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# The Work and Health in Southern Africa (WAHSA) Programme – overall experiences and the way forward

## ABSTRACT

The Work and Health in Southern Africa (WAHSA) Programme was inaugurated in October 2004, supported by the Swedish International Development Cooperation Agency (Sida), to an amount of 5 million SEK/year for the first four years of Phase I. The programme was intended to continue until 2016.

The overall purpose of the programme was to contribute to poverty reduction by socio-economic development in the SADC region through improvements in occupational safety and health. The programme, consisting of ten projects, included research, training and development aspects within action-oriented projects. Significant advances have been made in occupational health and safety in southern Africa through the programme, as well as learning about the complexities of running regional programmes. A network of WAHSA participants has been established throughout the region.

The Paris Declaration on Aid Effectiveness that aimed to better manage the process of providing aid probably contributed to the realignment of the Swedish government's international aid policies. Thus, despite the favourable recommendations of the external evaluation, Sida was not able to continue funding the programme beyond Phase I. The funding of activities ended in May 2009.

This paper sets out the origins and objectives of WAHSA; provides an overview of the various projects within the WAHSA Programme; addresses some of the lessons learnt and discusses the reasons for its early termination.

**Key words:** Work and Health in Southern Africa Programme, Swedish International Development Cooperation Agency, SADC, occupational health and safety

## INTRODUCTION

The Work and Health in Southern Africa (WAHSA) Programme, launched in October 2004, in Gaborone, Botswana, was planned as an innovative long-term collaborative programme that would substantially address the health of workers and their working conditions. The Programme set out to do this in a series of three four-year phases, with Phase I focused as a pilot and developmental phase. Unfortunately, due to the early termination of funding, the long-term objectives of WAHSA were not to be realised. However, it made a significant impact, not only in the specific activities that were conducted in Phase I but also in establishing a framework in which future programmes of this nature could be implemented. The projects that constituted Phase I, the successes and experiences are explored in this paper in greater detail.

## PROGRAMME INITIATION

The idea of cooperation between Sweden and the Southern African Development Community (SADC) for a regional programme for occupational health and safety, (OH&S),

started with a suggestion from the Minister of Labour for Zimbabwe in 1997. The minister pointed out the great need for building capacity to improve workers' safety in all countries in southern Africa, and thereby preventing and reducing poverty. She was aware of Sweden's good record in the work environment, and suggested this area for long-term cooperation. The suggestion was presented to Sida that funded a planning study and inventory of the most urgent needs expressed by governments, labour market partners, labour inspectorates and the research community. The summarised results follow.

- Activities that support advocacy are needed. For example, profiling OH&S at community/district/country level and collecting data on the impact of occupational disease and injury; mechanisms to feed into policy; and effective means of communicating and creating awareness. Employees, employers and state agencies would all have to be empowered by these activities.
- Concrete interventions in the most important sectors are warranted to improve practice and develop show-case successes for advocacy. Agriculture, mining and related

enterprises (with occupational lung disease a key issue), the informal economy, construction, and transport were suggested.

- Long-term actions are necessary.

### THE WAHSA PROGRAMME

The proposal was developed over a number of years with SADC officials, occupational health stakeholders (including employer and employee representatives) and occupational health professionals and agencies from the region. The SADC officials were from all the appropriate sectors, including both Labour and Health. On the Swedish side, the National Institute for Working Life (NIWL) and Swedish National Institute of Public Health (SNIPH) were

**Table 1. WAHSA projects in Phase I**

1. Establishment of resource complexes.
2. Profiling occupational health and safety.
3. The basis for planning future interventions.
4. Training of health and safety professionals.
5. Access to information.
6. Advocacy and awareness raising.
7. Action on silica, silicosis and tuberculosis.
8. Action on pesticide poisoning.
9. Action on health and safety in small scale informal sector enterprises.
10. Planning of Phase II of the programme.

**“... purpose of the programme was to contribute to poverty reduction by social and economic development in the SADC region through improvements in OH&S.”**

the original partners in the programme. When NIWL was closed by the Swedish government in 2007, the Royal Institute of Technology joined SNIPH as a contracting Swedish partner.

Sida supported the goals and the long-term perspective and contributed 5 million SEK/year for four years as Phase I. The programme was inaugurated in October 2004, one year after a similar programme had started in Central America – Salud y Trabajo, SALTRA.

The overall purpose of the programme was to contribute to poverty reduction by social and economic development in the SADC region through improvements in OH&S. The programme aimed at promoting regional cooperation between countries within southern Africa as well as with Sweden and similar initiatives in Central America.

Based on the feasibility study, the long-term goals were set to contribute to the reduction of poverty, promotion of human rights and the empowerment of the region's workers. The WAHSA Programme wanted to contribute to these goals through integration of occupational health into key social and economic activities (see Box 1).

### CONTENT OF THE PROGRAMME

An important and successful feature of the WAHSA Programme was the twinning between a university department in one of the universities in South Africa and a relevant organisation in another SADC country for carrying out the action projects. A position for Regional Programme Director with administrative support, an Executive group and a Steering Committee with representatives from African as well as Swedish participating institutions and headed by SADC have been important and effective features of the governance.

Phase I was organised into ten projects (Table 1). The first project was designed to establish institutional

infrastructure and the capacity to undertake some activities of the programme. The next three (i.e. Projects 2-4) aimed to collect large amounts of data on OH&S in the region and some of the factors that influence the provision of occupational health services. Project 5 was to strengthen access to occupational health information from the regional service based at the NIOH and Project 6 was to increase awareness of the essential role of healthy work. Seven to nine were action-orientated projects to reduce the negative impact of exposure to silica and pesticides, and to reduce work-related health risks in the informal sector.

### ACHIEVEMENTS OF THE PROGRAMME

The first four years of the programme produced significant outcomes. These are outlined hereafter.

#### Box 1. Integration of occupational health into social and economic activities

- *Improving economic performance* as improved occupational health promotes productivity and the competitiveness of enterprises and reduces poverty of injured workers and their families. “Health is wealth” is clearly understandable in this context.
- *Stabilisation of society* is enhanced by reducing the pool of marginalised and disaffected injured and diseased workers; by promoting fairness and equity in society; by giving effect to provisions of national constitutions and statutes.
- *Improved general health* is promoted by integrating health promoting activities into occupational health services. An accessible population is available, for example for smoking reduction and HIV prevention actions.
- *Environmental considerations* are taken by programmes that reduce workplace pollutants, manage waste products and reduce the inappropriate use of agricultural chemicals.
- *Capacity to effect change* is strengthened through advocacy and improved knowledge and skills of the social partners.

Major objectives during the first phase were to foster regional networking between OH&S professionals and institutions, to gather information by which conditions in the region could be profiled and on which further meaningful interventions could be based. This was achieved.

Projects 1 to 6 have resulted in the availability of information about OH&S in the region, as well as the sensitisation of stakeholder representatives to the problems that exist. The country profiles (see separate article on page 7) have provided a picture of the information gaps that exist, while the addition of questions to the 2008 Zambian Labour Force Survey, (this is a survey conducted by the Zambian Ministry of Labour at regular intervals), is likely to have stimulated interest in the active collection of information for managing OH&S on a national level and to supplement existing information.

Project 3 highlighted industries and issues of particular concern that should benefit from pilot interventions in the next phase.

Project 4 has underlined the need to improve access to training, and to ensure the deployment of those trained. A funding proposal is being drafted for the development of a repository of distance learning material to facilitate improved access to education and training in the region.

Inspired by the WAHSA concepts and experiences, SADC has reconstituted the Technical Subcommittee on Social Protection. If adequately resourced, this hopefully will lead to greater proaction on OH&S issues in SADC as well as in governments of the region.

Inroads have been made into interventions to mitigate

the effects of pesticide use, exposures in the informal sector, and exposure to silica dust:

- Pesticide registrars in SADC and other African countries have for the first time received training, been exposed to conditions in small scale farming and have benefited from a communication network via a list server established and maintained by WAHSA.
- Labour inspectors have been trained in silica dust measurement and principles of control, and a dust measurement laboratory has been established in the region.
- Tangible interventions have been introduced to improve conditions among groups of informal sector workers in Mozambique and Tanzania, and more importantly a process has been piloted for risk assessment, education and intervention in this sector.

Experiences from the three major action projects (Projects 7, 8 and 9) are described in separate articles in this issue of *Occupational Health Southern Africa*.

Phase I of the programme has been subject to an external evaluation, the results of which were extremely favourable and recommended that the programme should continue. Therefore, it came as a great shock and disappointment that Sida would not continue the funding support for Phases 2 and 3 due to new policies and priorities from the Swedish government. The funding of activities ended in May 2009.

## LESSONS LEARNT

The experience of WAHSA and the Central American SALTRA as well as other international programmes were discussed at a special session of the 29th International Congress on Occupational Health in March 2009, and the observations highlighted in that discussion (Box 2) are relevant to the experience of WAHSA overall.

Concerning the premature termination of the WAHSA Programme specifically, the feelings were as outlined below.

- WAHSA was developed with 12-year perspectives in mind, with the support of regional stakeholders and Sida for this longer term framework. It enabled appropriate timelines for planning.
- Contrary to their long-term aim, objectives and design, programmes were discontinued too early for measurable, sustainable impact. Had a four-year timeline been initially imagined, a different approach would have been adopted.
- SADC and Sida lost an excellent opportunity to make a difference; a potentially novel opportunity for a model for development cooperation was lost and several international and national organisations and institutions have expressed their disappointment and regrets.

WAHSA made a concerted effort to try to build leadership in the region that did not preference South Africa above other countries but it was difficult to achieve that to the full, partly due to the drastically shortened length of the programme. However, Mozambique and Tanzania played important roles in the project and a good start was made in a few more countries.

Photo: Nils Peterssen



Political commitment from regional leadership is essential for a programme with this vision. We had the possibility to present the progress of WAHSA several times to the SADC ministers and gained increasing support. Hopefully the newly reconstituted Technical Subcommittee on OH&S will support a continuation of this process.

We found a strong overlap between occupational health and environmental health within a public health perspective in the WAHSA as well as the SALTRA Programme and we recommend that this is explicitly approached in the continued processes.

This was partly because there was not explicit provision for this in the proposal and there was an urgent need to begin work on the project outputs, but also because, as alluded to above, those involved in the programme tended to be very busy people and finding time when they could be available for such activities was difficult.

The degree of uncertainty within the programme, and the quality of communication with the funder, was problematic. It was apparent halfway through the programme that Sida's funding policy might change, but the decision not to fund another WAHSA phase was finalised and communicated

***“The . . . WAHSA Programme . . . was planned as an innovative long-term collaborative programme that would substantially address the health of workers and their working conditions.”***

We explored industries and issues of particular concern that should have benefitted from pilot interventions in the next phase. Occupational and environmental health aspects should be assessed as early as possible in development agendas.

The extreme scarcity of OH&S expertise in the region for participation in the programme was an obstacle for WAHSA, but also one of the reasons for the programme. It was possible to find a small number of senior researchers and officials to participate, but they were, in most cases, committed to other projects and priorities and, in several cases, the additional demands of the WAHSA Programme were experienced as a significant burden. This placed a strain on relations within the WAHSA Programme and on the regional programme directors, who had sometimes to step in to complete work for partners that would not otherwise have been completed. Competing interests, and a mismatch in terms of available capacity or institutional mandate, were among the more significant problems in the programme.

Financial matters and financial reporting were complex and quite difficult. Despite the engagement of generally competent financial managers in South Africa, they were not involved in the development of the programme reporting system. In retrospect, funds should have been set aside to allow for networking of financial departments and for the development of reporting systems by financial managers.

With hindsight it is clear that the project outputs and activities were too ambitious for the time available. Preparations for the programme and for individual projects and activities were time-consuming and laborious. These ranged from drafting contracts and having them approved by different institutions, the nomination of individuals to represent those institutions, to negotiations with workplaces for access in new inventories to be compiled.

We did not allow sufficient time and resources for the consolidation of, and capacity building within, the network.

only in the last year of the first four-year phase of the programme. In times of change, programmes can deal more effectively when decisions are not delayed and communication prompt and clear.

#### **THE “PARIS DECLARATION ON AID EFFECTIVENESS”**

The “Paris Declaration on Aid Effectiveness” (the “Paris Declaration”)<sup>1</sup> in 2005 established new ground rules and has played a major role in the premature closure of WAHSA and SALTRA. The Declaration emerged at a 2005 conference convened by the high income countries of the Organisation for Economic Co-operation and Development (OECD), with developing country representation, as a

#### **Box 2. International support for regional occupational health development programmes**

- International cooperation programmes have contributed significantly to the development of occupational health in the developing world.
- Conditions for success included visionary but realistic goals, longer term perspectives and sustainability of funding.
- Action-oriented programmes had much potential for benefit.
- Lacking capacity was a problem, and senior partners tended to over-commit themselves; there is a need to ensure that mid-to-low level organisation capacity can be utilised and developed by programmes.
- Aspects of international development cooperation are problematic. For example, that aid objectives are determined by the agencies without consultation with beneficiary organisations; and initiatives such as the Paris Declaration have largely imposed onerous governance requirements and reduced access to aid (see further above).
- Development cooperation agency funding agendas are pre-determined and almost none appear to include occupational health.
- Funding difficulties are aggravated by, and in turn exacerbate, a lack of regional co-operation and collaboration.

revised and co-ordinated approach to development aid. The Paris Declaration aimed to better manage the process of providing aid; ensure alignment with national development strategies and encourage beneficiary control and leadership in development programmes.

However, there is already recognition of some gaps between the noble promises and the outcomes to date. A 2009 OECD report<sup>2</sup> commented on fragmentation of effort, observing that “the international development effort now adds up to less than the sum of its parts”. Sixteen sub-Saharan countries were noted to have between 24 and 30 external funders, and eight of these to have between 15 and 20 external funders, suggesting that the rationalisation intentions of the Paris Declaration have not been met.<sup>2</sup>

Despite the promise of better co-ordination, the Paris Declaration has also left a significant gap in partnership on occupational health, notwithstanding the recognition of the contribution of employment and workplace risks to health equity in the recent report of the WHO Commission on the Social Determinants of Health.<sup>3</sup> Funding for occupational health does not seem to be on the agenda of any major bilateral funder (excluding foundations such as the Fogarty International Centre at the US National Institutes of Health whose focus is on research or capacity building for research). Given previous negative experiences of early termination of long-term external funding support to occupational health in the region in the 1990s, the Paris Agenda offered optimism for sustained predictable support to this neglected area. Instead, WAHSA as well as SALTRA met early termination, as the funding agency realigned from regional to country support. If there was cooperation and coordination between the donors one would expect that the Swedish donor had negotiated with other donors to take over the support for the sectors, countries and regions that Sweden left in order to concentrate in fewer sectors and countries. However, we have not been able to trace such information and formal negotiations do not seem to have taken place.

## WAY FORWARD

The African countries should improve their own resources for occupational health, not only to run the systems, but also to enhance and improve them. A focus on equity implies pursuing “fair trade not aid”, and occupational health could be funded in a sustainable manner from improving returns on economic activities and strategic resources in the region. During the structural adjustment era, occupational health responsibilities were deregulated and corporate obligations and taxes reduced to attract foreign investment (which often did not materialise). Claims for improved public funding for the health sector have had greater recognition, such as in the 2001 Abuja commitment made by African heads of state.<sup>4</sup> However, 8 years later, most countries in the region have failed to meet their Abuja targets. Further, specific recognition for improved regulation and funding for occupational health is still absent. Yet, as production and financial activities are increasingly globalised, with recognition of

the environmental, economic and social obligations this generates, so too should investment in occupational health be prioritised and located as a matter of international responsibility, in line with fair trade, economic justice and rights to health.

It is time for a movement from within and beyond the trade unions, occupational health, economic and trade justice communities, to link with the public health and health justice activists to raise occupational health within global, regional, national and local agendas. To support this with sustained and self determined action within the region, there is a need to strengthen regional organisation and networking to provide evidence for and engage with local and regional policy-makers, including with intergovernmental forums such as SADC, to ensure sustainable domestic and regional resourcing of occupational health, and to advocate on the priorities for occupational health in the region within the international community.

Significant advances have been made in OH&S in southern Africa through the WAHSA Programme. A great deal has been learnt about the complexities of running regional programmes. It is a significant setback that the programme has been cut short, and particularly at a time when funding has become more difficult to access given the current global economic climate.

However, the programme to date has afforded the opportunity of participants to be involved in a range of projects, a programme and a network that they would not otherwise have had. All involved have learnt through their participation, and have established relationships within and between the participating regions that will support and sustain their further work in this field of work. Many of the regional participants have moved to more senior leadership roles in local and, in some cases, international institutions.

The WAHSA website will be taken over and managed by National Institute for Occupational Health in the Republic of South Africa. It has also expressed commitment and continued support for regional activities in line with the WAHSA concepts. It is hoped that alternative funding for at least some of the projects can be procured before critical momentum achieved in the programme to date is lost.

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