

## Occupational Health and Safety: Key Issues and Concerns in Ghana

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### Abstract

*According to the World Health Organisation (WHO) poor occupational health and reduced working capacity of workers may cause economic loss up to 10-20% of the Gross National Product of a country. In countries like Ghana with fast growing workforce coupled with a growing informal sector, workers have tended to fight for job security neglecting the need for quality work life. It is argued that poor countries and companies cannot afford safety and health measures. However, there is no evidence that any country or company in the long run would have benefited from poor safety and health. This paper examines occupational health and safety (OHS) issues in Ghana and reveals the lack of a comprehensive OHS policy, poor infrastructure and funding, insufficient number of qualified occupational health and safety practitioners, and the general lack of adequate information as among the main drawbacks to the provision of occupational health and safety services.*

**Keywords:** Occupational health and safety, Ghana, Fundamental rights, Workforce, Globalization, Quality of work life

### 1.0 Introduction

*“Safety and health at work is not only a sound economic policy - it is a basic human right” (Kofi Annan, Former UN Secretary General).*

The right to life is the most fundamental right. Yet every year 2.2 million 2005 men and women are deprived of that right by occupational accidents and work related diseases (ILO, 2005). By conservative estimates workers suffer 270 million occupational accidents and 160 million occupational diseases each year (ILO, 2005). This is perhaps just the tip of the iceberg, as data for estimating nonfatal illness and injury are not available in most developing countries (DCPP, 2007). Occupational injuries alone account for more than 10 million Disability-Adjusted Life Years (DALYs) lost, or healthy years of life lost whether to disability or premature death, and 8% of unintentional injuries worldwide (DCPP, 2007). Poor occupational health and reduced working capacity of workers may cause economic loss up to 10-20% of the Gross National Product of a country (WHO, 1994). Globally occupational deaths, diseases, and illnesses account for an estimated loss of 4% of the Gross Domestic Product (Takala, 2002).

According to the World Health Organisation (WHO), a substantial part of the general morbidity of the population is related to work (WHO, 2006). This assertion, though frightening, is not surprising as workers represent half of the global population and contribute greatly to the economic and social value of contemporary society (WHO, 2006). Indeed, people spend a significant portion of their lives at work with their jobs often bringing meaning and structure to their lives (Jahoda, 1982). Because work is a central part of many people’s lives, it generally is recognised that individuals should have a safe and healthy working environment (Warr, 1987). According to the WHO Health for All principles and ILO Conventions on Occupational Safety and Health (No. 155) and on Occupational Health Services (No. 161) every worker has the right of access to occupational health and safety services, irrespective of the sector of the economy, size of the company, or type of assignment and occupation. The Rio Declaration on environment and development (1992) also states that “human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature.” Clearly the ability to enjoy a safe and healthy working environment is an important part of a sustainable future.

To date, occupational health has not attained a high profile in the sustainable development agenda particularly in developing countries where most people are engaged in primary industries such as agriculture, logging and mining. Although the right to health and safety at work has been stipulated in the Constitution of the WHO and ILO and is supported by a number of other United Nations documents, no country has so far been fully successful in achieving this objective for all workers. Hence occupational health infrastructure and programmes should be further developed in every country employing a non legislative approach to supplement any existing legal requirements.

### ***1.1 Occupational health and safety defined***

Health is a positive concept that includes social and personal resources as well as physical capabilities (Nutbeam, 1990). It has been conceptualised as the ability to have and to reach goals, meet personal needs and cope with every day life (Raphael, Brown, Renwick & Rootman, 1997). The WHO defines health as not just the absence of disease but as a state of complete physical, mental and social well being (WHO, 1986). A joint definition of occupational health endorsed by the ILO and WHO (as revised in 1995) states that:

*“Occupational health should aim at: the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the workers in an occupational environment adapted to their physiological and psychological capabilities; and, to summarize : the adaptation of work to man and of each man to his job” (WHO, 1995: 3)*

Thus occupational health has gradually developed from a monodisciplinary risk-oriented activity to a multidisciplinary and comprehensive approach that considers the individual’s physical, mental and social well-being, general health and personal development (WHO, 1994). The above understanding coupled with the fact that at the core of every business is man whose output is partially dependent on his state of health, an appreciation of the concept of occupational health and safety becomes imperative to the success of any organisation.

Occupational health and safety (OHS) is a multidisciplinary concept touching on issues relating to such disciplines as medicine, law, technology, economics and psychology (Leka, 2003). As a broad based concept, occupational health and safety encapsulates the mental, emotional and physical well-being of the worker in relation to the conduct of his work. This therefore makes it an important discipline contributing to the success of any organisation. However, considering the multiplicity of disciplines subsumed in it, it has been treated as a “throw-away” subject with all the other disciplines such as law, economics, medicine, technology, psychology among others feasting on it when “hungry”. Thus not only do the various disciplines focus on aspects of the concept but they also make reference to it only during critical situations. For instance, the law discipline makes reference to the concept only when employers are to pay compensations for health and safety failures.

Traditionally, the focus of OHS initiatives has been on chemical, biological and physical exposures or hazards, diseases, disorders and injuries related to or affecting work, while psychosocial risks at work are still largely neglected and their causes and consequences still insufficiently understood especially as they pertain in the developing country context (WHO, 2007). However, health issues involving the physical space of work; types of occupation and their effect on health; job stress, work schedules, and other psychosocial issues in the work environment affecting work (Warr, 1987) are all being given some attention in recent OHS initiatives particularly in developed countries. According to the WHO, all workers have the right to healthy and safe work and to a work environment that enables them to live a socially and economically productive life (WHO, 1994). This statement puts the human life at the centre of all productive activities, which must not be compromised at any cost.

### ***2.0 Importance of OHS***

It is in the interest of workers and their representatives to earn a living, and also to reach old age in healthy conditions (WHO, 2007). These interests are not contradictory but complementary to company interests. Organisations have traditionally evaluated their health in terms of the bottom line (Robin, 2003). However, with past research uncovering enormous financial and human costs associated with unhealthy organisations (Cooper, 1994), human resource professionals have begun to position healthy workplace programmes and activities as a source of competitive advantage to curtail increasing health care costs; assist in the attraction, acquisition and retention of employees; better manage the employer-employee relationship; meet the needs of an increasingly diverse workforce, and boost employee morale (Fulmer, Gerhar & Scott, 2003; Jaffe, 1995; Pfeffer 1994).

The goal of many organisations has been to avoid being unhealthy as opposed to optimizing health. There is however, a growing recognition that financial health correlates with investments in employee well-being (Goetzl, Guindon, Turshen & Ozminskowski, 2001), a condition which is gradually putting health and safety issues at the front end of work, job and organisational design efforts. Indeed, the costs of unsafe, stressful and unhealthy workplaces are horrific in personal, economic, and social terms (Kelloway & Day, 2005) and therefore require immediate attention.

The past decade has witnessed an increasing number of publications addressing interventions aimed at preventing work-related illness and injury and employee health. The rising interest and investment in workplace health promotion raises no questions as a cost benefit analysis of the subject matter is more likely to go in its favour - an affirmation of Frost and Robinson's (1999) assertion that many business scholars are recognising the importance of healthy organisations and healthy people. For instance, a 2007/2008 survey by the Health and Safety Executive (HSE) on work-related illness estimated 34 million lost work days; 28million due to work related illness and 6 million due to workplace injury (HSE, 2009). Translating this in monetary terms means an erosion of a chunk of the profit margins of organisations. Jones, Hodgson, Clegg and Elliot (1998) in a similar study reported that 14% of the people in the United Kingdom who retired early did so because of ill-health and part of these ill-health conditions were believed to be the result of working conditions or at least made worse by working conditions. The belief that manpower is expandable (Stout, 1974) and that organisations can afford to lose some of their personnel only to be replaced in no time appears to be a thing of the past. Organisations no longer can afford to lose experienced and committed employees through ill-health caused by unhealthy working conditions as the cost of recruiting, selecting, developing, motivating and retaining new employees who take over from experienced employees lost through work related ill-health remains incalculable.

OHS therefore remains an important consideration for all organisations, particularly organisations engaged in high risk operations like the mining, logging and construction industries. Good OHS practices not only provide a safer working environment but also improve worker morale and productivity (ASCC, 2006). By pursuing good OHS practices, businesses face fewer workplace injuries and benefit from higher employee retention rates and enhanced corporate image. This reduces the costs associated with production delays, recruiting new staff and replacing equipment and avoids the resulting uncertainty and workload pressure placed on co-workers (ASCC, 2006). Businesses who strive to improve their OHS performance create safer workplaces, which benefit not only employers and employees but their families, their communities and their economies at large. This is evidenced by the effect of the Longford gas explosion in 1998, which left the state of Victoria in Australia without its primary gas supplier for 20 days. As natural gas was widely used in houses in Victoria for cooking, water heating and home heating, many families endured 20 days of cold showers and cold nights. Further loss to industries as a result of the crisis was estimated around 1.3 billion Australian dollars (Hopkins, 2001). The growing importance of the concept has led to some scholars advocating for it to be considered as a performance variable much like production, profits, sales, quality control or customer complaints (Kivimáki, Kalimo & Salminen, 1995).

Considering that working adults spend at least a quarter to a third of their waking life at work (Harter, Schmidt & Keyes, 2003) and the fact that job satisfaction is estimated to account for a fifth to a quarter of the satisfaction in adults (Harter et al., 2003), OHS issues in organisations, that include the emotional, physical, chemical and biological exposures of work should be of interest to all employers.

National economies also enjoy the benefits of a thriving OHS policy as the benefits accrued to industries tend to trickle down in the form of taxation and a reduction on other social services (e.g., health care facilities, social support benefits). A high standard of OHS correlates positively with high GNP per capita (WHO, 1994). The countries investing most in occupational health and safety show the highest productivity and strongest economy, while the countries with the lowest investment have the lowest productivity and the weakest economies (WHO, 1994). Thus, active input in occupational health and safety is associated with positive development of the economy, while low investment in occupational health and safety is a disadvantage in the economic competition.

### **3.0 Globalisation and OHS**

Globalisation, which involves the increasing integration of national economies into a world market (Taqi, 1996) also, involves major changes and redistribution of work and reorganisation and relocation of enterprises (Rantanen, 2001) all of which can affect the health and safety of employees. Globalisation leads to changes in production models, enterprise models, and structure of enterprises and also changes in technology (UNRISD, 2004).

Changes in production models lead to changes in working environment in terms of both better and worse conditions (UNRISD, 2004). The stress of global competition may lead employers to view the prevention of occupational injuries and the protection of workers' health not as an integral part of quality management but as a barrier to production, trade and commerce. This is further expressed by Goldstein, Holmer and Fingerhut (2001) who indicate that the global burden of occupational disease (Murray & Lopez, 1996) and work-related injury (Takala, 2000) remains unacceptably high because the majority of the world's workforce is still not served by occupational health services (Goldstein *et al.*, 2001). According to Alhasan and Partanen (2001), the global corporate policy is not favourable for financing health facilities and safety services in many developing countries due to other pressures in global competition. It is however, not acceptable for employers to derive competitive advantage through economies in the areas of health and safety and well-being of employees (Stiglitz, 2001; Stokke 2001). This could lead to the global figures on occupational diseases and work-related injuries soaring further.

Occupational disease has become by far the most prevalent danger faced today by people at their work (WHO, 2006). A new assessment of workplace accidents and illness by the ILO (2005) indicates that occupational disease accounts for 1.7 million annual work-related deaths and outpaces fatal accidents by four to one. Thus the focus of OHS is gradually moving from occupational accidents to occupational diseases. This shift in trend perhaps tells of:

1. The recent trend in global industrialisation;
2. The over concentration of efforts in the area of occupational safety to the neglect of occupational health in the past;
3. The gains made in the area of occupational accidents

New work-related hazards and diseases have emerged in some countries as a result of globalisation. In Vietnam just like all other developing countries for example, many new chemical substances have been introduced in industries such as organic solvents in the footwear industry and pesticide use in agriculture. It is estimated that there are 5000 – 10,000 commercial chemicals that are toxic, of which 150-200 chemicals are known as possible causes of cancer (Vu Nam, 2000). Other problems linked with globalisation are unemployment and the precariousness of working conditions due to new systems of work organisation and liberalisation of the industrial relations (Rantanen, 2000). Due to globalisation and its resultant changes in the nature of work, people in developing countries have to deal with increasing work-related stress (WHO, 2007). In industrialised countries however, people are becoming more familiar with what work-related stress is and how to manage it (WHO, 2006; WHO, 2003), a situation which may not yet be the case in developing countries.

New estimates by the ILO (2005) suggest that the number of job-related accidents and illnesses, which annually claim more than two million lives, appears to be rising because of industrialisation in some developing countries. Globalisation leads to subcontracting and flexibility, which may cause a further compromising of health and safety standards in many developing countries (Holkeri 2001). Indeed, industrialisation in developing countries, which is a product of globalisation, is a much welcome phenomenon in principle but with its associated health related problems many will soon wish it never came. Despite significant improvements in health and safety in many parts of the world over the past several decades, the global challenge of providing for worker health and safety is ever greater today (ILO, 2005). The International Commission on Occupational Health (ICOH) in its centennial declaration in Milan also stated that: "In spite of the impressive progress made in the improvement of health, safety and social conditions of work, in the industrialised countries, the need for occupational health and safety is as evident as it was 100 years ago.

While the nature of the problems, hazards and risks has changed, the traditional hazards and particularly the new problems of work life still need much expert knowledge, research, training and information in order to be controlled, managed and prevented" (ICOH, 2006). These emotional statements further express the frustration faced by health and safety experts and other researchers engaged in finding an antidote to OHS related problems in the developing world. This challenge has arisen perhaps because of the rapid industrialisation taking place in the developing world as a result of globalisation. The globalisation process has not succeeded in equalising the condition of work, in fact, the opposite has occurred; the gaps are increasing. Poverty, inequality and under-development are closely associated with poor safety, health and social conditions of work, as they are also linked with illiteracy, lack of education, poor access to health services and low or non-existent social protection (ICOH, 2006). Thus globalisation and its associated changing nature of work has made the management of OHS more challenging than ever. The majority of the developing countries have very poor investment in research and still have many unsolved problems (WHO, 2007) particularly in the area of OHS and the changing nature of work.

This explains the dearth in generating proper data and evaluating the impact of the changes at work. The situation is quite disturbing in the face of WHO figures showing that about 75% of the world's labour force (which counts about 2400 million people) live and work in developing countries (WHO, 1994). Developing countries like Ghana who are at the receiving end of industrialisation especially in the mining and minerals sectors; classified as hazardous industries (Gyekye, 2003), therefore present an avenue for an exploratory study on OHS, quality of life and employee well-being.

#### **4.0 The case of Ghana**

The African continent is witnessing a verifiable shift towards peace, stability and economic growth. This situation is making the world appreciate West-Africa for its significant investment opportunities. Ghana is one such country in the sub-region experiencing rapid industrialisation in recent times.

Industrialisation as discussed above comes with its own problems, one of which is OHS. In countries like Ghana with a fast growing labour force coupled with a growing informal sector as opposed to the formal sector, workers have tended to fight for job security while neglecting the need to promote the quality of work life, although the provision of a safe and healthy work environment is a human right issue, and investment in occupational health and safety yields improved working conditions, higher productivity and better quality of goods and services. A commonly used argument has been that poor countries and companies cannot afford safety and health measures. However, there is no evidence that any country or company in the long run would have benefited from a low level of safety and health. On the contrary, studies by the ILO based on information from the World Economic Forum (2002) and the Lausanne Institute of Management IMD demonstrate that the most competitive countries are also the safest. Selecting a low-safety, low-health and low-income survival strategy is not likely to lead to high competitiveness or sustainability (ILO, 2003).

Lack of comprehensive OHS policy, poor infrastructure and funding, insufficient number of qualified occupational health and safety practitioners, and the general lack of adequate information are among the main drawbacks to the provision of effective enforcement and inspection services in most African countries (Muchiri, 2003). The Republic of Ghana epitomises the above assertion in its entirety.

In spite of the numerous investments that the country attracts with its accompanying OHS related issues, Ghana as a nation still has no national policy on OHS. A draft occupational services policy jointly developed by the Ministries of Manpower Youth & Employment, Health and Lands, Forestry & Mines as far back as the year 2000 is yet to be adopted. The governments of Ghana, past and present, have not shown any political will, commitment and support for bold occupational health and safety policies. This is evident in the fact that out of over 70 conventions/recommendations of the ILO that are OHS related, only ten have been ratified by the government of Ghana (i.e., Conventions 45, 81, 89, 90, 103, 115, 119, 120, 147 & 148). Surprisingly the four core conventions on occupational health and safety (i.e., Conventions 155, 161, 170 and 174) have all not been ratified. Though the recently promulgated labour Act 2003, Act 651 has a section which covers OHS (i.e., Section 15), it is amazing that the very tenets on which the section is built (i.e., ILO Conventions 155 and 161) have not been ratified by the government as yet. Indeed, the ratification of ILO conventions cannot be said to be the panacea to the numerous OHS issues that confront today's organisations. However, it sends a strong and clear message to investors and employers that the country attaches some importance to issues of OHS. This kind of message is bound to reflect in their commitment and approach towards OHS when in operation. The reverse is also a possibility.

Two main statutes have informed the execution of OHS in Ghana. These are the Factories, Offices and Shops Act 1970, Act 328 and the Workmen's Compensation Law 1987, PNDC Law 187. The main provisions of the Factories Offices and Shops Act 1970 concerns improvements necessary to attain internationally accepted standards of providing for the safety, health and welfare of persons employed in factories, offices, shops, dock work and construction. Missing in the coverage of industries under the Act is the vast majority of industries including agriculture, and most of the organisations under the informal sector. Provisions in the Act are also very limited in scope providing inadequately for prevention. Preventive strategies like risk assessments, medical surveillance and control of hazards are not for instance catered for in the Act. Also missing in the Factories Offices and Shops Act are standards against which services will be measured. The lack of uniform standards against which organisations could be evaluated has resulted in factory inspectors assuming a lot of discretionary powers and falling to the temptation of abuse of power. Apart from the Radiation Protection Convention, 1960 (No. 115) ratified in 1961, there are no regulations and rules for certain classes of hazardous work situations such as agriculture, construction and others. This makes it more difficult for employers to comply with laws and further add to the discretionary powers of inspectors.

The Workmen's Compensation Law 1987 provides for the payment of cash compensation by an employer to an employee in the event of injury resulting from accident on the job and in the event of death, payable to dependants through the courts. The question that many have asked in the past and continue to ask is: what amount of money can compensate for the loss of a limb or at worst a loved one? Compensations as prescribed by the Workmen's Compensation Law bear no relation to the level of risk to which workers are exposed. In fact, the prosecution and court processes associated with compensation cases are laborious and time consuming for the meagre amounts prescribed by the laws. This may imply that laws are not just a cosmetic decoration for employers but somewhat unnecessary. Some organisations in Ghana still operate under the assumption that the protection of limb and life should be a reason sufficient enough for workers to behave safely. Hence they tend to trample flagrantly on the rights of employees by not providing adequate health and safety protection. Indeed, many are the organisations that operate under the assumption that the provision of personal protective equipment is sufficient to prevent occupational accidents. Other statutes that have bearing on OHS in Ghana are the Mining Regulations 1970, LI 665, the Environmental Protection Agency Act 490, 1994, the Ghana Health Service and Teaching Hospitals Act 526, 1999, Ghana Aids Commission Act 613, 2002 and the Labour Act 651, 2003.

Facilities for providing occupational health services in Ghana consist basically of government and private and faith based health facilities in the communities. However, a few companies have their own facilities that cater for the health and safety needs of their employees. Services provided by the existing facilities are very limited as compared to those prescribed by the ILO Convention No. 161 on Occupational Health Services. Primary medical care is the norm with the provision of basic curative care and first aid becoming the order of the day. With the exception of a few multinational companies who undertake comprehensive preventive occupational activities, (i.e., medical surveillance, risk assessment, worker education on HIV/AIDS prevention programmes) these are grossly lacking in the country.

The key staff represented in the country's occupational health services are the typical health care workers found in health institutions (i.e., doctors, nurses, and paramedics). Seriously lacking in the country are professionals specifically trained in the area of occupational health. Records from the Ghana Health Service (GHS) indicates that there are only four occupational health physicians, one occupational health nurse and 34 trained factory inspectors (GHS, 2007). The situation is further compounded by the absence of institutions that offer the requisite training programmes in the area. The School of Public Health at the University of Ghana, which was established in 1994 with the mission to train public health practitioners who will be leaders and change agents for health development in Ghana in particular and in the wider African context is still struggling to institute an occupational health programme. Capacity building, a prerequisite for obtaining the right calibre of staff to man occupational health services, remains a major challenge in Ghana. The above description of the state of occupational health services in Ghana reflects the safety culture of the nation; "All die be die" to wit every death is ordained. Thus in a poverty stricken country like Ghana, people are prepared to sacrifice their lives to earn a living. This, considering the large investment inflows into the country in the area of mining and construction (two hazardous industries) should raise concern for researchers and policy makers in the country.

### **5.0 Conclusion**

Occupational health and the well-being and quality of life of working people are crucial prerequisites for productivity and are of utmost importance for overall socio-economic and sustainable development (WHO, 1994). Health at work and healthy work environments are among the most valuable assets of individuals, communities and countries. Occupational health is an important strategy not only to ensure the health of workers, but also to contribute positively to productivity, quality of products, work motivation, job satisfaction and thereby to the overall quality of life of individuals and society (WHO, 1994:2). In spite of this, conditions at work and in the work environment of many organisations in Ghana still involve a distinct and even severe hazard to health that reduces the well-being, working capacity and even the life span of working individuals. According to the WHO (1994) workers in the highest risk industries such as mining, forestry, construction and agriculture, which employ about 80% of workers in the developing world are often at an unreasonably high risk and one-fifth to one-third may suffer occupational injury or disease annually, leading in extreme cases to high prevalence of work disability and even to premature death. Most of these disabilities and morbidities are preventable with the help of modern occupational health approaches. However, they go undiagnosed, unreported and as such incremented. OHS hazards which are common in many developing countries including Ghana persist partially because of the one-sidedly ambitious economic programmes instituted by governments, non-existent or low coverage of legislation and inspection, non-existent or weak infrastructure for monitoring and services, and a universal shortage of expert manpower and institutions for occupational health

The damaging effects of occupational hazards, most especially in primary industries as agriculture and mining on individuals, organisations and economies at large and potential benefits that may be accrued through the elimination of these hazards as discussed above, calls for the need to raise awareness and encourage the execution of effective OHS policies and practices amongst governments and organisations respectively.

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