Mining: blood on coal

A case study of one industry, mining, points to the situation with regard to conditions of work in other industries in India.

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THE safety set-up for mining is the best of any industry in the country. The legislation is the most comprehensive. National tripartite conferences on safety in mines are held, and each mining company is supposed to comply with its recommendations as well as the law. There is a good national inspectorate, the Directorate-General for Mines Safety (DGMS), based in Dhanbad, with local offices, though it is far too small in size.

If, despite all these provisions, the safety and health situation is poor, one can reasonably assume that every other industry is in worse shape.

While most attention is concentrated on disasters such as New Kenda (1994: 54 deaths; *Frontline,* February 25, 1994), Gaslitand (1995: 65 deaths; *Frontline,* October 20, 1995) and recently Bagdiggi (2001: 29 deaths; *Frontline,* March 2, 2001), there is a steady toll of smaller accidents. Among the major hazards are roof falls in underground mines, and incidents of workers being run over by machinery in open cast mines. In the case of units under Coal India Limited (CIL), the annual number of deaths runs at an average of 190.

Are accidents caused by careless miners, or callous management? Prof. B.K. Kejriwal of the Indian School of Mines, Dhanbad, has analysed the major accidents and disasters in Indian mines from 1901 to 1994. A disaster is defined as an accident in which 10 or more miners are killed; in a major accident, between four and nine persons are killed. Kejriwal's study includes several extracts from the reports of courts of enquiry set up after mining disasters and should be compulsory reading for everyone involved in the mining industry.

A BHOPAL A MONTH – II
In this second article in the series on deaths owing to workplace accidents and occupational diseases in India, presenting a case study – of the mining industry.

His criticism is that much of accident analysis is superficial and does not examine the "root causes". In conclusion he writes:

> "In most cases it would be found that the root causes relate to weaknesses in the management system. They may be due to the lack of a sound safety policy, lack of inspection procedures, poor definition of responsibilities, lack of supervisory or employee training, and so on."

It is also instructive to quote from the findings of the court of enquiry into the Kessurgarh colliery disaster 1975 in which 11 miners were killed:

> "... The management had shown no signs of being anxious to promote safety on its own but was keen to keep an appearance merely of being law-abiding... The attitude of management was primarily one of defence against the criticism of possible violations of the safety regulations. Underlying this attitude are the assumptions that all the wisdom in regard to safety matters is contained in the regulations and there-

SUSHANTA PATHONDISH

September 1995: At the Gaslitand open cast coal mine, after the disaster which claimed at least 65 lives.

fore nothing further needs to be done and the duty of pointing out violations of these regulations lies entirely with the DGMS... It must be clearly understood that the primary responsibility for safety is that of the mine management. It should be for the management to prove that all possible precautions, whether or not they were required by the DGMS, were taken and that the practices followed were justifiable on their own merit."

Inundations have caused some of the most serious disasters in Indian mines, which include Chasnulla, where 375 miners drowned in December 1975. Professor Kejriwal concludes a review of inundation disasters with this remark:

"Almost all cases of inundations have occurred due to gross negligence and utter disregard for the safety regulations on the part of the management."

SUBHANTA PATRONOBISH

At the Gaslitand colliery in 1995.

We are unlikely to find such valuable information in future courts of enquiry. The Gaslitand enquiry was dragged out by litigation by mine managers and foot-dragging by the Judge put in charge. The government terminated the enquiry before any conclusion was reached. There is no commitment to maintain the high standard of earlier enquiries.

Another story which illustrates CIL's commitment to safety is the fact that in September 1998 the press reported that CIL had spent $1.2 million on 30,000 self-rescuers. This device permits miners to breathe in an atmosphere thick with carbon monoxide caused by fire. It gives them precious time to escape from the mine. The self-rescuers purchased by CIL were sub-standard, but it had not checked them. In this instance, a safety expert from the unions had raised concerns about the supplier, but these were ignored by the CIL management. CIL had not even withdrawn the faulty self-rescuers when asked to do so by the DGMS.

THERE is an increasing problem of use of contract labour in mines. Untrained and improperly supervised, they are vulnerable themselves and endanger the permanent mineworkers as well. A study by the DGMS in Mahanadi Coalfields Ltd. (MCL) in Orissa found that all the fatal accidents in open cast mines were suffered by contract workers, although they constituted only 50 per cent of the workforce. This is no surprise. The international experience is that contract workers suffer accident rates worse than the permanent staff. The National Union of Mineworkers in the United Kingdom found that the accident rate of contract workers was double that of permanent workers.

A Swedish study concluded:

"It is clear that the official statistics do not reflect the real level or structure of risk in the mining industry today due to the involvement of contract workers.

"Our findings imply that a considerable part of dangerous jobs in the mining industry are performed by contract workers. Contract workers seem to get injured more often and sustain more severe injuries..."

If this is the case in an advanced country like Sweden, the situation in India can be imagined. There is evidence that often instances of fatal accidents to contract workers are not recorded, and so do not show up in the statistics. It is alleged by unions that the bodies of contract workers killed in open cast mines are sometimes dumped by the roadside so that it could pass off as death due to road accident.

In this context the call for the law on contract labour to be weakened, is inexplicable. Contract labour in India needs more, not less protection. Quite simply, in every sector, not just coal mining, the more contract labour is used, the more workers will die.

The official number of workers in mines registered with the DGMS is approximately 750,000. But the number of workers in informal and small-scale mining in Rajasthan alone has been calculated at 1.8 to 2 million. There is a huge amount of stone mining or quarrying in India. Assuming a fatality rate of only double that of the "formal sector", one would arrive at an estimate of at least one thousand deaths a year.

PROLONGED exposure to coal dust causes coal miners pneumoconiosis (CMP). It is a very unpleasant disease. The lungs lose their natural flexibility and it becomes increasingly difficult to breathe. Simple tasks like walking up stairs become impossible. It is a slow and painful death from suffocation. There is no cure. The only steps are to remove the patient from exposure to dust in the early stages to prevent more severe damage.

Official statistics reveal an average of 72 new cases of the disease a year between 1980 and 1994. This figure is simply not credible. Coal dust in India is no different from coal dust elsewhere in the world, nor are Indian miners' lungs different from the lungs of other miners in the world. In the U.K., in the 1980s, the annual figure for new cases of CMP was more than 300 cases and the government is now paying out hundreds of millions of pounds in compensation to sick miners. Sample surveys in India have produced estimates as high as 40 per cent of the number of miners with CMP.

Every miner I have ever met has talked about the problem of dust causing "TB". In India, dust-related lung diseases are routinely diagnosed as tuberculosis and the link with dust at work is not made. There is a well-established relationship between occupational lung diseases, caused by dust, and TB (Charles Thackrah, the founder of industrial medicine in England, remarked on this link as long ago as the 1830s.) A mine worker with pneumoconiosis is much more vulnerable to TB. But medical literature on TB in India has not paid attention to this fact.

Dust control measures in India have not been and are not now, as rigorous as they could be, according to the many miners I have met in the last 10 years at workshops all over the country.

Coal mining is comparatively well regulated. Other minerals are mined with much less regard for workers' health. Silicosis in stone quarrying is a well-known hazard and must be widespread in India. There is hardly any data on informal mining in India.

In 1995, the International Labour Organisation (ILO) adopted a new Convention on Health and Safety in Mines – ILO Convention 176, which laid down minimum standards for mines safety. In accordance with the ILO Constitution, the government should have submitted this to the Lok Sabha by December 1996 at the latest. It still has not done so. In February 2000, the 9th tripartite National Conference on Safety in Mines was held in Delhi – the first such conference held since the ILO adopted the convention. The Ministry of Labour draws up the agenda – Convention 176 was absent. It is difficult to believe that the Ministry of Labour is unaware of the Convention. The Indian National Mineworkers Federation (affiliated to the Indian National Trade Union Congress) tried to raise the issue but was ignored. Sometimes it would seem that the sole purpose of India's membership of the ILO is to provide a reason for Ministers and officials to travel to Geneva for the ILO conference every June. No doubt a few miners would also like to escape there.

Mines are paying a high price. There is blood on coal, iron ore, the marble in our bathrooms. And remember – this is probably the best regulated industry in India from a safety standpoint. When coal-mining was nationalised in the early 1970s, one of the reasons given was the industry's poor safety record. Safety standards are far from satisfactory in the public sector and very poor in the unorganised sector. We know from experience in other countries that privatisation produces a worse safety record. With the private sector now about to invest in mining, it will be interesting to see the consequences. ■

REFERENCES

Dr. A.S. Mandal, *Pneumoconiosis in India*, Dhanbad, 1992.

Donald Hunter, *Health in Industry*, Penguin, 1959.

B.K. Kejriwal, *Safety In Mines*, Dhanbad, 1994

V.L.G. Blank *et al*, "Hidden accident rates and patterns in the Swedish mining industry due to involvement of contractor workers." *Safety Science* 21 (1995) 23-35.

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■ PHARMACEUTICAL INDUSTRY

For affordable medicines

A campaign to ensure access to essential drugs to the needy forces some international drug majors to make seemingly generous offers. But are these part of an overdue process of accountability for the profiteering of earlier years, or a bid to ensure that the social costs of patents do not come under the world's gaze?

SUKUMAR MURALIDHARAN

WITH the international campaign on access to essential drugs to the needy acquiring an irresistible momentum, giant pharmaceutical companies are being convulsed by what can only be described as a religious experience. The latest to see the light is the American drug major Pfizer. The company announced on June 6 that it would be able to produce a patented anti-fungal drug, Diflucan – better known by its generic name of fluconazole – in "unlimited quantities" for distribution free of cost to the governments of 50 of the world's poorest countries.

A vital treatment tool for meningitis associated with HIV/AIDS infection, fluconazole was till recently sold by the company at $12 (about Rs.560) a tablet. At the same time, generic drug manufacturers in Thailand were offering an identical dosage at a price just in excess of 50 cents (about Rs.23). Pfizer fought a long process of attrition against this cut-rate offering, frequently threatening legal action for alleged infringements of its patent on the drug. It also lobbied successfully through the powerful industry organisation, the Pharmaceuticals Research and Manufacture America (PhRMA) to have Thailand notified under Section 301 of the U.S. Trade Act as a country that provided inadequate standards of protection for intellectual property.

If Pfizer was stopped in its tracks and deterred from following up on its threats, it was a tribute to the global mobilisation on access to essential medicines. The credibility of the drug majors has plummeted ever since the U.S. government intervened on their side in 1997, compelling South Africa to scrap plans to put in place an AIDS therapeutic system based on cheap generic medicines. A phase of virtual guerilla warfare followed, with activist groups coordinating their efforts to ensure that no major health conclave ended without a scathing censure of drug multinationals.

Beginning in 1999, the drug majors began coordinating their defence strategies. The outcome was the "accelerated access initiative" announced by a cartel of five firms which between them accounted for all the anti-retroviral drugs used in AIDS therapy. In May 2000, in an effort blessed by the United Nations, five companies – Pfizer, Glaxo SmithKline, Boehringer Ingelheim, Bristol Myers-Squibb and Hoffman-Laroche – announced a programme of subsidised drug supply to the countries worst affected by the AIDS pandemic.

Price cuts since then have come at a rapid clip, though Pfizer's "no cost" offer is by far the most dramatic. This seeming generosity could be interpreted as being part of a long overdue process of accountability for the rampant profiteering of earlier years. But there is another reading which is gaining credibility, cutting at the roots of the patents system that the drug companies have managed to enforce through the World Trade Organisation (WTO). The "accelerated access initiative", it is now widely recognised, was a concerted effort by the drug giants to ensure that the crisis in obtaining affordable medicines did not engender an examination of the social costs of patents. It was also meant to head off a challenge from manufacturers of cheap generic drugs in the developing countries – notably Brazil, India and Thailand – which were working their way around stringent patent rights enforced by the multinationals, and providing access at much more reasonable prices.

INDIA'S growing profile in the international campaign on access to medicines was in focus at a recent international sym-