity base. An aspect of this that would in addition to strengthening technology transfer also serve to curb the brain drain of trained professionals would be to build into consultancy assignments the component of ‘local counterparts’ to work hand in hand with foreign consultants.

5. Finally, funding support would be needed by way of infrastructure to set up training programmes and other support services, such as occupational health laboratories.