CHAPTER VI
DISCUSSION

Health is a durable good or type of capital that provides services. The flow of services produced from the stock of health capital is consumed continuously over an individual’s lifetime. The stock of health depreciates with age and can be augmented with investment in health services.

At Independence, India espoused a philosophy of heavy state responsibility for providing for people’s health. Initially, resource allocations from the Government were well below the recommendations of the Bhore Committee\(^1\). Though the Committee’s recommendations on health spending were not acted upon, actual spending levels were very high relative to those of other poor countries. In subsequent plans, health spending lost grounds and regained in 1980s.

It has been observed that physical labour in the construction sector compared to other type of physical work is highly painful and risky besides being rewarded badly. The workers are not enjoying even the minimum protective mechanisms that are found to be mandatory in many of the developed and developing countries, at least when workers are engaged in risky operations. Moreover, in the context of
globalization/liberalization, the construction activities are becoming highly sophisticated and it becomes dangerous for the women workers to adapt themselves to the changing needs of construction activities.

The relation between division of labour and gender discrimination has been a concern of many scholarly works. In the review of literature, this relationship has been poignantly highlighted. As it is elsewhere, in the present study, we have found that there is a gender dimension in the distribution of labouring bodies in the spectrum of differing jobs within the construction sector. There are specific jobs which are carried out exclusively by women and there are other relatively skilled jobs which are reserved for men. This distribution across different jobs is on the basis of gender, skill and toughness of jobs. Despite many changes in the organization of productive activities in the construction sector, the pattern of distribution has a long continuity. Nevertheless, in the new labour process in the construction sector, especially in very big construction activities, most, if not all, of the jobs are carried out by male labourers. This is a new phenomenon in Kerala. Since there is no women participation in this sub-sector, it remained outside the scope of this study. A general proposition that can be stated is that, there is a gender bias in the health status of the construction labourers in terms of gender difference. Analysis of women’s health status, health care availability and possibility for taking care of oneself do not leave us with optimism.

In general, the women working force are more prone to health problems and receive lesser health care when compared to the male
members. This could be because of several reasons including the labour processes and organization of work for a long period; that is historical reasons including cultural elements that influence the specificities of the historical conjectures. Maternity cycles also influence their health care practices. When we examine the political economy of the labour process at the work site, the daily duration of work of women is longer than the male workers. However, there are exceptions to this which happens in the major construction sites. But then, in general, the proposition holds good for all casually employed women population in this sector.

The health of women and the disparities in health between the sexes are often critical indicators of equity in society. Women in developing counties are often with poor health, overburdened with work. Many suffer from malnutrition and chronic ill health due to lack of personal attention and adequate health care. The construction industry employs large number of casual labourers. Women tend to perform less skilled and less paid casual work. The practice of early marriage, repeated child bearing, ignorance, poverty and manual labour all have deleterious effects. Women’s special needs have often been ignored by planners and have thus had to bear a disproportionate share of unmet health needs.

Construction and building industry with its labour intensive operations provides a large base for unskilled, semi skilled and skilled labour for its growth and development. Since the seventies, employment growth in this industry has been three times the national average. But
this sector seems rarely regulated and the government and employer have taken little attempt in ameliorating the miserable standards of the working population. Equally important is that the workers in this sector are seldom united; this has been mainly due to the sticky nature of wage and employment.

Relatively lesser health status of women is reflexive of the general gender discrimination prevalent in the society. What is not reflexive of the general socio-political processes is that there is very weak labour organizations in the construction sector, although it is not so in other sectors. Governmental intervention in this sector is also not impressive although their exist Construction Workers Welfare Board. Majority of women workers refrain from associating with this Board due to practical and personal problems. Even those who associate with it get little assistance. Under such circumstances, the prevailing gender discrimination in terms of wage, quantum of work, hours of daily work, allocation and distribution of women workers across different jobs etc. appears to continue without rupture.

In general, the health profile of Kerala population is higher when compared to many other States in India. This is true, in terms of morbidity, longevity and availability of health care infrastructure. However, what is paradoxical about the health status of Kerala is that although much attention has been given to the physical health care provision, mental health remains to be clinically less attended. In fact, the very term ‘health’ refers only to physical health, and mental health
aspect has always been overlooked. This is true in the case of construction sector as well.

Another dimension of discrimination is that, frequency of work availability is lesser and erratic. This poses severe problems to them as they depend on daily wage with little savings. Even when they get work, wages are very low. Health insurance still remains something that need to be achieved in far future. Most of the people are not even aware of the availability of health insurance schemes. In the study, the increasing awareness of male workers about health insurance scheme is evident.

Regarding dietary practice, it was found that women workers generally carry their food cooked at home whereas majority of men depend on hotels for their midday meal. What is peculiar is that although they consume sufficient quantity of food, there is no concern about the quality of food. With the low income, it is extremely difficult for them to expend on additional food items which are rich in nutrients.

Concerted efforts must be made to bridge the food energy gap of the poor. This has to be supplemented with efforts to eradicate micro-nutrient deficiency. Nutrition intervention programmes such as Integrated Child Development Services and Midday Meal Schemes should be scaled up. Nutritional status also depends on factors outside the food sector, including social, economic and environmental conditions. Sukhatme, in his pioneering study on malnutrition explained that conversion efficiency of food depends on the access to safe drinking water, health care and environmental hygiene.
In this context what is more precarious is the drinking water facility. There is no proper drinking water supply in most of the work sites. Further, there is no system to ensure the quality of water. In the worksite, women workers are mostly exposed to severe hardships, with no basic amenities such as toilets, crèches, drinking water and health care during pregnancies. (Geetha, (1993){superscript}2. Though provision of these as well as canteens, restrooms and crèches are mandatory according to Contract Labour Regulation Act, workers remain outside the provision of all type of health facilities. The act explicitly states that if contractor fails to provide amenities the principal employer can provide them and recover the cost from the contractor.

It has been observed that there is no job security and therefore, wage bargaining is non-existent. Absence of trade unions aggravates this situation. Moreover women are said to be overrepresented in the informal sector due to the flexibilities of work involved in such activities. Much work on the formal sector is based on the “male bread winner” model which does not give adequate space or freedom to women who also has other domestic responsibilities. This situation is exploited by employers to ensure more work and less pay.

In the study it has been noticed that women workers often complained of neck pain, chest pain, head-ache, body ache and fever, exhaustion and problems arising out of carrying wet construction materials on their heads. Long hours of work involving continuous handling of cement lime or other corrosive construction material lead to the feet and hands being bruised, burnt and eaten away. Women workers
who carry the cement mix and wet bricks on their heads suffer from serious problems like head ache and fever. Pregnant women who carry such heavy loads run a high risk of abortion. In general, no medical facility was given to workers engaged in the informal sector activities and also in construction sector. Seeking appropriate medical care has been found to be highly unaffordable to workers in the construction sector since it limits the actual working days and hence reduces the income.

In certain sites construction work has been proved to be fatal particularly to women workers. In many sites, workers have to carry heavy weight to the top of multilevel constructions. In the event of causalities, the employer cleverly escapes from the scene byshouldering the entire responsibility of the accident upon the poor worker. In this context it is highly suggestive to implement necessary regulatory measure with the strict monitoring of the government.

It is also true that women are paid less than men. In addition, men are likely to have more regular full time work and receive greater seniority and benefits. The difference is difficult to be estimated due to limited data and segregated nature of labour force.

In the construction sector many jobs are potentially dangerous for both men and women. But the risk of women increases as they have lesser lung capacity and are not as strong as men. The failure to take occupational health of women seriously is reflected in the methods used to determine appropriate standards for physical working conditions such as temperature, ventilation and cleanliness of toilets as well as maximum
weight to be lifted. Health problems related to workplace, hazards of pollutants on women who work during childhood, adolescence, pregnancy and lactation can be dangerous to both women and foetuses. It has been noted that harmful diseases such as TB, allergies, abortions, and bronchial disorders, death of unborn children, anaemia, toxicity, disfigurement and menstrual cycle disruption create serious health problems to women. Many women suffer from musculoskeletal disorders- most common among women workers. These disorders are generally associated with heavy weight lifting.

A variety of factors continue to impede women’s right to health in general and reproductive health in particular. Gender combined with geographical location, social class and ethnicity constitute powerful barriers. Lack of control in the area of sexual and reproductive health prevented many women from improving their status and exercising autonomy in their personal lives. Availability, affordability and inaccessibility to quality health services had acted as powerful barriers. The discriminatory practices that existed created wage differentials, occupational immobility and inaccessibility to education and training opportunities.

Poverty of developing countries along with the concomitant occurrence of rapid population growth, inadequate nutrition and poor housing forms the basis of many of the health problems. It is generally acknowledged that women are concentrated in labour intensive, low earning and low status occupation. This type of labour market segmentation is linked to social norms and patriarchal ideology which
propagates that women are more suited to such jobs. Moreover due to lack of horizontal mobility, women often compete for same type of job and as a result of “crowding out” effect wages paid to women are generally lower than men.

Household is undoubtedly the immediate health environment of its members and also their main socializing unit. This has got important implications for the acquisition, transmission, prevention and treatment of disease. The differentiation within the household in terms of the inequality in education and empowerment made available for women and men, the food and nutrition intake, performance of roles and tasks, control over income and expenditure has important implications on health. Unless her education standard is raised, she has no access to training and job opportunity of a higher nature. The arena of problems faced by women are many and varied when they break in to the masculine preserves.

Micro level studies on specific sectors and specific industries (Banerjee, Nirmal et al. 1997)³ has shown that women’s employment has increased mainly in unorganized and informal sector activities and that they are mostly concentrated in the lower level of employment. The exploitation of informal workers is possible since they have only verbal contractual relations with loose labour regulations. In another study Rubery, Smith and Fagan (1996)⁴ also brings out that women’s jobs are low paid, they experience precarious job status with poor working conditions, inadequate social coverage and limited scope for promotion and upward mobility. Among those who are left out of any social
protection system in India and amongst those who are poor, women form a major group as they are employed mostly in the unregulated, unregistered informal economy.

Another general observation to be discussed is their education. Girls are withdrawn early from school and their economic potential is truncated at an early age. This is the most important reason for their failure to achieve both validity as worker later and to be admitted to work with a salary scale comparable to men.

There is a clear sexual division of labour in construction work. All the skilled operations are done by men. In unskilled work, while men helpers dig earth, mix the mortar and carry cement bags, women head load, carry bricks and other construction material. Carrying of water is also done by women. Women stand at the bottom of the hierarchy, employed as assistants, but doing the most arduous work. While men in unskilled work are able to pick up skills on the job and move up in the hierarchy, women are seldom given opportunities for mobility.

In regions were water borne diseases are endemic, women are more exposed to it as many of their tasks require them to be around water. The effects of inadequate water supply and lack of sanitation are compounded in an urban setting by an over crowding and the makeshift nature of dwellings. In addition, in cities they are exposed to lead exhausted from vehicles, paints in old buildings, harmful chemicals or radiations from factories with grave health risks for themselves.
In developing countries, malnutrition is the pivotal factor in many of the circular relationships between women, health and development. So here, apart from making women aware of their own nutritional needs and how they can be met, women in developing countries need be assured a consistent food supply. People should be persuaded to abandon food taboos and customs that contribute to malnutrition. For this, traditional leaders and the entire community should be provided with the knowledge that changes and development is for the good of the entire society.

One major concern that calls immediate attention is the health care needs of the poor particularly women and children employed in risky operations. The emerging private health insurance market does not provide solutions for the poor and high risk segments of the population. Initiatives taken by some NGOs such as Voluntary Health Service (VHS), established in 1958 in Chennai, and Home Based Neonatal Care (HBNC) intervention in a tribal region of Maharashtra are based on community participation that include the poor and the vulnerable. Initiatives of this type emphasize preventive care and have positive health impacts. Replicating such successes on a larger scale on the loosely regulated construction sector require a group of committed workers that will be feasible when there is highly regulated strong trade union involvement for the better health of workers in the construction sector.

India is now moving towards a market driven health care system. There is a trend towards greater utilization of health care from private
providers. Poor access to public facilities has been identified to be one of the reasons. But an outcome of this is an excessive use of diagnostic medical services. This will increase cost and also lead to misallocation of scarce resources. It is not only inefficient and iniquitous, but also compromises on the quality of care. There is also a possibility of slackening in the research and development efforts associated with the diseases that most commonly affect the poor. A necessary pre condition for the success of private sector participation is an effective regulation of the cost and quality that includes clinical and non clinical services.

Globalisation is said to have increased the employment opportunities of women. Growth of industrial employment due to subcontracting and fall in household income due to poor performance of the economy increased the number of women entering the informal sector. Globalisation unleashes the forces of competition and would marginalize those who are unskilled and incompetent. The decrease of traditional jobs and lesser access to skill required for new jobs also pushes women to the informal sector. In developing countries with Structural Adjustment Programmes, decrease in modern sector employment has compelled more women to seek income earning opportunities and finally are being reported categorized as self employed.

In a World Bank health study (1994), women’s nutritional need is seen to increase in adolescence due to the growth spurt associated with puberty and the onset of menstruation. The situation of working women in the construction activity is all the more serious and in the absolute
sense they are deprived of the basic requirements of life. They can’t even think of high nutrient value food. Inadequate diet during this period can jeopardize their health and physical development with lifelong consequences.
Reference

1. Bhore Committee or the Health Survey and Development Committee (1946) was constituted by the Government of India with Joseph Bhore as Chairman to investigate and recommend improvements to the Indian Public Health System. Its recommendations include increased public health care spending, integration of preventive and curative services and development of primary health centres in two stages.


