# BOOK REVIEWS

## Ambe J. Njoh

## Urban Planning and Public Health in Africa: Historical, Theoretical and Practical Dimensions of a Continent's Water and Sanitation Problematic

Ashgate, Surrey, 2012, 237pp, $220.

**Reviewed by Franklin Obeng-Odoom**

Research in urban planning has neglected public health issues, but so has research in public health which does not usually take the 'urban' seriously. The neglect of the two themes in broader debates about health, which have tended to shift gradually but conspicuously from state, to market, and then to civil society led approaches to healthcare, is even more disturbing. Urbanists write variously about land, affordable housing, water, informal economies, employment, and food, among others, but they rarely strike the links with planning and health matters. Opportunities for synthesis and interdisciplinary research on urban and spatial aspects of health exist and can be published in heterodox political economy outlets such as this journal. Yet, to this day, the related fields of urban planning and public health continue to drift apart, especially in commentaries on Africa where the urban population is gradually becoming proportionately more than the rural population - albeit in an environment of great urban health penalty.

*Urban Planning and Public Health in Africa* has been written to address these matters, and to reflect on possible, probable, and preferable health and urban planning futures. The author is a highly respected urbanist and Africanist, with a long and sustained track record of stimulating urban analysis. The work under review is his tenth book on cities and planning in Africa – all of which have become major reference material for students, teachers, and researchers. He has consulted widely for the UN and carried out research in many African countries and on a variety of topics on urban life and society, planning, politics, society, environment, and economy.

He draws on his skills as a planner, teacher, and researcher to construct a compelling and credible case for change. Taking a distinctively postcolonial approach in his investigation, the author carefully and systematically links dots from the past to the present and from the local to the external in order to provide a critical account of the current state of public health and urban planning in Africa. He pays attention to the continuing effects of colonial and colonising urban planning creeds in the form of bye laws to understand their racist origins and expose the harm their continuing implementation brings to the bourgeoning population of Africans in cities. The role the state has played to date is remarkable but even more remarkable, the book reveals, is how seemingly local interests intersect with global aspirations to shape urban form and health.

Following this diagnosis, the book presents a novel remedy which is based on non-pecuniary proposals. Unlike the dominant and common 'more money is best' approaches which characterise the analysis of some major global development groups, this book calls for life style changes, the reconfiguration of power relations, and transformation of urban planning codes that harm, rather than heal. Above all, the book makes a strong case for urban planning and urban health to be re-coupled, if not married, in a way that is not modernist but is indigenised socially, culturally, and economically. It presents a direct challenge to the view that it is better modern technology that will improve the conditions in urban areas in Africa. To Njoh, matters such as sanitation require more than a change in gadgetry. Community or citizen participation, for example, is very important to him and is arguably based on Africanist principles of coming together to think about the collective good, for example, of a village or community. Such principles, Njoh argues, should be revisited or where they exist be substantially extended.

The book makes a strong case for taking public and urban health seriously in formulating development policy not only because health is an outcome of development but also because good health is a driver of development. Institutional change, the book argues, should not be driven by mimicry of Western society but should look inwards to learn from history and culture. The author is on solid grounds when talking about issues of tradition and custom for only a while ago, he published *Tradition, Culture and Development in Africa: Historical Lessons for Modern Development Planning* (Ashgate 2006) – also a major book, but focusing mainly on culture. In the current book, the interest is primarily in health and so the author gives copious examples of health-based

traditions to help correct historically misleading representations of Africans as having disease prone culture or having a culture of disease. Consequently, *Urban Planning and Public Health in Africa* calls on planners on the continent to 'Africanize' planning policies (37).

Often, titles with 'in Africa' tend to generalise about a continent where variety is the only common feature. Not so for this book. The author provides context and region-specific analysis in appraising urban health and planning dynamics on the continent. Thus, the book is rich in giving an African wide picture but nuances this representation by recognising, in a meaningful way, the differences that exist on the continent. The recognition of differences can be seen in the 'geographical twist' in the ten chapters that make up the book.

For readers looking for the scope of the book in this review, the following chapters are covered: history of public health and the built environment; the state, ideology, health and built space in Africa; town planning, public health and the colonial project; racism versus health concerns as the rationale for racial segregation; and public health implications of modernist planning. The rest of the chapters are hygiene and sanitation conditions in West and Central Africa, Southern Africa region, and Northern Africa, Solid waste disposal and sanitation technologies, determinants of access to improved sanitation, and sustainable hygiene and sanitation strategies – in that order.

This book is well-written and engaging, the argument persuasive, and the material well-structured - with only minor quibbles. While the nexus between poverty and health was convincingly analysed, unfortunately not much attention was given to inequality and questions of health - a topic which we know from the work of Kate Picket and Richard Wilkinson, *The Spirit Level: Why Greater Equality Makes Societies Stronger* (2009), is extremely important. There is already impressive analysis of segregation and inequality in the book, so it should be easy for the reader to make the connection or for the author to make it more explicit, if he chooses to write a second edition of the book. If he did, this reviewer wondered whether he would want to do away with the subtitle of the book. *Urban Planning and Public Health in Africa*, for this reviewer, is a more succinct title but, of course, this is a matter of personal preference and takes nothing away from the book.

*Urban Planning and Public Health in Africa* succeeds in achieving its goals and, in addition, powerfully reminds us of the need to eschew

monodisciplinary approaches to urban studies and indeed in the social sciences or even knowledge production generally. By doing so, the book is able to reveal that the several colonial projects portrayed as being for the public good, mostly ended up being racist and impacting negatively on the health of the natives. Fast forward to the post-colonial era and what we have is not entirely sanguine. Njoh shows that all too often, claims about modernisation, development, public health are ideological projects meant to advance the interest of certain classes and interest groups.

Ambe Njoh has once again made an important intervention in urban studies in Africa. This book is a must read for those interested in health studies generally, but also for those interested in public health and urban studies more specifically. Researchers, teachers, and practitioners in the fields of urban planning, geography, international development, and development studies will find this book very useful as will urban political economists, and those generally interested in African studies.

## Howard Waitzkin

## Medicine and Public Health at the End of Empire

Paradigm Publishers, Boulder CO, 2011, 256pp, $60.

## Reviewed by David Legge

Health is determined before and beyond the health care system: stunted girls in India, buried miners in China, AIDS in Southern Africa, gun violence in the US. It is self-evident that stocks and flows of the global economy powerfully influence population health and accordingly the political structures and relationships which shape the global economy powerfully determine population health outcomes. The challenge facing the institutions and practitioners of public health is how to engage with the structural determinants of health, including the dynamics of the global economy and its control.

The magnitude of the challenge is reflected in a grumbling debate between Anglophone public health which talks about the ‘social determinants’ of health and the Latin American social medicine movement which insists on the ‘social determination’ of health (Breilh 2013). The Anglophone focus has been on pathways of influence; the

Latin Americans have sought to direct our focus to the social relations which reproduce those pathways. It is a more overtly political analysis.

Public health needs to access the insights of political economy; needs to be able to see and talk about the economic dynamics and the political logics which reproduce an appalling global burden of preventable and treatable illness, injury and disability. However, it is a two way street. Familiarity with the political economy of health can enable political economists to follow these dynamics and logics through to their real impact on real people.

Building a conjoint discipline around the political economy of health is a neglected project, dependent on committed individuals who are willing to swim against the tides of empiricist scholasticism in public health and neoclassical mythology in economics. Such commitment is exemplified by Howard Waitzkin, Distinguished Professor Emeritus in the Department of Sociology and the School of Medicine at the University of New Mexico and primary care practitioner in rural northern New Mexico. During a career spanning over forty years, Waitzkin has published in sociology, health services research, political science, social policy and political economy. Through his work with the United Farmworkers' Union and in other fields he has blended political activism with his scholarly writing.

Waitzkin's 2011 collection, 'Medicine and public health at the end of empire', offers a window onto this career of engagement with the political economy of health. It is a reworking of some major research projects within an integrating narrative of 'empire past, empire present, and empire future'.

'Empire past' takes us from Frederick Engels and Rudolf Virchow in the 1840s, through an analysis of the 'medical industrial complex' in the USA in the 1960s and 1970s to a comparative analysis of revolution and reform in Cuba and Chile.

'Empire present' explores the period of neoliberal globalisation from the 1970s. In setting the scene for this section Waitzkin draws on the work of William Robinson (2004) who invites us to reconsider class analysis and the structures of governance in a globalised world. Robinson sketches the rise and composition of the transnational capitalist class (TCC) and in less detail describes the more fragmented subordinate classes, still largely circumscribed by national boundaries. Robinson also describes the

emergence and component structures of the transnational state apparatus through which the TCC effects its global hegemony.

Waitzkin uses this framework to describe and analyse the role of trade agreements in shaping health and health care; he analyses the WHO Commission on Macroeconomics and Health, demonstrating how the discourse of health policy is bent to meet the needs of economic governance; he explores in detail the phenomenon of 'managed care' both within the US and as part of the neo-imperial relationship with Latin America; and he explores the impact of the World Bank's project of 'health sector reform' in Latin America. A strong feature of this section is Waitzkin's use of discourse analysis to reveal the workings of political power.

Finally, in 'Empire future' Waitzkin looks for inspiration in the social medicine movement of Latin America and in the successes of popular struggles in El Salvador, Bolivia, Mexico City and Venezuela. This section is strong on inspiration but less clear in terms of analysis. Waitzkin's announcement of the 'end of empire' in the title of this collection is based on the emerging instabilities and imbalances of global capitalism; the weakening of US hegemony; and the growing willingness of Latin American countries to defy the imperium. The apparent optimism of his announcement is not linked to any analysis of the crisis of the global economy nor the scenarios of change which might emerge from such an analysis.

There are a few weaknesses which are inevitable in a project of this kind: sewing together a number of reports from different research projects within an integrating narrative that has been articulated in the writing of this book but was perhaps not the original purpose of the research. As a consequence there are some areas which could be attended to in the next edition: the funding crisis of the WHO warrants closer attention; the book is largely focused on the Americas and this detracts somewhat from the global perspective; and perhaps for this reason the underlying analysis of the global economy is not strong.

Nevertheless it is an important book, in part, because of the strengths of many of the chapters. However, the importance of this book is also because it belongs to a very small but important genus; surveys of population health which are embedded in a rigorous political economic analysis, in Waitzkin's case an explicitly Marxist analysis. Other iconic instances of this genus are Navarro (1976) and McKinley (1984). On the

other side of the debate, the World Bank maintains a continuing stream of beautifully produced, neoclassically inspired, accounts of the virtuous cycle linking health and economics: investing in health improves productivity which leads to improved population health outcomes. It is as if the industrial revolution never happened.

The project of building a stronger political economy of health is an important challenge for public health and for political economists. Waitzkin is a beacon to guide this project.

## References

Breilh, J. (2013), 'Beyond the current crisis: Mobilizing for health for all urgent agreement and agenda for life: towards an organic & cohesive world health movement', *Social Medicine* **7**(2): 42-46.

McKinlay, J. B. (ed.) (1984), *Issues in the political economy of health care*, Tavistock Publications, New York.

Navarro, V. (1976), *Medicine under capitalism*, Croom Helm Ltd., London.

Robinson, W. I. (2004), *A Theory of Global Capitalism: Production, Class, and State in a Transnational World*, Johns Hopkins University Press, Baltimore, MD.

## Matt Peacock

## Killer Company: James Hardie Exposed

ABC Books, Sydney, 2012, 416pp, $25.

## Reviewed by David Legge

Under globalisation the threats to population health are increasingly international; not just influenza and SARS but also tobacco, junk food and asbestos.

Since 2004 the Russian Federation, on behalf of its asbestos industry and with the assistance of Kazakhstan, Canada and a handful of other countries, has fought to prevent chrysotile (one of the main minerals containing asbestos; also known as white asbestos) from being listed in Annex III of the Rotterdam Convention.

The Rotterdam Convention (1998) provides that for certain hazardous chemicals (those listed on Annex III) ‘prior informed consent’ (PIC) must

be obtained from the importing country before those chemicals can be traded. While blue asbestos (crocidolite) and brown asbestos (amosite) are listed and are being progressively replaced in production, the Russian industry is mounting a rearguard action to prevent chrysotile from being listed.

The WHO-sponsored International Agency for Research on Cancer (IARC) advises (IARC 2013) that chrysotile is a human carcinogen but that the expected cancer burden from chrysotile will be mainly lung cancer rather than mesothelioma. It appears that while crocidolite is a powerful cause of both lung cancer and mesothelioma, the cancer burden from chrysotile tilts much more towards lung cancer than mesothelioma.

WHO and IARC have concluded that all forms of asbestos are carcinogenic; that no safe threshold has been identified; and that it is extremely difficult to control asbestos exposure in the workplace (Fukuda 2013). However, Russia and Kazakhstan (supported until recently by Canada) argue that the mining and processing of white asbestos can be made safe (Ustinov and Karagulova 2013). Even if this contention were supported by the evidence, which it is not, it has no bearing on the logic of Annex III of Rotterdam which is that countries, to which Russia and Kazakhstan hope to export their chrysotile, should have the right to give or refrain from giving prior informed consent.

In a previous round in this debate, a delegation from importing countries lobbied the Canadians over the export of chrysotile asbestos, arguing that many Asian countries have poor or non-existent asbestos regulations in workplaces, and those that exist are poorly enforced (Kirby 2010). More recently (May 2013) a WHO representative warned the 6th Conference of the Parties to the Rotterdam Convention that: '…owing to the widespread use of chrysotile in building materials and other asbestos products it was not possible to prevent the exposure of workers and the general public. Furthermore, the chemical could not be used safely owing to the way in which products containing it were produced and handled and degraded in situ, as well as the challenges that they presented in decommissioning and subsequent waste management. She added that WHO and IARC had conducted an evaluation of fibrous chrysotile asbestos substitutes and had concluded that safer alternatives were available'. Nonetheless the chrysotile exporters were able to prevent listing of chrysotile yet again (COP6 2013).

Matt Peacock's devastating chronology of the greed, cynicism and dishonesty of so many business people, lawyers, doctors, politicians and spin doctors associated with James Hardie in Australia provides useful insight into the continuing struggle to control asbestos exposure globally.

Much of this story is generally known, at least in outline, owing in part to Peacock's record of radio and TV coverage as well as the broader media coverage and the persistent lobbying of unionists such as the late Bernie Banton. Some of the key elements of this background include the following:

- By the 1920s it was known that occupational exposure to asbestos led to fibrous scarring of the lungs (asbestosis) and a high death rate. By the 1950s it was known that occupational exposure was associated with a much higher rate of lung cancer deaths than would otherwise be expected. By the 1960s it was known that occupational exposure led to mesothelioma, a cancer of the lining of the chest wall or abdominal wall. By the 1960s it was also clear that public exposure to asbestos dust (dumped tailings, working with building materials, washing family members work clothes, etc) was associated with asbestosis and probably lung cancer, mesothelioma and other cancers.
- Despite the science, James Hardie directors and executives, supported by lawyers, spin doctors, occupational physicians, government officials and pliant politicians, continued to deny, diminish and obfuscate the hazards of asbestos. However, in 2004 Meredith Hellicar, then board chair, explained to Peacock that it was just a 'big mistake'.
- The exposure of the reality was due to the courage and commitment of (some) unionists and officials (let Bernie Banton stand for these); the integrity of (some) scientists (let Irving Selikoff or Barry Castleman stand for these); the persistence and competence of (some) litigation lawyers; and the professionalism of journalists such as Peacock and before him Paul Brodeur (1974).
- Ultimately it was the pressure of litigation and compensation which forced asbestos out of the manufacturing supply chain in Australia, rather than effective statutory regulation.

There is much more to it than this. Peacock's book also documents the withholding of information from workers; failure to implement the most basic occupational protections; the widespread dumping of tailings; the

role of hessian bags in exposing both workers and public; deliberate court delays so that litigants would die before settlement; and much more.

There are important threads in this story which deserve to be more widely understood. Outstanding among these is the mechanism through which Hardies sought to cap its obligations to the Medical Research and Compensation Foundation when it moved its headquarters to the Netherlands.

From 1989 Hardies had built what became a highly profitable subsidiary in the USA (not involving asbestos containing products) and was therefore less dependent on asbestos based products in Australia. However, the tsunami of compensation claims was approaching (from occupational and public exposure) and the board adopted a devious plan to cap its exposure to such claims. This plan involved:

- moving the parent company to Holland partly because of its low taxes and partly because Australia did not have a treaty with Holland for the reciprocal enforcement of legal judgements;
- setting up the Medical Research and Compensation Foundation with the public promise that it would be 'fully funded';
- hiding and minimising the actuarial predictions of likely successful claims into the future against Hardies;
- locating the rump of Hardie's assets in Australia as a subsidiary to the foundation and selling shares in the Australian shell to the Dutch parent, but not fully paying for the shares;
- partially funding the foundation up front but promising that in the event of a shortfall the shares would be fully paid for entailing a substantial reinfusion of money to the foundation; and
- finally and secretly cancelling the shares.

The plan sort of worked. The foundation was established in 2001 but the directors of the foundation discovered sooner than expected that they were seriously underfunded and relations with Hardies deteriorated. So, instead of locating the Australian shell in the foundation, a new company was formed for this purpose with the partly paid shares vested in the new company ('ABN60'). This enabled the board of Hardies to cancel the shares (in 2003) without the knowledge or cooperation of the foundation.

In the years following the establishment of the foundation the directors of the foundation complained increasingly about underfunding. Hardies

argued that the problem was laxity in the statutory compensation arrangements in NSW and argued for legislation to curb compensation payments. By 2004 the rat was smelling worse and the NSW government set up a special commission, the Jackson Commission, to investigate how a fully funded foundation had run out of money and whether the problem was skulduggery or overly generous compensation payments.

The bomb exploded when the Commission was told about the cancellation of the shares and that the Supreme Court had not been told of the share cancellation when it sanctioned the transfer to the Netherlands. The Commission's report (2004) was not kind to Hardie's directors, executives nor Allens, its lawyers. However, it did not recommend criminal prosecution.

A long period of brutal negotiation over Hardies funding obligation followed the Jackson Commission. Hardies refused to make good its promises of full funding but the Carr government stood firm and progressively upped the pressure on Hardies: the findings of the Commission were shared with the US Securities and Exchange Commission; legislation was passed to allow all the documents collected by the Jackson Commission to be shared with the Australian Securities and Investment Commission (ASIC) and the Australian Consumer and Competition Commission (ACCC); legislation was foreshadowed to unwind the transfer to the Netherlands. Finally (February 2007) a deal was done and Hardies agreed to further funds for the foundation. However, a year later the sub-prime mortgage crisis hit the housing market in the USA and Hardie's US profits plummeted. Finally, the Commonwealth and NSW governments were forced to step in to support the foundation.

On the 15th February 2007, one week after Hardies and the NSW government signed their truce and one day before the statute of limitations would expire regarding the setting up of the foundation, ASIC launched civil proceedings against a number of directors, executives and advisors. The proceedings turned on the promise of a fully funded foundation which was clearly a lie. The ruling of the NSW Supreme Court (April 2009), ultimately supported by the High Court (in 2012), was extremely critical of the Hardies team. However, no-one has gone to gaol and the liars and cheats continue to protest their integrity and enjoy their wealth.

John Della Bosca, Carr's industrial relations minister, described to Peacock an interview he had with then CEO of Hardies, Peter Macdonald, in February 2004, just before the Jackson Commission was announced:

> He wasn't angry, he wasn't rude, he just very calmly said to me: 'You can't do this to us. You're a pissy little provincial government. You can't stop us. We're now a global company and we have done what we think was in our shareholders' interests. That's my job and that's what I have done. And if you have a different view, well, you go get yourself a multi-billion-dollar company, become its chief executive and you can have a different view (247).

So, what kind of light does the Hardies saga throw upon the defence, by the Russians, Canadians and Kazakhstanis, of their right to continue to export asbestos products to developing countries with weak regulatory structures without 'prior informed consent'?

The tactics are remarkably similar: lies and spin, drawing on tame professionals to obfuscate and delay, and leaning on government officials and diplomats to front the play. The stakes are also comparable. Peacock ends his book with a reference to 20,000 Australian families which have been affected by Hardie's products. We do not have an estimate of the numbers of families who have been and will be affected by the export of Canadian, Russian and Kazakhstani asbestos but it likely to be many orders of magnitude greater.

Is there something about asbestos (or tobacco or banking) which poisons the morality of businesspeople, lawyers, consultants and officials? Or do these cases simply reveal more clearly how the disciplines of capitalism work because of the longer lag times, the higher profits, and the more appalling consequences.

And what are the omens for effective regulation or honourable business practices under neoliberal globalisation? The power of money and spin to corrupt democratic process is not new but globalisation has given new powers to the corporate sector: the race to the bottom, or competitive deregulation. To this is now added the pressure to incorporate investor state dispute settlement into trade agreements (such as the Trans Pacific Partnership Agreement), threatening governments (particularly small governments) with hugely expensive litigation from transnational corporations with very deep pockets and close friends on the tribunals.

In the halls and corridors of global health governance the new jargon is multi-stakeholder forums, collaboration with the private sector, and win-win outcomes. Indeed it is regarded as poor form to even mention regulation. What are the implications of the asbestos case study for the regulation of pharmaceutical marketing or for junk food?

Aggressive marketing by big pharma drives the over use and misuse of pharmaceuticals with consequences for health care expenditure and corporate profits. In the case of antibiotics it is driving antimicrobial resistance and the obsolescence of most of our antibiotics. Getting big pharma to accept effective regulation of pharmaceutical marketing is less likely than Russia and Kazakhstan accepting the Rotterdam Convention.

Rich countries and poor countries alike are facing an epidemic of non-communicable disease (NCDs): obesity, diabetes, high blood pressure, heart disease, tobacco related cancers. In the Pacific this epidemic is referred to as a tsunami. While these conditions present a marvellous marketing opportunity for big pharma they also represent a significant burden on governments and families and a terrible toll in terms of sickness, disability and premature death.

One of the major factors driving the NCD epidemic are the changes in our food environment driven in part by changes in price relativities as energy dense products gain price and marketing advantages over fresh vegetables. The statement which emerged from the UN high level meeting on NCDs in September 2011 (UN General Assembly 2011) says nothing about international regulation to promote more healthy food environments. Clause 44, calls upon the private sector to 'strengthen its contribution to non-communicable disease prevention and control' by: taking measures to implement WHO recommendations on the marketing of unhealthy foods and beverages to children; by considering producing and promoting more food products consistent with a healthy diet; and working towards reducing the use of salt in the food industry. Not surprisingly there was widespread concern expressed (Third World Network, Young Professionals Chronic Disease Network *et al.* 2011) about the influence exerted on the final text by the corporate sector.

The asbestos example does not bode well for more effective regulation. As more countries get locked into investor state dispute settlement provisions through trade agreements meaningful regulation at either national or global levels will become much more difficult.

Effective regulation of the corporate sector at the national level is difficult; at the international level, so much more difficult (Braithwaite and Drahos 2000). Understanding the political economy of particular industries and of the wider economy within which they are embedded is a basic prerequisite. However, building a constituency across sectors and countries that can overcome the threats, spin, and bribes of the corporate sector, at both the national and international levels, is where the deep challenge lies. There is much to learn from Bernie Banton.

## References

Braithwaite, J. and P. Drahos (2000), *Global business regulation*, Cambridge University Press, Cambridge.

Brodeur, P. (1974), *Expendable Americans,* Viking Press, New York.

COP6 (2013), *Item C. Consideration of chemicals for inclusion in Annex III to the Convention. 5. Chrysotile asbestos*, Sixth Meeting of the Conference of the Parties to the Rotterdam Convention, UNEP and FAO, Geneva.

Fukuda, K. (2013), *WHA66 (May 2013). Item 18, Progress Reports. J. Workers' health: global plan of action (Resolution WHA60.26)*, Sixty Sixth World Health Assembly, Geneva.

IARC (2013), *IARC participation in a conference in Kiev, Ukraine, entitled: 'Chrysotile Asbestos: Risk Assessment & Management'*, available: *http://www.iarc.fr/en/media-centre/iarcnews/pdf/Chrysotile.pdf* (acessed: 14 October 2013).

Kirby, T. (2010), 'Canada accused of hypocrisy over asbestos exports', *Lancet*, Vol. 376, No. 9757, pp. 1973-4.

Third World Network, Young Professionals Chronic Disease Network, U.A.F.E. Medicines and K.E. International (2011), 'Action alert - UN HLM on non communicable diseaes: a threat to human rights', *Don't trade our lives away*, available: *http://donttradeourlivesaway.wordpress.com/2011/08/30/action-alert-un-hlm-on-non-communicable-diseases-a-threat-to-human-rights/* (accessed: 18 Decemeber 2012).

UN General Assembly (2011), *Political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (A/RES/66/2)*, United Nations, New York.

Ustinov, G. and Z. Karagulova (2013), *WHA66 (May 2013). Item 18, Progress Reports. J. Workers' health: global plan of action (Resolution WHA60.26)*, Sixty Sixth World Health Assembly, Geneva.

# Labour and Industry




*Labour and Industry* is a peer-reviewed journal that publishes research offering a multi-disciplinary perspective on all aspects of the social, organizational and institutional aspects of work and industrial relations. The aims of the journal are to encourage debate and the exchange of views between researchers, to challenge the conceptual boundaries of work and industrial relations, and to contribute to the generation of new ideas by drawing on insights from diverse disciplines.

The journal encourages submission from researchers reporting original and innovative research that contributes to the theoretical, practice and public policy dimensions of work and industrial relations. It encourages researchers to locate their contribution in the local context of a study, within the context of international debates, and in developments in the study of work and industrial relations.

The journal also encourages research teams to submit proposals for themed Symposia on new streams of research that stand to make a significant contribution to research.
All submitted manuscripts are initially reviewed by an editor and, then, if considered suitable for the journal, subject to a blind review by at least two independent referees.

## Notes to Contributors

JAPE is published by the Australian Political Economy Movement.

A prime concern is that the journal reaches the widest possible audience. Contributors should write plainly, avoid unnecessary jargon and employ economy in use of footnotes.

Contributions should be sent to the Editorial Coordinator, Frank Stilwell. All contributions go through a refereeing process to determine their suitability for publication. Papers must **not** be simultaneously submitted to another journal. Include an address and telephone number to facilitate editorial liaison and an abstract of 40-80 words.

The normal maximum length for articles is 8,000 words. References to cited works should be placed in the text's body, not as footnotes. For each quotation/statement requiring reference, place the citation in parenthesis (author's last name, year of publication, and page/s cited), e.g., (Mandel, 1975:231) or (Crough and Wheelwright, 1982:124-29). Footnotes should only include material that cannot be placed in-text.

All references should be listed at the end, alphabetically by author's last name (and chronologically for two or more titles by the same author/s) as indicated below:

Burgess, John (1989) 'Productivity: a Worker Problem?', *Journal of Australian Political Economy*, No 24, March, pp. 23-38.
Grieve, Norma and Ailsa Burns (eds) (1986) *Australian Women: New Feminist Perspectives,* Melbourne: Oxford University Press.



## Editorial Collective



Please address all editorial correspondence to Frank Stilwell, Department of Political Economy, Faculty of Arts and Social Sciences, University of Sydney, NSW 2006; or email *frank.stilwell@sydney.edu.au*.

Correspondence regarding subscriptions and financial matters should be sent to JAPE, Department of Political Economy, University of Sydney, NSW 2006; or email *frank.stilwell@sydney.edu.au*.