CHAPTER - VIII

HEALTH BEHAVIOUR OF THE JUTE MILL WORKERS

INTRODUCTORY STATEMENT

The health behaviour of a population is a function of availability of health care facilities, health education, the kind of medical aid available, inoculation and family planning facilities etc. It is further influenced by the socio-economic conditions and the environment in which the population reside and work. Hence, it is often found that the morbidity pattern of the workers and their health behaviour are interdependent on each other. The cultural and social responses to health and illness are characterised by concern with people's conceptions of their own health and necessary preventive action to conserve or enhance it, their definitions and responses to symptoms or illnesses, and the effects of varying attitudes and behaviour on the course of illness and the success of rehabilitation. The sociological aspect generally focuses on social and cultural differences as they affect orientations towards health and illness and on process of social interaction that affect patient's prescriptions, understandings and responses. The studies in this area cover a wide scope including such diverse concerns as cultural differences in response to pain, interactional effects on the perceived magnitude of disability, attitudes towards death and morbidity, and willingness to take actions conducive to health, such as exercising, dieting etc.
The area of public health is an old and traditional field in medicine that developed from the reform movements of the nineteenth century. Early emphasis in public health was devoted to immunization, improvement of sanitary conditions, and control of the communicable diseases. In recent years public health has become much more concerned with the various chronic diseases, environmental threats and pollution, preventive health practice and health education. These concerns make the work of social scientists indispensable, since public health practice is largely concerned with producing change in the social environment and in people's behaviour. As a result, such traditional areas within sociology as social influence, organisational change, and the community play an increasingly prominent role in public health work.

At the present time the field of public health is in a state of change, for the concerns of such practitioners have changed largely in recent years. The traditional concerns have receded in importance while new challenges in such fields as industrial health, nutrition, environmental pollution, accidents, health education and behaviour change, health services research, social epidemiology and health care administration looms very large.

To understand the pattern of health behaviour of the workers of the jute mills, some indicators of health behaviour are being discussed in this chapter. The pattern of inoculation and family planning, addiction pattern, health care pattern, pluralistic use of medicine etc. are
all basic parameters of a person's interaction with the society in general and with modern medical sphere in particular.

INOCULATION

Mortality and morbidity pattern of a social group are largely dependent on the inoculation practices. Early inoculation can prevent quite a number of water-borne, vector-borne and other diseases. A large amount of morbidity and mortality-causing diseases (e.g. Cholera, Typhoid, Tetanus, Diphtheria, Tuberculosis, Poliomyelitis, Measles etc.) can be checked with proper and timely inoculation.

Among the workers of the jute mills, the inoculation practices are quite irregular. In Meghna Jute Mill 43.3% of the total households practice partial and/or total inoculation. In Birla Jute Mill 63% of the total households have inoculation. The larger percentages of households practising inoculation in Birla Jute Mill is an indicator of a better medical facility available to them. On the other hand, a lack of basic medical facilities available to the workers of Meghna Jute Mill is reflected in their inoculation pattern. The impact of the difference in the inoculation pattern is found in the difference in the rate of child mortality. While 54.9% of the total households in Meghna Jute Mill is without child mortality, the corresponding figure is 70.1% in Birla Jute Mill.
FAMILY PLANNING

The essential objective of family planning in India are to ensure the survival of the mother and the child (preventive obstetrics) and promote the well-being of the family from a physiological point of view. There also are various community aspects of family planning based on various social, economic, political and environmental hypotheses.

Family Planning is based on the concept that a small family will serve the welfare of the individual and of the family; its ultimate goal is human welfare. Only a planned family can produce children of the right type of social behaviour. Family planning therefore is a family welfare programme. Lack of social welfare at the family level is the reason for want of social welfare at national level. From a social point of view, the aim of family planning is to create a social welfare state. Another aspect of family planning is that it is supposed to minimise poverty, hunger, unemployment, sickness, low standard of living and poor housing by checking population increase. Thus family planning will indirectly pave way for increased agricultural production and improved economy. Various other political problems like political instability, civil disobedience, wars and racial tensions will be eased.

In India, family planning is a comparatively new concept and are generally adopted by the poorer section of the population. Lots of social and religious stigma are still attached to the practice of family planning. Among
the workers of jute mills, family planning is not quite popular. Only 12.7% of the total workers in Meghna Jute Mill and 24.8% of the total workers in Birla Jute Mill practice family planning. Non-availability of family planning devices, lack of health-care facilities, lack of counselling and follow-up practices, social and religious stigma attached to family planning etc. are root causes behind the unpopularity of family planning practices in general.

**ADDICTIONS**

Drug addiction is described as "a state, psychic and sometimes also physical, resulting from the intervention between a living organism and a drug, characterised by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Drug addiction may create social, physical and emotional harm. A person may be dependent upon more than one drug.

The addiction to various drugs and alcohol is considered a disease and the drugs a "disease agent" which cause acute and chronic intoxication, cirrhosis of the liver, toxic psychosis, gastritis, and neurological disorders. Alcohol and drugs are important aetiologic factors in suicide, automobile and other accidents, and injuries and deaths due to violence. The health problems for which drugs and alcohol are responsible are only part of the total social damage which include family
disorganisation, criminal behaviour and loss of productivity.

Drunkenness and intoxication of various types among the workers ceased to be a vice, it is phenomena. Addictions of different types are their only source of pleasure; many workers of both mills listed expenditure on alcohol and tobacco as expenditure on recreation. The environment of the workers conspires to make them accessible to the workers. The worker comes from his work tired, exhausted, finds his home comfortless, damp, dirty, repulsive; he has urgent need for recreation, he must have something to make work worth his trouble, to make the prospect of the next day endurable. His unnerved, uncomfortable, hypochondriac state of mind and body arising from his unhealthy condition and especially from indigestion, is aggravated beyond endurance by the general conditions of his life, the uncertainty of his existence, his dependence upon all possible accidents and chances, and his inability to do anything towards gaining an assured position. His weak and diseased frame, weakened by bad air and bad food, violently demands some external stimulus; his social need can be gratified only in the arrack-shop, he has absolutely no other place where he can meet his friends. Apart from the chiefly physical influences which drive the working man into drunkenness, there is the example of the peer group, the neglected education, the impossibility of protecting the young from temptation, in many cases the direct influence of intemperate elders, who introduced their own children to
DIAGRAM 30

ADDICTION PATTERN OF THE WORKERS

MEGHNA JUTE MILL

BIRLA JUTE MILL

ADDICTION PATTERN

SCALE: 1 cm = 10 UNITS
liquor are the main reasons of the workers turning to intemperance.

The workers in the jute mills are addicted to various drugs and drinks, most of which are cheap and country-made. The modes of addiction are more or less following the traditional Indian pattern of addiction. Smoking and chewing tobacco, country liquor, ganja, bhang and pan are widely used. The addiction pattern of the workers of both mills are given below:

<table>
<thead>
<tr>
<th>Drugs Used</th>
<th>Meghna Jute Mill (%)</th>
<th>Birla Jute Mill (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco (Smoked)</td>
<td>56.3</td>
<td>50.2</td>
</tr>
<tr>
<td>Country Liquor</td>
<td>17.2</td>
<td>13.3</td>
</tr>
<tr>
<td>Ganja/Bhang</td>
<td>-</td>
<td>3.5</td>
</tr>
<tr>
<td>Pan, Khaini</td>
<td>26.5</td>
<td>33.0</td>
</tr>
</tbody>
</table>

From this table, it is found that smoking tobacco (i.e. biri and cigarettes) is the most common form of addiction; 56.3% and 50.2% of the total number of workers smoke tobacco in Meghna and Birla Jute Mill respectively. Addiction to Pan and/or Khaini comes next. A sizeable section of workers (26.5% and 33% of the total number of workers of Meghna and Birla Jute Mill respectively) are addicted to these things. Country liquor is consumed by a smaller section of workers, mainly because it is costlier and cannot be easily carried like biri and pan. In Meghna Jute Mill 17.2% of the total workers drink country liquor while in the Birla Jute Mill, the percentage is less (13.3%). Ganja and Bhang are consumed occasionally and a negligible percentage of workers
are addicted to them.

The workers of Birla Jute Mill have less number of addicts compared to Meghna Jute Mill; 9.4% of the total number of workers and in Birla Jute Mill 23.4% of the total number of workers are without addiction of any kind. In Meghna Jute Mill 26.1% and in Birla Jute Mill 17.8% of the total number of workers have multiple addiction. The lower percentage of addicts among workers of the Birla Jute Mill are probably due to better living conditions which prevent the workers from going out of home for comfort.

The workers are generally addicted from early adolescence. Most of them started addiction with the onset of working in the factories, which usually started at the teen age. A large section of the workers started regular habits of smoking and drinking with his first pay. The duration of addiction of the workers are given below:

<table>
<thead>
<tr>
<th>Duration of Addiction</th>
<th>Meghna Jute Mill (%)</th>
<th>Birla Jute Mill (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 years</td>
<td>2.2</td>
<td>5.6</td>
</tr>
<tr>
<td>10 - 20 years</td>
<td>43.9</td>
<td>40.4</td>
</tr>
<tr>
<td>21 years and more</td>
<td>44.5</td>
<td>30.6</td>
</tr>
</tbody>
</table>

From this table it is evident that most of the workers are serious addicts with the habit of a long time. This makes the worker more prone to illnesses. It is commonly known that tobacco aggravates respiratory problems. The high incidence of respiratory diseases among the workers is
directly related to the smoking problem.

HEALTH CARE PATTERNS

The term "health care services" includes not only the traditional public health services, but also "medical care" and related "education and research".

In this context, the term "medical care" was defined by W.H.O. (1959) as "a programme of services that should make available to the individual, and thereby to the community, all facilities of medical and allied sciences necessary to promote and maintain health of mind and body. This programme should take into account the physical, social and family environment, with a view to the prevention of diseases, the restoration of health and the alleviation of disability. The extent of these services will vary according to local conditions."

The general objectives of health services, according to this report are -

a) Health promotion,
b) Prevention, control or eradication of disease and
c) Treatment and rehabilitation.

The present concern of health care services is how best to deliver the health services to the population ensuring total coverage by deploying the available resources of personnel, equipment and materials as effectively as possible. Health care facilities are demanded by the general people as a matter of fundamental rights and comprehensive and compulsory health care have received wide acceptance both inside and outside the health field.
The term "comprehensive health care" implies the provision of curative, preventive and promotional services from "womb to tomb" to every individual residing in a geographical area.

The Bhore Committee (1946) in India defined "comprehensive health service" as having the following criteria:

i) provide adequate preventive, curative and promotive health service;

ii) be as close to the beneficiaries as possible;

iii) has the widest co-operation between the people, the service and the profession.

iv) is available to all irrespective of their ability to pay for it;

v) look after more specifically the vulnerable and weaker sections of the community, and

vi) create and maintain a healthy environment both at home, as well as working places.

The objectives of "comprehensiveness" are the reduction of premature death, disease, disability, discomfort, delinquency and disruption. Such a care needs to be complete, competent, continuous, co-ordinated, compassionate and for the whole community.

Provision of comprehensive health care required maximum utilisation of all the available skills, in order to ensure the maximum economic provision of health services. Furthermore, the success and effectiveness of providing comprehensive health care depends on the co-operation and
active involvement of the community with the staff of the medical institutions providing the services. In India, it implies an awareness and acceptance of modern concepts in health and sickness involving a change in the traditional pattern of living and availability of basic sanitary amenities. The essence of comprehensive health care is that the available doctors are concerned not only with the illnesses of the individual man but also with the factors which govern the well-being of the whole community, thus paving way for the attainment of "positive health".

Among the Indian population in general and the workers of the jute mills in particular comprehensive health care facilities are still quite a remote phenomena. The health care pattern in India is still influenced by the colonial set-up and does not follow need-based planning. The availability of health care facilities are still quite haphazard.

Health care pattern of a group of people depends on the morbidity pattern and vice-versa. As the workers suffer from various types of diseases, they need various types of specialized health care, which are not always available in the general hospitals. As treatment in the hospitals is a time-taking process, the workers are usually forced to go to a private clinic and buy the prescribed medicines from the market. On the other hand, in case of diseases that need hospitalisation, the workers prefer to go to a hospital. The availability of specialist doctors in a neighbourhood also influences the people. For example, in the immediate
HEALTH CARE FACILITIES AVAILED BY THE WORKERS

MEGHNA JUTE MILL

BIRLA JUTE MILL

HEALTH CARE FACILITIES

NO. OF WORKERS

HEALTH CARE FACILITIES

PRIVATE DOCTORS
LOCAL HOSPITAL
TB HOSPITAL
SPECIALIZED HOSPITALS

SCALE: 1cm = 10 UNITS
neighbourhood of Meghna Jute Mill there is an Ayurvedic doctor who specialises in the treatment of gout and spondilitis. It is found that most of the workers suffering from those diseases prefer getting treatment from this particular doctor.

The availability of the health care facilities as well as the preferences of the jute mill workers towards them are given below:

<table>
<thead>
<tr>
<th>Types of health care</th>
<th>Meghna Jute Mill (%)</th>
<th>Birla Jute Mill (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private doctors</td>
<td>78.6</td>
<td>91.4</td>
</tr>
<tr>
<td>Local Hospital</td>
<td>18.9</td>
<td>8.3</td>
</tr>
<tr>
<td>T.B. Hospital</td>
<td>1.7</td>
<td>-</td>
</tr>
<tr>
<td>Specialised hospital</td>
<td>0.8</td>
<td>0.3</td>
</tr>
</tbody>
</table>

From this table it is evident that workers generally prefer to visit the private doctor. Most of the workers (78.6% of the total workers of Meghna Jute Mill and 91.4% of the total workers in Birla Jute Mill) visit private doctors. Though at Birlapur there is a hospital where workmen get treatment at a subsidized rate, it is found that the workers of Birla Jute Mill get very little treatment from the hospital (only 8.3% of the total workers visit this hospital). On the other hand, 18.9% of the total workers of Meghna Jute Mill get treatment from the local municipal hospital. The reason behind this unnatural preference of the workers of Birla Jute Mill towards the private doctors is not very clear. It seems that the local hospital in
DIAGRAM 32

TYPES OF MEDICINES CONSUMED BY THE WORKERS

MEDICINE TYPES

MEGHNA JUTE MILL

MEDICINE TYPE

- ALOPATHY
- HOMEOPATHY
- AYURVED

SCALE: 1 cm = 10 UNITS

BIRLA JUTE MILL

MEDICINE TYPE

NO. OF WORKERS

NO. OF WORKERS
Birlapur is somewhat irregular in its functioning.

In both mills, the workers do not get E.S.I. facilities and hence visit to E.S.I. hospitals and dispensaries are out of question.

**TYPES OF MEDICINE PREFERRED**

The workers use various types of medicine. They are sometimes found to take different types of medicine for different diseases at the same time. The type of medicine taken is generally disease-specific. The consumption pattern of a certain type of medicine depends upon various factors like the effectiveness, availability and market price of that medicine.

The consumption pattern of different types of medicine are given below:-

<table>
<thead>
<tr>
<th>Type of medicine</th>
<th>Meghna Jute Mill (% )</th>
<th>Birla Jute Mill (% )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allopathy</td>
<td>88.6</td>
<td>92.1</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>6.2</td>
<td>5.3</td>
</tr>
<tr>
<td>Ayurved</td>
<td>5.2</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Among the workers of both mills, allopathy is widely consumed. In both mills, it is the only type of medicine which cuts across all age and disease groups. Children are generally taking homeopathy medicine. For minor ailments like cough and cold, fever, headache etc. people generally prefer to take homeopathy medicine. The use of ayurvedic medicine is mostly in the case of gout and skin diseases.
There is no gender bias regarding the use of different types of medicine. The criteria for using different types of medicine and health care is mostly disease-specific and sometimes age-specific.

CONCLUDING STATEMENT

The health behaviour of the workers reflect the general poverty, ignorance and squalor of their surrounding. The non-availability of basic amenities and medical facilities force the workers to adopt a lifestyle which is harmful to themselves and the member of their households. The health behaviour of the workers is the end result of this unhealthy existence.