

The Burden of Asbestos-Related Disease in South Africa and the Struggle for Prevention and Compensation

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Abstract

Asbestos mining in South Africa started around 1895 and continued until 2001. The shrinking international asbestos market resulted in a decline in production from 1978 onwards. The National Union of Mineworkers (NUM), concerned about high levels of exposure and disease, organized for audits of surveillance programmes at various asbestos mines.

Screenings involved review of occupational and medical histories, chest radiographs and spirometry. Chest radiographs were read using the standardized International Labour Organization (ILO) classification for pneumoconiosis. Lung function tests were interpreted using the American Thoracic Society (ATS) criteria. Records of more than two thousand workers in crocidolite, amosite and chrysotile mines were reviewed over an 8 year period. Prevalence of asbestos-related disease (ARD) amongst retrenched workers ranged from 21-39% (crocidolite mines); 26-36% (chrysotile mines) and 37% in one amosite mine. Workers were also exposed to asbestos in the transport, construction, asbestos-cement, motor, energy, textile and waste-disposal industries. In addition, community members have been exposed to asbestos because of the extensive contamination of the environment. Given the epidemic proportions of ARD among exposed workers and surrounding communities, the Parliamentary Asbestos Summit was convened under the auspices of the Department of Environment and Tourism (DEAT) in the National Parliament of South

Africa (1998). All major role-players were involved, and practical recommendations were made to address the asbestos epidemic. The DEAT recently announced in Parliament that asbestos use will be prohibited and will be phased out over three to five years for products where no current alternatives are available.

Trade Union and civil society organizations as well as litigation have been important in attempts to address the asbestos legacy of injustice, poverty, inequality and disease burden left by apartheid.

Future intervention challenges include further implementation of the Asbestos Summit recommendations; developing responsive models of health service delivery for asbestos sufferers; improving the quality of life indices (education, skills level, employability, income, social security, health) of affected individuals; adequate funding and resource allocation for sustainable development programmes and further environmental rehabilitation and preventive measures with community participation.

1. Historic Factors and Asbestos-Related Diseases (ARDs)

The mining of asbestos has played an important role in the industrial development of South Africa. The mining activities generated wealth for the mining companies but resulted in extensive exposure of workers and communities to asbestos dust. The historic stratification of South African society along class and racial lines, land dispossession, gender differentials and the migrant labour system influenced the pattern of health outcome.

South Africans from all socio-economic backgrounds have paid a heavy price with their health for the negligence of companies and the apartheid government with regards to occupational health and safety (OHS) practice. However, given the legacy of the past system of gross inequality, the previously disenfranchised and poor majority carry a disproportionately large burden of preventable ARDs caused by inadequate dust control measures. This was aggravated by differential and unequal availability of diagnostic, health, medical surveillance and compensation services to address the diseases caused by unsafe and unhealthy industrial processes.

There was extensive industrial asbestos contamination of the environment with resultant further exposure of entire communities. This is demonstrated by the hundreds of un-rehabilitated or partially rehabilitated asbestos mine dumps scattered throughout large parts of the country. These dumps are usually close to where communities live. A visit to the previous mining areas today, tells a sad tale of extensive environmental asbestos pollution far beyond the operation of the mines. Debilitating ARDs have reached epidemic proportions in former mining and labour sending areas (called homelands under apartheid). The result is poor quality of life of the affected workers and community members. The ill-health caused during the unjust economic and social system of apartheid continues to be an enormous drain on the

Public Health resources of the new democratic South Africa. More so since ARDs have a long latency period and many of the companies have closed their operations.

Asbestos dust exposure is ongoing not just in the mining and associated industries but in the construction, ceramic, motor industries as well as in the informal economy. Transport workers have been exposed in the past and remain at risk as we still import asbestos-cement products and export asbestos for neighbouring countries through our harbours. Construction workers remain at risk because of the use of asbestos-cement products in the building of mainly “low-cost houses”.

Asbestos was used extensively in the building industry in the past and many homes, schools, libraries, hospitals and other public buildings have asbestos in place. Exposure takes place when the asbestos-cement products become friable with age and acid rain and the asbestos fibres become airborne when installations, renovations and/or changes are made to the buildings. Harvesting of rain water is a common practice especially in rural communities. Asbestos-cement roofs and water storage tanks therefore continue to pose a risk to health.

2. Unemployment and Socio-economic Factors

Over the past two decades there have been ongoing asbestos mining job losses in four provinces. Several towns in these provinces developed as a corollary to the development of mines and associated mining activities. The decrease in mining activities in these provinces had an impact on the economic growth, industrial development and job opportunities in surrounding communities. The intense scaling down of the asbestos-cement industry resulted in large numbers of workers returning to the Eastern Cape Province which, historically, has been a major labour-sending area under the migrant labour system.

Some of these towns and community settlements have imploded since the closure of the mines with no alternative employment opportunities in place. The majority of the asbestos workers in mining and non-mining operations have lost their jobs even though it should have been possible to save jobs by using alternatives to asbestos or sustainable development programs. Many of these workers find it virtually impossible to obtain jobs in other industries because of their history of exposure to asbestos.

A survey done among more than a thousand ex asbestos mine workers indicated that more than 70% of them live in poverty in underdeveloped rural communities, dependent on a social pension from the new government.

3. Studies Demonstrating High Prevalence of ARDs

Many of the now unemployed asbestos workers developed asbestosis, asbestos-related lung cancer and mesothelioma. In addition, all exposed workers and community

members carry a life-long risk of developing mesothelioma and lung cancer. These diseases are often not recognised as being work related and therefore remain undiagnosed and uncompensated.

In a study of 770 women who worked for former asbestos mines in Limpopo Province, Davies diagnosed 741 women (96.2%) with ARDs. The results suggest that the majority of workers who worked in asbestos mines are likely to develop ARDs with time.

Felix did an in-depth epidemiological study of village communities in the Mafefe area in Limpopo Province where several asbestos tailings dumps have been left by asbestos mine owners. Her study found that more than 40% of villagers suffer from ARDs and that women constitute the majority of those affected. Rehabilitation of the asbestos dumps has not been completed yet.

Studies done by Kisting and Jeebhay among 947 workers exposed to crocidolite asbestos showed the prevalence of ARD for different screening periods to range between 21-39%. The higher prevalence was documented among groups of older long-serving workers.

Several asbestos mines operated near the town of Prieska in the Northern Cape. For many years an asbestos mill was operational in the centre of the town. The mill closed in 1970 but the extensive contamination of the environment continues to take a toll on families. Crocidolite asbestos containing materials were used in constructing homes, streets and public facilities. A community survey done in 1997 by Randeree et al estimated that at least 25% of a population of 15,000 in Prieska suffer from ARDs. An active asbestos community support group has been established in the town.

The last operating amosite mine closed in 1992 and 591 workers were retrenched. Abdullah and Jeebhay found an ARD prevalence of 37% among workers at the time of retrenchment.

Kisting, Jeebhay et al assessed the records of more than 1200 retrenched workers exposed to chrysotile asbestos in Mpumalanga Province. This was done as audits of medical surveillance programmes requested by the National Union of mineworkers (NUM) between 1995 and 2000. They found that between 24-36% of retrenched workers suffered from ARD.

Roberts examined the effects of asbestos mining in Sekhukuneland and reflects on the social impact of the asbestos tragedy on the lives of members of the poor rural community.

4. Compensation and Social Security – companies pay far too little for causing work-related diseases

The need to apply for compensation for a sick worker is an indication that the system of workplace control measures to protect OHS has failed. Compensation tends to address the symptoms of an industrial system that has failed to prevent disease and in essence provide a type of insurance for employers. Compensation per se is therefore not the only solution to the high prevalence of ARDs. **The failure of the system of prevention at workplace level should be addressed as a matter of urgency.** Compensation, however, is essential for workers made sick by work; it should be adequate and cover medical, rehabilitation and palliative care costs. The compensation system should be accessible and transparent and should have adequate human and financial resources to deal with the magnitude of the problem.

The studies listed under section 3 amply demonstrate the high prevalence of ARDs in South Africa. Given the lack of appropriate unemployment insurance, access to compensation payments is often the only source of income for former asbestos workers. However, in order to receive compensation, ex workers must be correctly diagnosed. This in turn is dependent on a good level of awareness about ARDs, appropriate training of health service providers and an efficient, empathetic compensation system.

Even if those living with ARDs are compensated, the amounts paid are totally inadequate and range between ZAR25,000 and ZAR85,000. Companies pay inadequate amounts into the Compensation Fund, particularly for miners. Unless companies pay more money into the Fund the provision of compensation will always remain inadequate and waiting periods long. The current problems with compensation is a clear example of how it was actually cheaper for the asbestos industry to have made people ill and pay towards compensation rather than put preventive measures in place.

There is a great need for active intervention to improve the quality of life of people already affected, for ways of ensuring sustainable development and intense efforts to prevent further exposure of current and future generations. In addition, it is essential to develop greater diagnostic and research capacity among health service providers (at primary, secondary and tertiary level) to ensure a measure of redress via adequate diagnosis, compensation, rehabilitation and palliative care.

5. Access to Health Services – the Public Health service provides the care for work-related ARDs

The Department of Health (DoH) has played a central role in attempts to address the problem of ex-miners at provincial and national level. The White Paper on Health of

the DoH specifically states that the health needs of ex-mine workers should receive special attention. The Benefit Medical Examination (BME) programme of the DoH has over the past few years greatly improved access of ex-miners to post-employment medical surveillance. In spite of this major achievement with regards to the certification process, the impact this has had on the quality of life of those suffering from ARDs is limited by the small amounts paid out for compensation.

The Public Health service carries the responsibility of caring for the majority of workers suffering from ARDs. The Public Health service is therefore spending limited resources on work-related diseases that should be taken care of by companies and appropriate levies paid by them.

6. Women and Children

Even though legislation in the past prohibited women from being employed underground and children under the age of 16 from working in mines, women and children were employed in asbestos mines as cobbers, sorters and domestic workers. The result is those who became sick because of exposure, bear the additional burden of having to prove that they actually worked for a particular mining company. The previous South African government facilitated the employment of women and children by granting exceptions for the employment of women and minor children with parental permission.

There are therefore large numbers of women and those who were exposed as children (men and women) suffering from ARDs who have no proof that they have a legitimate claim for compensation either under the ODMWA or should they wish to go the litigation route.

7. Environmental Contamination

The asbestos mining industry in four provinces left behind more than 150 known asbestos tailings dumps in mainly rural areas. Communities living near these dumps have been exposed on an ongoing basis since many of the dumps have not yet been rehabilitated. By 1998 the Department of Minerals and Energy had already spent over ZAR100 million on rehabilitating derelict and ownerless asbestos mines and estimated that much more is still needed to complete this task.

There are women and men suffering from ARDs, who have never been employed in jobs considered to be risk work under the Occupational Diseases in Mines and Works Act (ODMWA). Their exposure is considered to be related to the extensive environmental pollution caused by industrial activities. Unfortunately they are not eligible for compensation under the current version of the ODMWA and this has a further adverse effect on their quality of life.

8. Asbestos in Homes, Schools, other Public Buildings and Disposal of Asbestos Waste

There are thousands of homes where asbestos-cement products have been used in the construction process. The risk to health has not been assessed in this area. The new Asbestos Regulations (2002) begin to address this important issue. An asbestos register for buildings has been started and there are efforts to ensure greater control measures to protect workers and communities.

The disposal of asbestos containing materials continues to constitute a risk to health both for workers in the waste disposal industry as well as communities living near disposal sites. The new Asbestos Regulations (2002) of the Department of Labour should help to address the problem.

9. The role of Litigation

Asbestos exposed workers and community members in South Africa, with the support of the National Union of Mineworkers, instituted court cases against Cape Plc in London and against GEFCO and GENCOR in Johannesburg. After prolonged legal battles a total amount of ZAR121 million rand was to be paid to more than 7,000 Cape Plc workers. Gencor/Gefco agreed to pay an amount of ZAR448 million into a Trust Fund for settlement of claims against them. This Trust Fund has to be in operation for the next 25 years. These are commendable victories.

These major victories cannot compensate for the injustice, poverty, pain and suffering the asbestos exposed people have been subjected to. The litigation process, however, sends a powerful message to multi-national companies that they will not go unchallenged for causing ill-health and contamination of the environment in their pursuit of profits. The money also makes it possible to assist with strengthening the infra-structure to provide medical and social support beyond the compensation for the individual.

10. The future

The magnitude of the asbestos epidemic requires collective, inclusive and decisive actions including the following:

- ensure companies pay adequate compensation for the true cost of causing ARDs and contaminating the environment;
- address asbestos-related poverty, ill-health and poor quality of life;
- stop the import of asbestos-cement products;
- prevent asbestos exposure to current and future generations;
- stop the import of asbestos containing materials;
- adequately rehabilitate the contaminated land to prevent further disease;
- plan sustainable development programmes with affected workers and communities.

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