

Contextualising workers' health and safety in urban settings: The need for a global perspective and an integrated approach

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Abstract

This paper focuses on the need to contextualise and to address the neglected occupational health and safety rights of workers in the informal economy. Informal economy workers constitute the majority of workers in most countries and the number of informally employed, unprotected and low-income workers is increasing rapidly in both developing as well as developed countries. National and international policies have not acknowledged the linkages between poverty, employment, working conditions, living environment and health inequities. Information on the scale of the problem and the health impact of worsening informal working conditions is still limited.

However, the occupational health and safety hazards they face are often added to those of poor living environments, poor nutrition and unsatisfactory housing. They are not covered by social protection or comprehensive health care and besides work-related injury and disease, they are commonly affected by poverty-related diseases. The authors argue that the current context of workers' health differs in many aspects from the past. Therefore, conventional occupational health and safety mechanisms, such as norms and good practices enforcement are insufficient to address the challenges that informal work and poor living environments poses for workers and their families. Given the nature of globalisation and urbanisation, an integrated rights-based approach of determinants at various levels and a more people-centred empowerment perspective is needed.

Informal workers' representation, organisation, participation is important for ensuring the right to health of workers in the informal economy. Social mobilisation may prove critical as it did in the past.

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Introduction

The millennium development goals (MDGs) have underlined the multi-dimensional nature of poverty and the connections between health and social conditions, but they have failed to acknowledge the crucial linkage between poverty, employment, working conditions, place and health, as well as the need to address the increasing health inequities and neglected health rights of workers in the context of economic globalisation and urbanisation.

Occupational health and safety concerns are not a priority in the global restructuring of the economy that has taken place over the past three decades. Hazardous industries and work are being relocated to many developing countries. The Bhopal disaster continues to illustrate the potential implications for workers', the environment and the community, particularly in low-income and densely crowded urban settlements (*Permanent Peoples' Tribunal, 1994*). The large majority of workers in developing countries are currently employed in the informal sector of the economy, and they form a particular *vulnerable* group. Known approaches to occupational health and safety (OHS) problems have been developed under the framework of the "formal" or "organised sector" of the economy in high-income countries (where employers and lines of responsibility are more easily identifiable), mostly for the manufacturing industry where chemical or physical risk factors can be identified and controlled. The established frameworks of OHS are unable to protect those working in the informal economy and the need to take the social and environmental context of the workplace and people's health rights (both as worker and as resident) into account has been repeatedly underlined (*Barten, 1993; Barten, Fustukian, & de Haan, 1996; Lund & Marriott, 2005; Marriott, 2006*). These approaches, if looking beyond occupational diseases and injuries to the escalating number of work-related mental or musculoskeletal disorders, also are not longer responding to the workers needs.

Following this introduction, the paper then describes the current features of the wider restructuring of the economic context, as well as some changes in trends that impact on working conditions and worker's health. It continues with a description of the informal economy. The next section examines the health and safety impact of informal working conditions. The following section highlights the need to take a more people-centred perspective and an integrated approach. The paper then addresses the challenge not only to address the immediate, but also the underlying and structural causes at multiple levels. It seeks to underline the need for an integrated approach and a more people-centred perspective, but in particular for social mobilisation to prioritise worker's health rights.

The context of workers' health and safety

Globalisation of the neo-liberal economic system over the past three decades has increased global competition and opened up job opportunities in low-wage countries, lowered the cost of consumer goods in high-income countries, but also resulted in the reduction of wage controls, union protections, and workplace standards. In both poor as well as rich countries there are now more "flexible" work arrangements, fewer institutional protections, and greater job insecurity (*Hogstedt, Wegman, & Kjellstrom, 2007*). On the other hand, the recent waves of economic reforms in many poor countries have added to the complexity of informal labour markets, where high and sustained growth rates are not necessarily accompanied by increased growth in formal employment (*Guha-Khasnobis & Kanbur, 2006*). These changes also imply that a fundamental shift in employment relations and *power* has taken place (*Amable, 2002; Benavides et al., 2000; Benach et al., 2002; Barten, Mitlin, Mulholland, Hardoy, & Stern, 2006*). According to *Scott (2004, p. 143)*, work-related insecurity has become a structural feature and a core value of the new global labour market, while the diminution of worker's power in the new flexibilised relationships has several implications for long-term health outcomes at the individual and societal levels (*Marmot et al., 1997; Schwebel, 1997*). Also, the concept of workplace has become relative, as an increasing number of workers are self-employed, work on the streets or in informal shelters. The large majority of workers in many developing countries are currently employed in the informal economy (*ILO, 2002*) and are unprotected (beyond the reach of established legislation and labour regulation and social security institutions established to ensure the economic and social protection of workers, including OHS).

One of the new challenges of globalisation is the increasing number of transnational urban migration (Balbo and Marconi, 2006; Barten et al., 2006). The most recent estimates (United Nations Populations Division, 2002) of a world total of 175 million international migrants, do not include the rapidly increasing number of undocumented migrants, estimated 15–30 million worldwide. Balbo and Marconi (2006) underline the need for policies that address these issues as most international migrants add to the low-income population, are particularly affected by social and economic exclusion, discrimination and often have no rights to participate in local decision-making processes. A further problem is that they have no rights to health care if they are illegal. It is clear that this is adding to the already complexity of workers health and safety, particularly in poor countries. Migrant workers receive low wages, are not covered by labour and social legislation. Construction work in particular has a long tradition of exploiting migrant labour from lower-wage economies, and has become increasingly insecure and temporary. Workers often live in poor conditions and are exposed to hazardous work leading to serious and entirely preventable health effects. Seventy percent of the world's poor are women (UNDP, 2003) and half of the world's legal and illegal migrants are now estimated to be women (Ehrenreich & Hochschild, 2003). They bear the burden of many adverse health impacts linked to globalisation (Wamala & Kawachi, 2007) and while it enhances their earning power, it also affects their family life's and put them under the threat of exploitation and discrimination.

The world is becoming increasingly urbanised and poverty is becoming an increasingly urban phenomenon. Urbanisation is hardly new and throughout history cities often have provided new opportunities for improving living conditions and health development. According to recent projections, the world's urban population will increase from 2.86 billion to 4.98 billion by 2030, when about 60% of the world's population will live in urban settings. However, high-income countries will account for only 28 million out of the expected increase of 2.12 billion (National Research Council, 2003, pp. 82–83). The rapid growth of the urban population over the past two decades has particularly taken place in some of the less-developed regions of the world, where urbanisation is expected to continue for decades and the growth of squatter settlements often equals urban growth (UN-Habitat, 2006). Although, there are important regional differences—the proportion of the “slum” population in cities is estimated to vary between 5% and 10% (advanced and transition economies), 43% (developing) and 78% (least-developed countries)—poverty is growing and living conditions are deteriorating in *all* cities (UN-Habitat, 2004). The population living in deprived and unplanned urban settlements in low- and middle-income countries is likely to double in less than 30 years (UN Millennium Project, 2005; UN-Habitat, 2003) and the largest cities in the world—*megacities*, with conurbations of over 20 million people—will be concentrated in developing countries (UN-Habitat, 2006). Most of the world's population, however, will continue to live in smaller towns, where urban growth is occurring faster than in megacities.

In many cities, urban services and infrastructure have not kept pace with rapid urbanisation and an increasing proportion of the people in urban areas will live without adequate social infrastructure, especially housing, water supply, drainage and sanitation facilities. While still exposed to the traditional health hazards related to poverty, unemployment, malnutrition, poor shelter and inadequate environmental and social services, the urban poor are also more exposed to hazards related to “modernisation”, unhealthy urbanisation, pollution and unsafe and precarious working conditions. At the same time the lack of social support systems in cities and social exclusion increases the risk of psychosocial problems (Rossi-Espagnet, 1983, 1984). In Sub-Saharan Africa mainly due to the HIV/AIDS epidemic a rapidly increasing number of children is working and living on the streets, while children head many households, social security is absent and public health systems are on the verge of collapse (Foster et al., 1997).

Urbanisation also needs to be examined within the context of the impact of wider social, economic and political changes in rural areas (Castells, 1977; Harvey, 1985), and it is worth noticing that the most rapid pace of urban growth is taken place in Africa and Asia, while these continents were still almost wholly rural in 1950 (Brockerhoff, 2000; Pacione, 2005a). It is beyond the scope of this article to examine the impact of policies applied in the recent 20 years, but the increase of rural poverty, conflicts and environmental disasters all continue to push and pull people into the cities and the impact of climate change probably will only accelerate this (Davison, 2007).

It is however noteworthy that although urban growth rates in Africa are at present twice as high as average and to be compared with growth rates of the towns of 18th and 19th century Europe, there is a critical

difference: rapid urbanisation in Africa is not accompanied by significant economic growth (Auclair, 2005), but by an informalisation of the economy.

This paper argues that the nature of this globalisation and urbanisation have important implications for public health—including occupational health and safety—in particular of workers in the informal economy in developing countries, their families and wider “communities”.

Informal workers

The informal economy comprises a heterogeneous group of economic activities that usually have poor level of organisation and technology, reduced capital and are out of the State control (ILO, 2002). Most firms from the informal economy are small-size, home-based shops, or family business that may involve not only family members but relatives, neighbours or friends either partners or employees (Akinboade, 2005; ILO, 2002; Lund & Nicholson, 2003). Their products are commonly handicrafts, clothing, shoes and food, or services such as electronic or auto repair, food and beverage commerce, cleaning or domestic services (Lowenson, 1998; Lund & Nicholson, 2003). Because of their proximity with the workers domicile or neighbourhood, the informal economy has close ties with the social or family life (Lund & Nicholson, 2003), culture, and sometimes represent ancient cultural traditions (Chattophadyay, 2005; Fonchigong, 2005). According to ILO (2002), informal economy differs from subsistence production because they involve good and services for trade not for their own consumption.

The informal economy concentrates most of the informal jobs, i.e., those that are unregistered, non-regulated and entail informal contracts based on mutual confidence between the contracting part and the provider. These workers are called own-account, ‘day jobs’, *biscateiros* or *cuenta propia*, usually with low payments and no coverage by fringe benefits, social or health protection. They need to be distinguished from the self-employed or autonomous workers whose activities may be regulated, registered, and entitle high-qualified professional activities, such as consultant workers, who may have high payments although social protection is absent or limited. Besides these own-account workers, the informal economy also involves individuals who perform occupational tasks in regular basis for firms, are wage earners, but have no formal job contracts (ILO, 2002). Therefore they also are destitute of labour rights granted to formal workers, such as the before mentioned social and labour protection. It is worth noticing that since informal firms are not registered they are not reached by norms and regulations aimed at to prevent occupational risks and health-related problems. Overall, they are not subjected to safety or occupational health inspections, for example.

Informal workers are not only a feature of the informal economy. Formal firms may have part of their workers illegally unregistered, thus avoiding taxes, the compliance with labour laws, norms and regulation, such as the minimal wage and barriers to firing. Also, formal firms may keep workers from the most dangerous activities unregistered to avoid fines in case of occupational accidents or diseases. Informal employment is all employment without secure contracts and worker benefits of social protection. Precarious employment has also been the focus of a number of studies conducted in developed countries. These represent temporary or contingent job contracts, most of them part-time jobs that may have fewer social and work-related benefits as compared with full-time workers (Quinlan, Mayhew, & Bohle, 2001). A definition of informal employment that encompasses and underlines the perspective of the workers and the level of social protection they have, has in recent years been developed by the Informal Employment Globalizing and Organizing (WIEGO) network with the ILO. WIEGO defines informal employment as “employment without secure contracts, worker benefits, or social protection” (Chen, 2002; Chen et al., 2005).

Informal economy and informal jobs always existed, but after the World War II it became more visible as a dark side of the economy following the flourishing of welfare states in Europe. The so-called traditional sector or underground economy was thought to be a transition step that would be overcome through the expected post-war economic growth and social development. However, this was not the case. Instead, after the 1980s there have been a steady growth of the informal economy and informal jobs throughout the world, reaching several developing as developed countries. It is clear that this growth occurred simultaneously with the advance of globalisation of markets, and the macroeconomic adjustments programs supported by international institutions such as the International Monetary Fund and the World Bank. The most studied consequence of this process is the unemployment, but when there are no available insurance for those who lost

their jobs, the survival strategy will commonly involve the entrance in the informal economy, as a small entrepreneur, own-account self-employed or employee (ILO, 2002). The growth of informal economy and informal jobs cannot be understood as a separate phenomena of the formal economy since one sustain each other and there are explicit integration, particularly when production chains, at national or multinational level, are considered (Lund & Nicholson, 2003). Overall, informal economy is a large and visible part of cities, mainly in degraded poor areas, near slums placed in the outskirts of metropolitan regions and is strongly associated with other dimensions related to work such as child labour, youth or senior workers, gender, ethnicity, and migration (ILO, 2002).

Worker's safety and health

In all these arrangements, informal workers are in disadvantage since State regulation is the most common mechanism used to protect workers rights and to maintain safety and health standards in the workplace environment. Several studies have shown that informal workers stand poor life conditions, a result of low wages or income, and lack or limited access to indirect salaries like health insurance, fringe benefits, and social protection, exemplified by unemployment insurance (Brown, Pavri, & Lawson, 1998; ILO, 2005; Pick, Ross, & Dada, 2002). Low-skilled, less-educated workers, or those having limited occupational training are over represented in the informal economy or informal jobs, which is a result of the chronic limitation of opportunities or limited access to develop human capital faced by poor families (Holland, 1995). In addition, human capital is a strong predictor of social mobility and better life conditions, a mediate factor for better health awareness, health behaviour and access to health resources. Another drawback for informal workers is the limited ability to unionisation, since most of the organised worker movements rely on the legal or formal status of employees, who are eligible to force employers to comply with labour laws. Strong labour unions are recognised as a major factor to warrant safe workplaces, appropriate wage levels and other workers' rights.

The type of workers placement in the labour market is not recorded in most official information systems, therefore occupational-related statistics are scarce while the linkage between hazardous living environments and working conditions is largely under explored. Most of the available knowledge relies on research from developed countries, where the focus is more on precarious jobs rather than informal workers. In a detailed and broad review (Quinlan et al., 2001) of studies on precarious jobs and health outcomes, the large majority of the selected 93 studies showed detrimental effects of precarious jobs on health ($n = 73$, 78.5%). These results did not vary across qualitative or quantitative approaches, or the nature of measures, whether objective or subjective. Findings from studies that have separately addressed self-employment are inconsistent. For example, the British Household Panel Survey showed that small employers and self-employed workers were more likely to have a disabling disease than their counterpart regardless gender differences (Bartley, Sacker, & Clarke, 2004). In other developed countries self-employed workers were also more commonly affected by poor self-perceived health (Dolinski & Caputo, 2003), stress (Jamal & Badawi, 1995) than wage earners. However some studies failed to demonstrate similar results, reporting no association between self-employment and health outcomes (Parslow et al., 2004; Prottas & Thompson, 2006). Results are also inconsistent with regard to occupational health and safety of self-employed workers. For instance, there is no relative excess of deaths caused by occupational accidents when self-employed are compared with other workers in Australia, when industrial trades were used to adjust association measures (Driscoll et al., 2003), but in the US, own-account workers were at increased risk of occupational-related death than employees (Mirabelli, Loomis, & Richardson, 2003).

Results of studies carried out with informal workers show that occupational hazards are common in their work environment, such as chemical and poisons (Lowenson, 1998; Nilvarangkul et al., 2006), excessive noise and dust (Rongo et al., 2004), awkward postures (Lowenson, 1998; Nilvarangkul et al., 2006), work overload (Fonchigong, 2005; Nilvarangkul et al., 2006), and poor sanitation (Acho-Chi, 2002; Da Silva, Fassa, & Kriebel, 2006) leaving them at increased risk of injuries or diseases. However, several independent community-based studies carried out in distinct regions of Brazil, a country that have a large proportion of informal workers, consistently reported no differences between informal and formal workers with respect to mortality (Nobre, 2007; Waldvogel, 2003), cumulative incidence (Santana et al., 2003), or incidence density rate (Santana & Loomis, 2004) for occupational-related accidents. However, positive associations between

informal jobs and mental disorders were estimated (Da Silva et al., 2006; Lurdermir & Mello-Franco 2002; Santana et al., 1997). In other developing country, workers having informal jobs were more likely to report poor self-perceived health (Dolinski & Caputo, 2003). Occupational discrimination (Iriart et al., 2007; Sales & Santana, 2003), violence and sexual abuse are commonly reported by housemaids (Oliveira, 2006) whose placement in the labour market is mostly informal. Descriptive studies also show increased complaints related to psychosocial stressors, such as pressures related to deadlines and loans among women from the weaving industry (Nilvarangkul et al., 2006) or physical and verbal abuse (Pick et al., 2002). Since most informal workers are women there are consequences in childcare. For instance, in Mexico City, street vendor women reported the lack of child care facilities which cause them to bring children to their workplaces, where they become vulnerable to a set of infectious diseases and injuries (Hernandez et al., 1996). Women employed as domestic workers and economic migrants often pay an important price in terms of their family life and interaction with their children. It is however difficult to make comparisons with the limited data that is available. The evidence suggests that health and safety is worse in the informal economy.

Most policies and programs of poverty alleviation set goals to improve employment conditions through the provision of means for income generation, such as micro financing thus affecting informal economy, reduce unemployment and poverty (Scheil-Adlung, 2004). Rather than their disappearance, this strategy targets their strengthening throughout access to credit, training, and technology. However, their sustainability has been under question, since micro enterprises often have short survival (Bruce & Schuetze, 2004) and may involve high level of pressures over their owners that can affect health and well-being (Shiva, 2007). Solidarity-based economy is an alternative strategy where cooperative instead of individual entrepreneurship is reinforced that may be more successful.

Addressing the social determinants of ‘worker’s’ health inequity?

People in urban settings and in particular in the rapidly growing and crowded unplanned settlements in many developing countries, are exposed to a variety of health hazards, which are inter-connected and often produce synergy with their health effects (Barten et al., 2006, 2007). Informal work is of course not limited to informal urban settlements (Werna, 2001). However, workers that survive in the informal economy in urban settings are a more *vulnerable* group. The worker’s health and that of the wider community cannot be considered in isolation of the rapidly changing context in many cities. These conditions are not addressed by health systems that prioritise curative care above prevention or that focus on changes in lifestyle only. Technological solutions are insufficient to address these problems and in particular their underlying causes.

In 1981, the Colombo Statement stressed the need to integrate occupational health services within primary health care.¹ In developing occupational health services duplication should be avoided, not only because of limited resources, but also mainly because occupational health should not be separated from general health care. It has been argued that workers should participate in all facets of occupational health programmes and that the Northern model of removing occupational health from the health ministry to the labour ministry is inappropriate in a context where most workers are not organised, consist of women and children whose health needs and risks cannot be separated into ‘home’, ‘school’, and ‘work’, and where industrial processes may affect not only workers’ health, but also that of the population nearby (Barten, 1993). A comprehensive approach of workers’ health needs and inequities in the above-mentioned context, needs to move beyond traditional and technocratic approaches of occupational health and safety that have been developed to address the occupational health needs of workers in developed economies (Barten et al., 1996; Lund & Marriott, 2005; Marriott, 2006). It appears that the responsibility for worker’s health should not be in the hands of the private sector that often prioritises cure or workers’ withdrawn from the labour market above prevention, and separates the provision of occupational health care from preventive activities and efforts that involve workers to ensure safe and healthier workplaces and living environments.

The urgent need for an integrated settings approach of the underlying social, economic, and political determinants also appeared to be relevant in 1992, when in Managua children in low-income neighbourhoods

¹The Colombo Statement arose out of the First Conference on Occupational Health in Developing Countries, held in Colombo, Sri Lanka.

died of lead poisoning and a large number of children upon examination were found to have unacceptably high blood lead levels. They lived in cottage factories where their families were involved in melting lead in order to recycle old car-batteries (Barten, 1992). Despite the fact that a large car-battery factory was located in the area, health personnel up to that moment was not aware of the fact that lead melting was also carried out by workers at home; nor had they any knowledge of the high vulnerability of young and in particular malnourished children to environmental lead exposure. Early detection did not find place and although the Ministerio de Salud (MINSA, Ministry of Health) conducted regular visits to ensure surveillance of workers in the formal car-battery factory, the potential high environmental lead exposure of children living in the densely populated and unplanned *barrios* around the factory and in the approximately 1000 other *illegal* cottage factories in the capital was not acted upon (Barten, unpublished comment). Due to low-intensity war and migration from the rural areas Managua's population had doubled in less than 4 years and people survived in the informal economy. The demand for car-batteries was high due to the war and embargo, while water for washing hands was scarce and rationed. In this context the MINSA decided to make resources available and to conduct an epidemiological survey of all exposed children that provided an evidence-base for ensuring action such as health information to affected communities. However, and as recently raised by the Commission on Social Determinants of Health (Solar & Irwin, 2005), "what sense does it make to cure a person and then to send him or her back to the same environment that caused the illness in the first place...".

In his book on Health and Wealth, Szreter (2005) underlines the disruptive influence that rapid economic change such as that occurring during the industrial revolution in Britain had on population health, and in particular of those living in the poor unplanned settlements of the manufacturing and rapidly growing towns of 18th and 19th century in Europe. Szreter first describes health deterioration and then analyses the factors that proved to be critical for health improvement. Although the analysis is limited to the situation in British towns in the 19th century, important policy lessons can be drawn. Emphasis is placed on the importance of *information systems* as well as of civic and political institutions in influencing the health development process. It also highlights the fact that "Britain, for two centuries before the start of the Industrial revolution, had a well-organised social security system and that the English Poor Law was crucial in facilitating development in the world's first industrial nation. This lesson has been neglected to date" Quote, source (Barten et al., 2006, p. 6).

It is important to continue raising awareness on the neglected occupational health and safety needs of workers in the informal economy, the increasing health inequity and the relationship with the environmental and living conditions in order to ensure these issues are included in the agenda of decision-makers, including organisations of workers. In many developing countries, however, existing weak information systems have been further affected by the near collapse of public health systems e.g. in Sub-Saharan Africa *People's Health Movement, GEGA & Medact* (2005). Adequate and accurate data on working conditions in particular of informal sector workers, migrant populations and other vulnerable groups such as women and children is needed. Unfortunately disaggregated data on people's living, working, and health conditions in deprived and crowded informal settlements in cities is often lacking (Stephens, 1996; Stephens et al., 1997). Strengthening health systems is considered essential to ensure this information, but also to address neglected health rights and this implies the need to address the causes of the current shortage of human resources *People's Health Movement, GEGA & Medact* (2005).

Engaging with workers' and recognising the relevance of their knowledge is crucial to develop efficient policies and programs that will impact positively in their health, safety and well-being. Workers' often are well aware not only of the occupational and the environmental health hazards that they face, but also of the need to address the underlying causal factors. This was stressed in a study on environmental and occupational health hazards among workers' in small-scale industries in the low-income districts Ilala, Temeke, and Kinondoni in Dar es Salaam that was conducted in 1994 (Rongo, 2003). In focus groups discussions employers as well as workers appeared to be aware of the occupational and environmental health hazards in several small-scale workplaces. In fact most of these were quite evident and did not require in-depth exposure or risk assessments (see Fig. 1). However, the unavailability of permanent workplaces and the lack of tenure security were referred to as the main factor for low priority by owners of small-scale industries to investing in health and safety in workplaces. The workers stressed the need to address these determinants by involving local governments and in particular the role of urban planning in extending workers' safety and health



Fig. 1. Hardwood sawmill workers in Tanzania. The photograph was taken by LMB Rongo.

protection (Rongo et al., 2004). In other settings, like Brazil where informal workers comprise the majority of the labour force the main reported needs from this group of workers are social protection, particularly paid retirement, followed by regulations of the work-time, usually extended without corresponding wage compensation (Iriart et al., 2007).

Although this may seem evident, the role of local governments is often not recognised or limited to some sectors e.g. health and environment, without including housing and urban planning. Cholera—now endemic in Dar es Salaam—is related to severe problems in ensuring access to sufficient clean water, sanitation and inadequate waste disposal in the informal settlements. It adds to the already existing health hazards that workers and the wider community face, but in particular affects street vendors, workers of small-scale industries and their families that are forced to move to peripheral areas where even more limited facilities exist.

In 1978, the Alma Ata conference defined health as linked to the living and working conditions of the population and acknowledged the role of community participation in health (WHO, 1978). This was stressed again in 1986 by the Ottawa Charter for Health Promotion which focused on processes of advocacy, enablement and mediation and on strategies to build healthy public policy, empower communities, create supportive environments and reorient health services (WHO Ottawa Charter, 1986).

Although the relevance of participation has been recognised by many agencies, in practice it has been more difficult to achieve and often took place in name only (Arnstein, 1969). Political commitment is often found lacking and the political ideology and attitude of government influences the extent to which demands by people's organisations are supported, neglected, manipulated, or rejected (Pacione, 2005b). Also political commitment for long-term planning processes is limited, particularly in a context of limited resources, donor dependency, increased fragmentation (Barten et al., 2007). Intersectorial collaboration e.g. on the issues of

urban planning, water, sanitation, housing, and health is limited, and occupational health and safety of workers in the informal economy is often neglected.

In a recent publication (Hogstedt et al., 2007) that discusses the changing consequences of economic globalisation on working conditions, labour relations and workers' health, reference is made to international agencies such as ILO and WHO and to the role of civil society that includes employers, workers and their organisations, health services, insurance companies, consumer organisations, and the community at large (p. 151) in ensuring safer workplaces. No mention is made of the role that local governments and urban planners can play and the implications of the linkages between shelter, employment and the informal city (Werna, 2001) for local as well as global governance and action in order to address the underlying causes of the above-mentioned issues. Health—and even less health equity—is still not considered a cross-cutting issue that is influenced by all sectors of government. There is poor co-ordination and unclear roles and responsibilities, both horizontal and vertical, among the government departments exacerbated by conflicting policy, legal and regulatory frameworks across sectors. However, there is also an increasing interest in environmental health impact assessments.

Integrated approach—social, political, economic and environmental determinants, workers organisation, and participation at all levels

As argued in this paper, it is urgent to address neglected health and safety rights of the rapidly increasing number of workers in the informal economy at global level. Contextualising occupational health and safety of informal economy workers in the rapidly urbanising cities of developing countries is important in order to understand the need for a people-centred perspective—recognising people as citizens, workers, residents, providers, and users of health care as well as agents for change—and for an integrated approach to improve working and living conditions. Firstly, low-income households living in urban settlements without adequate basic services and tenure security do not compartmentalise their needs (Barten et al., 2007). A people-centred approach would recognise the multiple roles that people have, how interconnected they are and how conditions in one area of their lives has important implications for the conditions under which they play out their other roles. It would provide external interventions that are respectful of people's ability to analyse their needs and interests and 'windows' for support that respond to people's own vision and struggle. Finally, a comprehensive approach of all the social, political and economic as well as environmental determinants of health—should not lose the focus on workers health, working conditions, and employment.

However, the implications for policy and practice are not yet well understood and often not recognised among decision-makers that are often located at considerable distance. The MDGs in principle present an opportunity to move beyond narrow sectoral interventions and to develop comprehensive social responses and participatory processes that address the root causes of health inequity. Clearly sectoral approaches and a focus on selective and often single issues such as promoted by many funding agencies, are not sufficient and above all so far have neglected to address the linkages between the issues described in this paper. This also implies the need to move beyond the monitoring of one indicator and to acknowledge the relation between poverty—employment—working conditions—living environment and health in a more explicit way.

The political and legal organisation of the policy-making process has been identified as an important social determinant of health, due to the role it plays in creating possibilities for participation, empowerment and its influence on the content of public policies and the distribution of scarce resources (Barten et al., 2007; Perez Montiel & Barten, 1999). It is worth mentioning the experience of participatory health planning undergoing in Brazil that engaged over 100,000 workers' delegates in the Third National Conference of Workers Health recently, at local, municipal, state, and federal level. Legislative frameworks are important, but appear not to offer a guarantee (Acioly et al., 2007). As no linear relationship exists between information and policy-making, the strengthening of worker's organisation and participation remains essential. However, it should be taken into account that tripartite agreements may obscure existing differences in interests, power and resources, and are difficult to realise due to the low proportion of organised workers in developing country contexts.

Participatory research methods can play a role in strengthening workers capacity, organisation as well as meaningful participation in decision-making to improve safety and health in informal economy workplaces (Kawakami, 2006). Labour unions often focus on workers in the formal and organised sector, but increasingly

also are searching for innovative ways to address the neglected occupational health and safety concerns as well as the poor and unsafe environments in which e.g. migrant workers live. A remaining challenge appears to be the need to address informal workers' health and safety in the rapidly changing urban context.

Healthy settings approaches that build on and involve community or family health programs are important to ensure healthier workplaces and to reach informal workers and their families when it is known that most jobs are performed individually or are home based. Health professionals should become more aware of the relation between poverty, employment, working conditions, living environment, and health. On the other hand, OSH workers need to develop abilities to collaborate with professionals with distinct backgrounds and approaches. This has implications for training and demands strengthening of health systems. A social and labour protection system that takes as reference the citizen rather than the contributor or tax-payer worker may open room for a perspective of universal welfare coverage. However, it is obvious that upstream inter-sectoral actions would prove more relevant, effective and efficient; and that policy development is lacking.

Nevertheless there have been substantive initiatives where local governments or civil society organisations have started to address the issues in a more comprehensive way and political commitment by national and local governments has in many cases been translated into policy and practice (Lund & Marriott, 2005; Marriott, 2006; Perez Montiel & Barten, 1999; Skinner & Valodia, 2003). However, many are limited as they are neither sufficiently broad in scope, sphere or scale, nor sufficiently maintained (Acioly et al., 2007; Barten et al., 2007).

Chopra and Sanders (2004) have analysed the health impact of the social, political and economic transition in cities of South Africa, and explored the parallel between the impact of the transition and that which took place in cities in 19th century Europe. The widening differentials in mortality rates, increasing inequalities in health and unemployment are comparable to those in 19th century Europe. They argue however that the potential of South African cities being able to reduce inequities and to improve on population health are considered limited within the current context that induces *uneven and combined* development within cities and between and within countries. Also, Robotham (2005) draws attention to the concentration of power and resources in the context of globalisation and argues that the main challenge is an increased social control to maintain and to enhance the democratic accountability of centralised global institutions at supra-local levels.

A global perspective of the social and environmental determinants is needed (Sanders, 2006) and local actors should address the supra-local levels that impact on cities (Werna, 2001) in order to challenge the distribution of power and resources at global governance level (Barten et al., 2002; Werna, 2001). As we have argued in this paper, it is urgent to include working conditions, living environment, worker's health, employment and safety in that perspective, while social organisation and mobilisation continues to be important—as history shows (Szreter, 2005)—to achieve this.

An important role is to be played by the state, the ILO, WHO, UN-Habitat and other UN agencies. The increased recognition of the need for inter-sectoral collaboration and the recent decision to operate as one UN at the local level is important to overcome the fragmentation and lack of coordination in addressing the challenges related to e.g. rapid urbanisation in Africa and Asia. Also, the WHO Commission of the social determinants of health (CDSH) represents an opportunity as it draws attention to the underlying political, economic, social and environmental determinants of increasing health inequities within and between countries (Solar & Irwin, 2005).

In sum, work is a major component of social and economic life and plays a substantial role in health determination. It is not possible to conceive effective policies focusing the overcome of social disparities in health without consideration of inequities in the access of decent employment, opportunities to improve personal capabilities and to enjoy a stimulating environment, thus recovering the original meaning of work as an important part of human social life that brings humanity to men and women. The linkages between healthier working conditions of informal workers, improved productivity, poverty and health need to be better understood and acted upon (Marriott, 2006), as well as the pathways that lead to increased vulnerability and exclusion of workers in the informal economy.

The commitment expressed by civil society organisations in Brazil to continue support for a social determinants approach of health inequities, even beyond the lifetime of the Commission of Social Determinants of Health, should therefore be considered of interest. Various national and regional networks have developed over the past years that involve workers' and other civil society organisations, health

professions' associations, trade unions, research institutes and that seek to build regional capacity on occupational health and safety in order to address some of the above-mentioned issues at national, regional, and global level (Varillas, 2005, 2007a–c).

Conclusion

The current context of workers' health as well as we have described in this paper is in many aspects different from the past—in particular in the challenges that it represents. The implications for development and for ensuring the right to health and safety in particular of workers in the informal economy, appear still not fully understood and in any case do not appear high on the political agenda. It is clear that if the rapidly expanding cities in developing countries are to contribute to poverty eradication, development and health equity, alternative avenues need to be explored urgently. Governments need to respond to people's rights and needs as workers and residents/citizens. It also implies the need to better understand and act upon the driving forces that determine the nature of the current globalisation, migration and urbanisation process in “developing countries”. Informal workers' representation, organisation, coordination with other social movements, participation and empowerment may prove critical.

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