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A Study On Occupational Health Challenges Of Constructional Labourer

Krishnaveni S.
MBA, Department of Management Studies
Bharath Institute of Science and Technology,
Selaiyur, Chennai, Tamil Nadu 600 073
Bharath Institute of Higher Education and Research

ABSTRACT

Construction sector falls under unorganized sector of an economy. Unorganized laborers refer to those workers who have not been able to organize themselves in pursuit of their common interest owing to certain constraints like casual and uncertain nature of employment, ignorance and illiteracy, small and scattered size of establishment etc.The work force in construction sector is most vulnerable because employment is permanently temporary, the employer and employee relationship is very fragile and most of the time short-lived, the work has inherent risk to life and limb due to lack of safety, health and welfare facilities, coupled with uncertain working hours. The construction workers usually belong to poor socioeconomic strata and thus lack the basic amenities. This paper aims to bring to light the different health problems among workers working in the building construction industry in Madurai District. The study found that the health status of constructional workers in Madurai is fair from the information collected with interview schedule. To maintain the health status, the pocket out expenditure is Rs350 on an average per person per month while a zero priced health service is available in rural and urban India. The working hours of health care service providers and drugs availability is needs to take care by state and central authorities. Labourer needs to be organized for representing their issues legally.

KEY WORDS: Occupational Hazards, Health Status, Constructional Labourer

1. INTRODUCTION

Construction industry is one of the stable growing industries of the world and in India it is the largest economic activity after agriculture. Construction workers are at a greater risk of developing certain health disorders and sickness than workers in many other industries. Very little research has been done on the occupational health, hazards and psychosocial problems of these workers especially in Asian countries like India.

REVIEW OF EARLIER STUDIES

Investment in health is also a key component of human capital. Inequality in health has a significant impact on economic growth, possibly through effects on labour productivity Chatterjee, Meera. (1990) studied about Indian women : their health and economic productivity. The relationship between women's health and their productivity is characterized by 'flows' in both directions and a host of intervening factors. Two statements summarize the major directional flows: (a) women's health affects their productivity, and (b) productivity affects women's health. This paper documents the nature of these relationships, using available data on Indian women which relate to a variety of health indices, and construing 'productivity' in the broadest possible way, including labor force participation, work output, income, and so

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on. The overall purpose is to discuss women's health within the context of the need to improve both women's productivity and welfare. Thus, women's health status, its determinants and consequences, are explored, leading ultimately to the identification of interventions required to improve it and thereby to improve women's productivity. The suggested interventions are viewed against the Bank's past and current efforts in the health (and nutrition) sectors in India and against current overall directions in Bank programming in these sectors; they may also signal possible new initiatives for Bank assistance for the development of women and health in the country. Vandana Kushwah (2013) analysed the Health Status of Women in India. This article highlights some of the basic issues of the women community in India and their remedies. The author used the secondary data from NFHS-3 and DLHS-3. The researcher used the Par diagram, Pie diagram for analyzing the data. It is a fact that most of the women are getting married before leaving the schools/ colleges in India and most women in rural areas are not aware of the different types of diseases. It has been found that most of the women are not using any kind of contraceptive device in order to prevent sexually transmitted diseases and more often women are being sterilized in our country other than males. The smoky places and smoking habit should be avoided to reduce the burden of respiratory diseases like asthma, bronchitis, emphysema, chest pain. To maintain flexibility women's should exercise regularly, they must walk, swim, jog, dance, garden that may burn their calories and accompany friends that make you happy in order to relieve the stress. Uma saha and Kalyan saha(2010) examined A trend in women's health in India - what has been achieved and what can be done. This article focuses on the trend in five key women's health issues: maternal and child health; violence against women; nutritional status; unequal treatment of girls and boys; and quality care. Data was extracted from the three Indian National Family Health Surveys (NFHS-1 1992-1993, NFHS-2 1998-1999 and NFHS-3 2005-2006) Sample Registration System (SRS) and National Crime Research (NCR) Bureau data was also used in an attempt to discover the extent of improvement or deterioration in these indicators. the sex ratio in India has been declining consistently over the century, from 972 in 1901 to 927 in 1991, a 45 point reduction. However there has been a marginal improvement in the last decade (6 points). Census 2001 recorded the overall female to male ratio as 933:1000.The life expectancy at birth among females has steadily improved from 23.3 to 61.8 in the years 1901 to 1997, and has surpassed that of men since the 1980s. In many states, the number of infant deaths among girls exceeds that for boys due to discriminatory child care practices. The worst case is that of Haryana, where the gender difference in the infant mortality rate is 19. This is followed by Punjab, Rajasthan and Tamil Nadu. However in Orissa, where infant mortality rates are the highest (96), girls have a marginally higher chance of survival than boys. The credibility of family planning programs in large parts of India and especially the states of Bihar, Haryana, Madhya Pradesh, Rajasthan and Uttar Pradesh is near zero. Those who are illiterate have not fully recovered from the shock of the crude 'body-snatching' sterilisation program during the period of the Emergency (for 19 months in the period 1975-1977. Author suggested that as women are better nourished and marry later, they will be healthier, more productive, and will give birth to healthier babies.

STATEMENT OF THE PROBLEM

Health care access is important for women as women's body changes throughout her life time, from foetal development to post menopause. They use medical services more often than men, especially during their reproductive years. Many women also face huge social, economic and cultured barriers to having lifelong good health. Several reasons have been found to cause health problems all over the country. There is a strong correlation between illiteracy and women's health.

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It has been found that children of illiterate mothers are twice undernourished as compared to the children of literate mothers. The educational level and place of residence has direct role in morbidity and mortality of women folk. Almost two-thirds (70%) of all illiterate women received no care compared with 15% of literate women. Women in rural areas were much less likely to receive ANC than women in urban areas (43% and 74%, respectively) Vandana Kushwah (2013). There is1 crime against women every 3 minutes,1 case of abuse by a woman's family every 9 minutes and 1 'dowry death' every 77 minutes.(Uma saha and Kalyan saha(2010)). The women who are working in unorganised sector are highly under risk in working spot. While women take on the role of breadwinners, often primary breadwinners, their role as home-makers remains unchanged. Women are thus burdened with double work. In addition to double work, the home often remains a site of violence, with domestic violence remaining a primary issue among women workers. This, coupled with the absence of the security of legal protection, such as maternity leave, exacerbates their vulnerabilities. Though the work of street cleaning might be portrayed as desexualized, this does not change 50 Visibility and Voice for Union Women attitudes and behaviour towards women, whose bodies remain sites of violence and discrimination. Women also experience discrimination as a result of the spatial organization of the city. While men have easy access to sanitation, for women the lack of public sanitation means that they must walk greater distances from the work site, take breaks from work, experience discomfort and often, health problems.An important question arises for their trade unions; how effective might they be in addressing the perpetuation of these marginalised groups within a marginalised workforce? In this, the gender dynamics within trade unions become paramount if union representation of workers and the medium of struggles for better livelihoods. Hence the researcher made an attempt to analyse the health status of women in constructional work.

2. OBJECTIVES

The objective of this study is to understand the occupational healthproblems of construction workers — building and civil, to compare the morbidities in Madurai city alone in Madurai district among these two categories of workers.

3. METHODOLOGY

The cross-sectional study was conducted at Madurai city by selecting the respondents in non-random sampling method specifically Purposive sampling method was used. There are 72 workers met and tried to collect the primary information required for the chosen research fact but 49 women workers responded to the researcher in their working site, in middle of their work. The researcher framed a interview schedule for data collection of the details of self-reported occupational history, past medical history, occupational accidents and tuberculosis (TB), vector borne diseases like malaria, dengue and leptospirosis, water borne disease typhoid, jaundice and sexually transmitted diseases (STDs) were collected. Further, history of hospitalization, injury during last 1 year was collected.

FINDINGS

All the workers (100%) were interstate migrants. Most of them were from Northern India .There were no significant difference in the prevalence of tobacco use (57.4% ,P = 0.28). Alcohol use was higher (8.7% , P = 0.001),The prevalence of past morbidity like TB, malaria, jaundice, typhoid

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were higher than general population in both groups without any statistically significant differences between them Since one-fourth of the workers were illiterate a lack of awareness about healthy choices and prevalence of addictions were expected to be high. Among the workers 60.2% were current users of tobacco, which was slightly higher .Most of them were using smokeless tobacco products. The absence of recreational facilities, the nature of work, hours of work, low pay, poor housing and separation from family, lack of job security and lack of access to occupational health services cause anxiety in workers are alcohol users.(8.7% P = 0.001) correspondingly they are more illiterate. Around 14.7%had current respiratory complaints with more among building workers (21.3% P = 0.009) which may be due to increased indoor pollution, exposure to dust, paint and allergens than outdoorcivil works, super added by use of tobacco. The workers have increased risk of developingpneumoconiosis like silicosis. Most of the complaints were cough and breathing which may beexaggerated by lack of personal protective measures such as, usingmask, work practices like wet grinding and overcrowdingScarcity of water, limited availability of cleaning facilities andclimatic conditions hasten the development of dermatitis inconstruction workers. The main skin problems were fungal infection,pyoderma and scabies, which was also similarly reported earlier. Eye problems were reported among 4.7%, with more amongbuilding workers (8.7% vs.1%. P = 0.003), which was

4. CONCLUSION

The prevalence of water and vector borne diseases, respiratory, dermatological and eye problems, injury and high risk behaviors were reported to be high among unskilled and semiskilled construction workers. Since the study was a cross-sectional study temporality, causation of the health outcomes were not proved and the actual incidence could not be recorded. Those workers with severe morbidity may leave the job and due to the “healthy worker effect” the results may be an under Measures are needed to improve the work environment of construction workers by ensuring availability of protective gears, good living conditions and sanitation facilities at the sites along within accessible, accountable occupational health services.

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