Compensation for Ex-Mineworkers in the Mthatha Region of South Africa: A Long Road to Travel

BL Meel[1-2]

[1]*MBBS, MD, DHSM (Natal), DOH (Wits), M.Phil HIV/AIDS Management (Stellenbosch),* [2]*Research Associate, Faculty of Health Sciences, Nelson Mandela University, Port Elizabeth 6031 South Africa*

Abstract

Background: Ex-mineworkers are sandwiched between scare resources and little hope of being re-employed. They do not have enough savings to support their families. Expenditure is at its highest when they return, as their children have grown and are in secondary or senior secondary school. Many are not re-employable because of poor health and some are disabled.

Objective: To highlight the compensation claims of ex-mineworkers in the Mthatha region of South Africa.

Method: Ex-mineworkers were examined and sent their reports to Medical Bureau of Occupational Diseases (MBOD) to claim compensation. The detailed histories of these ex-mineworkers were requested by a trained research assistant at the Benefit Examination Clinic (BEC).

Case Histories: Most mineworkers have indicated that the pride of being a male breadwinner is often lost, and their wives have to take over this role. Some take to drinking alcohol and run the risk of premature death. Everyone is healthy at the time of recruitment, but many return diseased. Pulmonary tuberculosis overshadows underlying silicosis among mineworkers. Oesophageal carcinoma is associated with silicosis and this could be the reason for its high prevalence in this region.

Conclusion: The MBOD recommended compensation in only 2.5% of cases during the last seven years in the Mthatha region. There is a long road ahead to get these claims paid out; meanwhile many of the claimants will die.

Keywords: *ex-mineworkers, psychosocial problems, compensation claims, pulmonary tuberculosis, silicosis.*

Introduction

The migrant labour system has had very extensive socio-economic effects in the Mthatha region of South Africa. At one stage it was estimated that 2 million of the 5 million black workers in South Africa were migrant labourers.[1] About 600 000 mineworkers were employed by the gold mining industry in South Africa alone.[2] Most of them were from the Transkei region. About 14% of the former mineworkers who visited the Umtata Benefit Examination Clinic (BEC) between April and August 2000 indicated that they were given no reasons for their retrenchment.[3] There is evidence of a huge accumulation of unrecognised, therefore uncompensated, cases of pneumoconiosis and/or tuberculosis among former mineworkers living in labour-sending regions such as Mthatha.[4] The purpose of this report is to highlight the problems of compensation in the Mthatha region of South Africa.

Patients and Methods

Ex-mineworkers were examined at the BEC, a clinic located in the chest section of Umtata (Mthatha) hospital, which previously (apartheid era) was known as the Henry Elliot hospital. The clinic was established by the author to provide voluntary services to ex-mineworkers every Wednesday from 10:00 to 13:00, with minimum resources. The establishment of this clinic was announced on community radio. It could be assumed fairly that ex-mineworkers presented themselves voluntarily. Those who attended could be considered a

cross-section of the population of ex-mineworkers. Full chest x-rays were obtained and physical examination of workers took place, while their mining history was recorded. Fingerprints were taken. The patient's name, age and occupational health registration number were also recorded. Patients were interviewed by a trained research assistant asking pre-designed questions about their psychosocial, familial and financial difficulties.

Case histories

The extremely high burden of lung disease in ex-mineworkers is an enormous challenge to the health services and compensation authorities. An X-ray-based study conducted by the author (2002) showed that 78.2% of ex-mineworkers had evidence of lung disease. Pulmonary tuberculosis (PTB) with or without silicosis was evident in 64.2% of the X-rays, silicosis with or without PTB in 34%, chronic obstructive pulmonary disease in 7%, and asbestosis in 1.5%.[5] The case below describes a wife taking over the role of her husband.

Case 1. This is an example of a family where the wife is the breadwinner and the husband is so ill that he cannot work. He is irritable and shouts at the children at the slightest provocation. This situation is compounded by his hearing impairment. When young, he was handsome and his wife was attracted to him and married him. Now she sells household items such as paraffin, candles, and soap. She is now the breadwinner, as shown in photograph 1.

Many are not re-employable because of their poor state of health and some being disabled. They get used to taking alcohol to drown their sorrows. The following is such an example.

BD, a-60-year-old ex-mineworker, died on 6 June 2000 at about 6.00. See photograph. His body was lying outside the gate of his house. He had come home late from a shebeen. He had the habit of jumping over the gate when it was locked. On the day of his death he was found on the other side. An off-duty policeman saw him, took him to his house, and informed his colleagues. The deceased had the habit of going to the shebeen in the evening and returning home the following morning and sleeping it off. At 60 years of age he was getting an old age grant and used that money for drinking. His wife left him as a result of the drinking problem and he was left with three children. His drinking started at the time he was retrenched. Two of his children were at school in standard 4 and standard 2 and the third was staying at home.

The discovery of gold provided the base from which South Africa was able to develop a substantial industrial capacity, but the mines demanded a reliable supply of labour, which could only be met by drawing in migrant workers from distant rural areas, both within and outside South Africa. The migrant labour system not only creates situations in which diseases such as tuberculosis and sexually transmitted infections flourish, but also serves to disseminate these diseases widely throughout the region.[6] Many of these migrants contracted fatal diseases in the mines. Historian Randall Packards[7] paints a fairly grim picture of this trend:

GK, a 49-year-old, was a retired mineworker from the goldmines. He earned a monthly wage of R1105, 66. He worked from 1977 to 1997, when he took a voluntary retirement package. He was awarded R14 031.48. He had five young children. In 1989 he was treated for PTB in the mine hospital and in 1998 for a relapse in the local hospital. At the same time cancer of the oesophagus was diagnosed. He had been a smoker and a consumer of alcohol. He died as a result of complications from the cancer.

Many mineworkers ended up disabled as a result of mining accidents. Many returned home without compensation and RM, the insurers, do not deal with old cases.

LT, a 40- year-old, started working underground in a mine in Elandsrand in 1984 and worked until September 1996. He died in 1999. When he left for the mines he was a healthy young man. He sustained a fracture while working underground and was discharged. After recovering he worked for a construction company for a meagre monthly salary of R260.

During an informal interview, a spouse described her ex-mineworker husband as "no longer the person I married." The man was impotent and could not meet her demands. The woman poisoned her husband. Her daughter revealed this before committing suicide.

ZZ, a 27-year-old female, hanged herself in Feb 2001. A suicide note revealed that she was taking her life because the mother was not close to her. The father had died of poisoning in 1998, but the police were not informed. He had worked in platinum mine in Rustenburg for 20 years. He was retrenched because of poor vision. His wife, the mother of the deceased, had poisoned the father as he used to sleep away from his wife. (The son-in-law of the elder brother of the father narrated this story.)

Little attention was paid to black mineworkers, even though they performed the most difficult jobs, such as drilling rocks at deep levels. The Occupational Disease in Mines and Works Act (ODMWA) used racial criteria in the past to determine the amount of compensation paid out to workers. White workers with PTB were paid 5.5 times more than black workers. White workers with silicosis were paid up to 13.6 times more than black workers.[8] Most of the ex-mineworkers are in their fifties (mean age 51 years), capable of re-employment if they are fit and healthy. However, many of them are ill and even if they are employed will get very low wages.

The family of an ex-mineworker was admitted to the local hospital with food poisoning. On inquiry it transpired that they had eaten the meat of a cow found dead. They decided to consume this meat as a result of poverty because they could not afford to buy meat from the butchery. Many ex-mineworkers live below the poverty line. Some get occasional work and earn a few rands, which is hardly enough to run a family.

Some ex-mineworkers suffer from mental illnesses. It is difficult to manage their illnesses, as health facilities in the rural areas of Transkei are inadequate.

On 11 May 2000, a 51-year-old ex-mineworker was knocked down by a car. It was a hit-and-run accident. He had a history of mental illness. He had been a mineworker in President Steyn Mines. After leaving the mine he was living without any money. He had been acting strangely, sometimes even running naked in the locality and collecting thrash. He had once been admitted to hospital in Queenstown in 1997.

A large number of ex-mineworkers have hearing impairments. Some of them are completely deaf. They find it difficult to apply for compensation, although their hearing loss is due to their mining job. If a miner applies for compensation, it has to be done within a year of retrenchment or retirement. In most cases this does not take place. As a result of this, most ex-mineworkers who end up with hearing loss get nothing in compensation.

A recent study conducted by the author showed that there is a high prevalence (54%) of hearing loss among ex-mineworkers. Of those affected, 33% were between 40 and 59 years of age. Twenty two percent who had worked in the mines for 10-20 years indicated loss of hearing.[9]

The returning miners affect their families and communities in two main ways. One is measurable and can be compensated. Disease and disability belong to this category. The other is issues such as their psychosocial impact. Diseases and disabilities could be assessed by age and the level of skills. The compensation commissioner's office makes use of such indices for payouts, either a lump sum or instalments. Only about 8-10% of mineworkers have been compensated. The liability for unpaid compensation to mineworkers for occupational lung diseases remains, and their families should be paid without any delay. There is a need for more clinics in rural Transkei so that mineworkers can enjoy easy access to medication for chronic diseases such as silicosis and chronic obstructive pulmonary disease from which they suffer. Doctors in public service are not fulfilling their legal obligation to submit claims for living and deceased ex-mine workers.[8] It is difficult to estimate the financial costs to the families because of ill ex-mineworkers.

The process of getting compensation is tremendously slow and inadequate, as shown in Table 1. Only 2.5% of ex-mineworkers were compensated between 1997 and 2000. In the meantime many ex-mineworkers have died. There is only one clinic in the area that serves the ex-mineworkers in the region.

Table 1: Statistics of ex-mineworkers from 1997 to August 2000.

Years	Examined	Re-examined	Compensated	RIP*
1997	601	------	9 (1.5%)	9
1998	1181	11	17 (1.4%)	18
1999	165	99	18 (11%)	20
2000(August)	80	62	7 (9%)	8
Total	2027	172	51 (2.5%)	55

*RIP= The rest in peace column indicates the subjects who were awarded compensation but died before receiving it.

Farming is the only productive work that most returning miners can perform. However, they lack land and farming skills . For as long as they worked in the mines the families were supported, but on their return they became dependent on others mainly because of poor and failing health. Most ended up destitute.

Conclusion

It is not only the ex-mineworkers who are often under psychosocial pressure, but also their families and the community as a whole. Extreme poverty is clearly evident in many families of ex-mineworkers and this need to be addressed by the government as a priority. These mineworkers must be adequately and promptly compensated before they die.

Ethical Issue: This report was approved by the ethical committee of the University of Transkei, South Africa for publication.

Conflict of Interest: None

Source of Funding: It is self-funded.

References

1. Wilson F, Ramphele M. Uprooting poverty: The South African challenge. 1989. Cape Town: David Philip.
2. Central Statistical Survey: South African Labour Statistics, Pretoria, South Africa: Government Printer, 1992.
3. Meel BL. The psychosocial effects of retrenchment. A testimony of migrant mineworkers. Journal of Psychologia (Unisa) 2002; 28:76-82.
4. Davies JCA. Silicosis and tuberculosis among South African gold miners - an overview of recent studies and current issues. S Afr Med J. 2001; 91:562-6.
5. Meel BL. Pattern of lung diseases in former mineworkers of the former Republic of Transkei: An X-ray-based study. Int J Occup Environ Health 2002; 8:105-110.
6. Jochelson K, Mothibeli M, and Leger J. Human immuno deficiency virus and migrant labour in South Africa, International Journal of Health Services. 1991; 21: 157-173.
7. Packard, RM. Industrial production, health and disease in Sub-Saharan

   Africa. Social Science and Medicine. 1989; 28(5): 475-496.
8. Jeebhay M. Setting up an occupational health service- legal obligations and practical considerations. Continuing Medical Education1996; 1321-1327.
9. Meel BL. Prevalence of Noise Induced Hearing Loss among ex-mineworkers of Transkei, South Africa. A paper presented at International Conference in Tokyo (Japan) in between 27th of March 2003 to 1st April 2003.