CHAPTER – VII

SUMMARY AND CONCLUSION

Conclusion

The construction industry is one of the largest and oldest industries to be generating employment in India, next to the agriculture sector. With labour intensive operations, the construction and building industry has a large base for employment and its growth. However, in recent years, major changes have occurred in these industries due to rapid mechanization. As an outcome of industrialisation, unemployment is rampant and women workers have turned to construction as an alternative source of income generation.

Construction sector unlike other economic activities warrant the coupling of workers from different specializations and level of skill orientation. The fast shift from the conventional to modern type of construction brings about drastic change in the type of technology used i.e. from labour absorbing to labour saving capital intensive technology. This resulted in the marginalization of workers particularly women in the construction field. With change in technology, the work became more complicated and it necessitates the concentrated work of labour
through day and night. In this context, the present study focuses on the work and labour of women in construction on the one hand and their health and living conditions on the other. The study on the problems of women and their health has been tried theoretically in many other situations. But explaining the health of women in construction and their work and labour has got immense academic and social life especially in the globalisation context.

The study makes a comparison of male and female workers engaged in more or less the same type of construction work and attempted to identify the extent of discrimination found among them. In the interview schedule, both the male and female workers were asked to respond to the same questions with a few exceptional questions to the females regarding their feminine health aspects. Interview schedule has been drafted very carefully by incorporating variables found highly relevant from the review of literature, the response from pilot survey and the inferences drawn from the discussions with experts, NGOs, social activists and from the workers and contractors. The study examines the socio-economic issues and identified the major health determinants by using econometric regression. The study also conducted a discussion with experts for arriving at substantive inferences for options towards better policy decisions.

Choosing the best variables or approach for measuring health should be dependent on consideration of the likely causal pathways and relevance of the indicator for the populations and outcomes under study. While research studies have established that socioeconomic status
influences disease incidence, severity and access to healthcare, there has been relatively less study of the specific manner in which work and labor in construction influences receipt of quality care and consequent morbidity and mortality among disease characteristics, particularly among those who have gained access to the healthcare system. It is unlikely that education, occupation and income disparities will be eliminated in the near future; in fact, there is some evidence that economic inequalities are increasing although, "policies are designed to improve aspects of 'socioeconomic status' (for example, income, education, family structure), no policy improves 'socioeconomic status' directly." In other words, while some barriers faced by populations disproportionately represented among lower levels might be removed, disparities in actual levels are likely to remain. Therefore, the current research challenge is to go beyond attributing well-documented variations in socioeconomic status, as measured by income, education or occupation to examining more proximal ways in which low income influences health status and health outcomes. More-detailed, better-specified and properly conceptualized studies on health can inform social policy and programmes intended to reduce health disparities in a socially and economically diverse society.

Women in the construction work enjoy low social status and most of them are from the lowest ranks of social ladder. Female workers join the construction sector as apprentices, continue as long as health permits and ultimately retire. Seasonality in the nature of work in the casual sector is found to be a major threat to the life and health of workers. In the case of duration of work, significant difference has been observed in
the case of female and male workers. Much work on the informal 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.

In the study, ‘health status’ is a composite variable calculated by measuring the level of living and quality of life. The level of living consist of objective criteria such as health, food, consumption, education, occupation and working condition, housing, social security, clothing, recreation and leisure and human rights. The quality of life can be evaluated by assessing a person’s subjective feelings of happiness or unhappiness about the various life concerns.

Life style and food habit of the individual are observed to be the most important factors affecting their happiness and unhappiness. The income and the consequent expenditure on food and other family expenditure become meager which have a direct negative impact on health. It is noted that workers are satisfied with the quantity of food that they take. But this food they consume is of inferior quality and this itself has been one of the reasons for the types of ailments from which they suffer. Most of the diseases identified from the construction sector workers are water born and allergic related.

Age is one of the important explanatory variables that determine the wage and employment in the construction related work. Aged people are not acceptable to this sector due to the risk and toughness of work. Always preference will be given to the young and the energetic. Long hours of strenuous physical work without sufficient rest have been the
major reason for the physical and mental disability of workers in the construction sector. Like any other capitalist, the aim of the construction contractor is also to reap maximum profit. This they are doing by either prolonging the working time or by paying low wages.

Considering the work, the wage structure in the construction is found grossly inadequate. Here the study observed differential wage system for the skilled and the unskilled labourers. For the unskilled labourers the wage comes below the required minimum. Savings of workers in the construction sector has been very low and in certain cases it is negative. The working hours of the construction labourers vary considerably among the skilled and unskilled. Majority construction sites impose 8 to 10 hours for unskilled women worker.

In order to study the facilities available to the worker from the employer, the variable – length\duration of association with the same employer has been taken as a determinant of health. 32% of female workers and 36% of male workers have been found to be working with the same employer for more than two years. 83% of female workers and 64% of male workers responded negatively to wage revision i.e. though the contractor revise the contract amount on ground of cost of construction, the benefit of such revision will never percolate to the ultimate workers. Majority of the workers were not associated with the Welfare Board and they find it worthwhile to work with SHG rather than being a member of KCWWF.

In the study, living environment and poor hygiene has been other important factors influencing health and work efficiency. Health of
labourers is not at all a matter of concern to construction companies. Majority companies do not pay medical cost incurred to the labourers, while in a considerable number of sites; labourers and company jointly meet the expenses incurred for the medical treatment. In the construction sector, the women labourers are not eligible to get any maternity benefits. Moreover the companies are not compensating the partial and full injuries of employee's and also not making any provision for insurance coverage.

Major health hazards relating to working women found in the different studies are respiratory infection, bronchitis, dermatitis, urinary infection, dehydration, amoebiosis, gynaec, pelvic, uterus infection, cervical spondilosis, spine injury, protein deficiency, variations in BP, silicosis etc. Early marriage and continuous pregnancy with insufficient nutritious food and hard physical labour has been found to be the major reason for the type of health problem. This is despite the fact that light work and more leisure is the medical advice to women during menstruation.

The construction company is not making any provision for electricity or sanitation facility to the construction labourers. Majority of the sites also do not have any toilets. Another exciting feature is the substandard toilets found in unhygienic situations in certain construction sites. There is limited provision of drinking water and the labourers have to depend on bore well, tanker lorry water or public water supply. The construction company is not making provision of water facility for bathing, washing cloths or cleaning their utensils.
Absence of sufficient time to sleep or disturbed sleep has been another important factor causing accidents or casualties at the worksite. Besides the strained family relations, the type of housing and the heavy burden of dependency have also been observed as one of the serious factors contributing to the deteriorating health situation of female working members in the construction sector. The institution of marriage, age of marriage, the antenatal care etc are also contributing negatively to their health. All the more, majority of these women are observed to be addicted to betel chewing and the consumption of drugs as an immediate remedy to overcome the problem of disturbed sleep and body pain due to day’s long hard work.

In the study, the explanatory variables - water intake at the worksite and at home, association with SHG and affordability of health expenditure are found to be highly positively significant. Wage level and the period of employment with the same employer signifies the positive indicators of favourable working environment and living conditions. The explanatory variables having significant negative influence on health are work during periods of menstruation, quantum of weight carried at the worksite, age at first pregnancy, number of deliveries, number of dependents and addiction to drinking and smoking. From this, it can be suggested that workers should be made aware of the cancerous effect of drinking and smoking by encouraging them to associate with SHG/NGOs. Health and the number of dependents are negatively related, as it reduces the nutritional level of food consumed and the level of leisure enjoyed.
Security of job and level of income is very low in the case of casual workers compared to workers in the minor and major construction sites. Moreover these workers have to work beyond their capacity level which is proved to be fatal to their life and wealth. Workers in major constructions, particularly women are deprived of their minimum right to organise and to share their grievances to get relief from further exploitation including sexual harassment.

In the study it is also noted that the habit of drinking and consumption of drugs among male workers severely affect their health and life expectancy. These workers admitted that the consumption of these cancerous byproducts are done intentionally to overcome the physical hardship and for enjoying sound sleep by forgetting the days long work.

Workers in minor construction enjoy fairly higher wage rate compared to workers in the casual and major constructions. Most of the minor construction activities are sub contractual in nature and the supervisor will always be with the worker with the deliberate intension of instigating and forcing the workers to perform well in the work site.

In major constructions, the workers are living together in temporary sheds made of canvas for preparing food and for the stay at night. The disturbing work environment coupled with the problems of family at distance has been the reason why most of the workers in the big construction site become addict to drinking and smoking. This attitude among the male workers gradually gives way to severe health problems like disability and impairment.
In the analysis, though certain factors are common for both males and females, the men are enjoying fairly better treatment than women. The reason for this discriminatory treatment for men has been attributed to their organizational spirit or their united group activities. With the emergence of group activities or the association of women into self help groups, it has been found highly positive in bettering the working and living condition of women.

In the study, intake of water at the worksite, duration of sleep and the problems related to medical expenses are found common to men and women. The negative factors like drinking and smoking are common; but the gravity is severe among men. The problems related to weight carrying and work during periods of menstruation are specific to women workers.

The important element in 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. This is true in the case of construction sector as well. Moreover due to lack of horizontal mobility, women often compete for same type of job and as a result of a “crowding out” effect, wages paid to women are generally lower than men. 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.

India is now moving towards a market driven health care system. It is not only inefficient and iniquitous, but also compromises on the quality of health care. A necessary pre condition for the success of
private sector participation is the effective regulation of cost and qualities that include clinical and non clinical services.

The labour force working in the informal sector is deprived of any organized medical or security mechanisms to mitigate their deprivation and ill health. The enactment of legislations and other measures to bring them under the regulatory and social protection mechanisms has proved to be a failure. In this context it is highly warranted that the government should play the role of facilitator and promoter so that the workers are able to get requisite level of protection and security and a decent work environment.

The unorganised sector has a crucial role in our economy in terms of employment and its contribution to the national domestic product, savings and capital formation. At present Indian Economy is passing through a process of economic reforms and liberalization. During the process, merger, integration of various firms within the industry and upgradation of technology and other innovative measures take place. In this situation, special care should be taken to protect the interests of the workers by providing them training, upgrading their skills and other measures to enable them to find new avenues of employment, improve their productivity in the existing employment which is necessary to enhance the competitiveness of their product both in terms of quality and cost which would also help in improving their income and thereby raising their socio economic status.

After examining the problems of informal workers in general and construction sector in particular, it is suggested that effective
implementation of labour laws and adequate intervention from the
government authorities are required for ensuring their health, safety and
welfare. Constant inspection from the welfare authorities is warranted to
reduce the severity of exploitation at worksites. Moreover medical
camps are to be organised for timely diagnosis of the health problems of
workers. In this context, constructive suggestions and support from the
trade unions are to be ensured where the government and management
failed to look after.

NGO's working for child welfare should consider the difficulties
of the construction labourers and plan strategies to ensure free education
for these children. They should extend open education to the labourers
so that they are made aware of their rights and become capable in
fighting against the atrocities done to them and for the setting up of the
grievances redressing mechanisms. In brief, all possible measures
direct and indirect in consultation with the management and workers
should be implemented to ensure decent working and living conditions
with proper contract and labour relations. It has been experienced that
formal sector could not provide adequate opportunities to accommodate
the workforce in the country and informal sector has been providing
employment for their subsistence and survival. Keeping in view the
existing economic scenario, the unorganised sector will expand further
in the years to come.