Today, our National Institute for Occupational Health (NIOH) is southern Africa’s major centre for occupational health development, training, service support and research, with a staff of around 90 people of whom half are scientists or professionals.1

There is a sense of both satisfaction and disappointment in tracing the evolution of the NIOH from its progenitor, the Pneumoconiosis Research Unit, established in 1956 within the grounds of the South African Institute for Medical Research.2 Satisfaction because the NIOH’s evolution has in the main been consistent with its goal to support the development of effective occupational health services; and because changes over many decades have produced a centre of knowledge and service strong in many of the disciplines of modern occupational health. But concurrently profound disappointment: in 2005, silicosis was found in 29.5% of gold miners, and presumably in other silica exposed workers, are again calamitous. At the same time, modernity has produced stressful and demanding working life; 24 hour societies, intense working pace and high loads, casualisation of work and constant change are features of much of modern work experience.

The dual burden of traditional and new work hazards is very evident in South Africa and our national institute has a more important and complex role than ever before.

A BRIEF HISTORY

Behind the great mining developments on the Rand ‘has laid (sic) another and sinister reality, that of miners’ phthisis’. So quotes Marais Malan in In Quest of Health, a history of the South African Institute for Medical Research (SAIMR) 1912–1973.5 As he explains, it is this reality that led to pneumoconiosis research in the Medical Research Institute and thus to the origins of the NIOH. From the early 1920s, research at the SAIMR on clinical and pathological aspects of dust diseases and the nature and measurement of dust was internationally recognised.

The Silicosis Act of 1946 introduced the concept of pulmonary disability in the compensation of miners and the SAIMR received an increasing...
number of cardio-respiratory organs of deceased miners for pathological examination. In response, in 1953 the Institute with the Department of Mines established the Pneumoconiosis Research Unit. In 1956, following a recommendation of a departmental committee of the Department of Mines, this Unit was incorporated into a new body with the same name established by the Council for Scientific and Industrial Research (CSIR). Thus the Pneumoconiosis Research Unit (PRU), the direct progenitor of the NIOH, came into being. According to Malan, the PRU had four divisions: Pathology, Statistics, Dust and engineering and Physiology – a solid foundation for a future national institute. (The Erasmus Commission identified the divisions differently, but covering the same functions.) The Pathology division was administered and staffed by the SAIMR; laying the ground for the close relations between this nascent national occupational health institute and the SAIMR and its successor, the National Health Laboratory Services (NHLS).

In 1969, medical research sponsored by the CSIR was taken over by the South African Medical Research Council (MRC) and this take-over included the PRU. For some years prior to this change, it had become increasingly clear that there were serious occupational health problems in non-mining industry and that a Unit restricted to mining issues was untenable and also unpalatable to organised labour. Consequently, in 1971, the PRU became the National Research Institute for Occupational Diseases (NRIOD) with an expanded role to cover all industrial sectors, not only mining. The subsequent history until the formation of the National Centre for Occupational Health (NCOH) is related in the 1976 Report of the Commission of Enquiry on Occupational Health (otherwise known as the Erasmus Commission). Prominent during the period were tensions between the MRC and the NRIOD. The MRC’s mandate was basic research and it felt that it had statutory obligations to restrict the NRIOD to this function. The NRIOD on the other hand felt compelled to respond to a multitude of occupational health problems in the country by conducting applied research and field surveys and performing services aimed at improving working conditions in industry, to diagnose and treat patients with occupational disease, and to expand as a centre for information and guidance. All of these were in line with developments of national institutes in many other parts of the world, but were in conflict with the mandate of the MRC. The conflict was resolved by following the recommendation of the Erasmus Commission and transferring the NRIOD in 1979 to the Department of Health as the National Centre for Occupational Health (NCOH).

Then followed a difficult period characterised by fragmentation, isolation and opposition by the Department of Health to the perceived worker bias of the NCOH. It was the intention of the Erasmus Commission that the NCOH would be part of a coherent national occupational health system governed by the Department of Health. As it turned out, overall control of occupational health did not go to the Department of Health and the NCOH operated in a fragmented system and in the absence of a national occupational health policy. At the same time, international isolation of South Africa gained momentum and the NCOH, previously very much part of a worldwide network, became increasingly cut-off from scientific and professional contacts. Tripartism among the state, organised labour and business was more and more the norm for occupational health and recognised by the NCOH. However, this was in conflict with the prevailing political polarisation in South Africa in the 1980s, and thus a source of tension between the NCOH and the Department of Health. Despite all of this the NCOH entered the new era fairly vigorous, fortunately because the 1990s brought a multitude of changes.

Among these changes was the Minister of Health’s Committee on Occupational Health which released its report (the Abdullah Report) in January 1996, establishing a model for doing the right thing at the right level (national, provincial and district) in the public sector. Also at the time, a Department of Labour Committee of Inquiry into a National Health and Safety Council was one aspect of a serious attempt to overcome fragmentation and to coordinate government activities. As part of these initiatives, the NCOH was restructured and a new establishment was approved in 1997. A substantial report on the rationale for the restructuring, Proposed Restructuring of the Chief Directorate: Occupational Health, is available from the NIOH. The changes to the NCOH were made to ensure that its activities supported the development of effective occupational health services and to design the NCOH to be an integral part of the occupational health system as envisaged in the Abdullah Report.

Subsequent to the restructuring, the NCOH emerged as a more modern institute with expanded
responsibilities for national indicators and surveillance programmes; more attention to occupational toxicology, information and advisory services; new units for Ergonomics and Bioaerosols; an expanded education and training programme, including a masters in occupational hygiene; and extensive international collaboration, notably with NIOSH, USA, the Health and Safety Laboratory, UK, and the ILO and WHO – the NIOH joined the network of WHO Collaborating Centres in Occupational Health in 2005.

The latest step has been the transfer of the NCOH as the NIOH to the National Health Laboratory Service, still with most of our funding and direction from the Department of Health, but with substantial support from the NHLS and a directive to supplement our budget with research grants and from other sources. Over the past few years the Institute has had a growing role in supporting the development of occupational health in southern Africa. Our goal now is typical of many national occupational health institutes around the world: to promote good occupational health and working life through being a centre of knowledge, development and support services, but the major statutory autopsy function remains integral to the institution 50 years after its inception, a unique function for any institute of this kind.¹

CONCLUSION
This brief glimpse into the NIOH’s history shows that each phase of its development has had unique opportunities and difficulties; the next period will be no different. Possibly most significant among many challenges will be: to find a balanced response to the new and traditional hazards of working life — for example, to define responses to occupational stress, irregular and long working hours and work organisational issues; to contribute most effectively in an integrated and coherent occupational health system, hopefully on the not too distant horizon; and to make sure that the next account of the history of the NIOH does not end with a description of a prevailing silicosis and tuberculosis epidemic in South African workers.

REFERENCES