INTRODUCTION

You can tell the condition of a nation by looking at the status of its women

– Jawaharlal Nehru

India is a fascinating and diverse country with many languages, cultures, castes and religions and is one of the largest and the most important developing countries of the world (Pandve and Bhuyar, 2008). Like many other societies, here too, the sons are considered to be superior to daughters, and women are forced to be submissive to men at home and at the work spot state Kingdon, (2001) and Bhagwat and Hemant, (2009). Though many poverty alleviation schemes are in force, still about 350 – 400 million people live in absolute poverty with an income of 275 dollars per annum and a majority of them are women (Nandal, 2005 and Government of India, 2006).

The economic development of any country requires an integration of both male and female labor forces, meaning women have to shoulder with men and contribute to economic growth and poverty reduction. Consequently from coffee to computers, women workers are endowed with the work that creates the goods (Abdullah et al., 2008). Yet, in India, a major chunk of labor force is employed in the unorganized sector- not being eligible either for paid, sick or annual leave or for any social security benefits given by the employer (http://wwwOrganizedLabor,Unorganized Labor.htm, 2007) - is a unique characteristic. The informal sector is officially synonymous with the unorganized sector (Venkata Ratnam, 2000).

Amongst those who are left out of any social protection system in India, and amongst those who are poor, women form a major group. This is because women, more so than men, dominate those forms of work that are unregulated and unregistered – found mostly in the so-called “informal economy” (Portes et al., 1989). About 340 million (roughly 92%) of the workforce is engaged in the unorganized sector, of which, around half of them are from the construction industry (NCEUS Government of India, New Delhi, 2006 and Rajasekhar et al., 2009).

According to Visaria (1996), the informal economy in India employs about 90 per cent of the country’s workforce and 97 per cent of it is women
workers. Many of these women workers are the primary earners in their families - their earnings necessary for their own and their families’ survival. With the economic reforms underway in India, some believe that such informal work, characterized by low earnings, irregular employment and unsafe working conditions, is likely to intensify in the coming years report, Oberai et al., (2000).

In India women workers constitute a major portion in the work force of the construction industry. Sad to say they remain not only unorganized but also unskilled as compared to male construction workers, who by virtue of their gender dominances have progressed ahead in their career from an unskilled worker to a skilled one, specifically as a mason, carpenter, welder and electrician. While on the other hand women construction workers start as unskilled helpers, they remain unskilled throughout their life and as a result are victims of gender discrimination. Traditions, culture and customs along with the attitude of society towards women have placed women workers at a great disadvantage. In addition to this, they are also unorganized and dependent on their husbands without any empowerment socially and economically. Most of the time based on the mistaken notion that women are incapable of doing heavy or rough work, women workers loose out miserably.

Women as a category of workers need special focus and analysis. In our society the contribution of women is systematically undermined. They are relegated to subordinate roles. Women are concentrated in the low end of the spectrum, in low paying and insecure jobs. Their work is insecure, irregular and often unrecognized. They balance children, home and work, and more often than not their income is not commensurate with their work. The impact of globalization on the nature of women’s work comes through in a variety of ways. Coupled with this is the complete lack of any access to skill training and technological know-how. There is also an absence of any widespread system for social security for women workers, thus further adding to their vulnerability (SEWA, 2002).

India’s economy is based on agriculture, industry, and services. Any industry plays an important role in building up of a nation. In India the construction industry is the second largest employer next to agriculture. Modernization and industrialization have paved a good way to the
construction industry. Expanding and fast growing construction sector and, in general, lack of greater employment opportunity elsewhere has drawn large number of workers in this sector. There are more than 20 million of construction workers in India at present (Narayanan, 2010 and http://www.indianmba.com/Faculty_Column/FC34O.fc340.html). The annual turnover of the industry in India is about 4000 Billion Rupees, which is more than six per cent of the National GDP, employing a large work force (Jain, 2007).

Around 16 per cent of the India's working population depends on building construction for its livelihood and the Indian construction industry today employs about 31 million people and creates assets worth over 200,000 million annually (India infra guru, 2008 and Government of India, 2008a). Construction industry in India is under code 5 (National Industrial Classification of all economic activities (NIC) CSO, 2007). The workers of the building construction industry are placed in code 7 and 9 of the National Classification of Occupation (National Classification of Occupations (NCO), 2004).

More than half of the 31 million construction workers in India are women and their potential is not used to the maximum. They clean the building sites, and they serve the skilled men workers by carrying materials as head load and doing tasks directed by them. The differentiation in work allotted to men and women on building sites occurs on the grounds of what is considered appropriate for men and women, and not on the basis of the skill and the capacity of the women to do the work (Government of India, 2008a).

Indian construction industry- overview

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Employment in Construction (millions)</th>
<th>Organized sector construction (millions)</th>
<th>Unorganized sector construction (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993-1994</td>
<td>12</td>
<td>1.2</td>
<td>10.7</td>
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<tr>
<td>1999-2000</td>
<td>17.2</td>
<td>1.2</td>
<td>16</td>
</tr>
<tr>
<td>2004-2005</td>
<td>25.7</td>
<td>1</td>
<td>24.7</td>
</tr>
</tbody>
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Source: Sen, 2009 (Construction industry in India-Safety and health perspective)
Employment in Public and Private Sectors of Construction Industry

<table>
<thead>
<tr>
<th>Year</th>
<th>Public sector</th>
<th>Private sector</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>894.30</td>
<td>54.81</td>
<td>949.11</td>
</tr>
<tr>
<td>2007</td>
<td>866.23</td>
<td>65.79</td>
<td>932.02</td>
</tr>
<tr>
<td>2008</td>
<td>851.57</td>
<td>69.30</td>
<td>920.88</td>
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Source: Indian labour statistics, 2009 and 2010 GOI

Status Quo of Construction Industry in India

Reports say 78 per cent of India’s 1.1 billion people to live on less than $2 a day and levels of malnutrition are almost twice as high as sub-Saharan Africa. Women workers bear the brunt of this poverty and are among the most vulnerable of India’s poor. Ninety six per cent of women workers are in the informal sector with no regular salary or benefits - they are mostly unorganized, isolated and living in extreme poverty (http://www.oneworldaction.org/OneStopCMS/Core).

Women usually labour more hours irrespective of the household's income status. They also relish less leisure than men, often carrying out several tasks concurrently in both house and outside. Women's working time, range from 16 to 18 hours including child rearing and household management as indicated in various household surveys. Women are particularly exaggerated by feelings of “Subjection” in the face of abuse and conventional channels of authorized right often are, or look as if, out-of-the-way or ineffective, to underprivileged women. Most of the women are exposed to regular pressures as part of their normal day to day lives with detrimental effects (Abdullah et al., 2008).

Majority of men and women in the construction sector have the lopsided view that women lack skills to carry out certain tasks in the construction sector. This mindset has led to the discrimination of women in the sector and is preventing women from being trained and employed as masons in construction sector (Lingam, 1998 and Shah, 1996). Work in the informal sector is poorly paid. More importantly, it offers women little social protection, is unorganized, employment is insecure, and there are no social security benefits. The preponderance of women in the informal sector may indeed be determined by their preference to combine work with domestic-childcare activities (Ruwanpura, 2004).
Women have been entering the labour force increasingly to contribute to family survival. Structural adjustment processes, financial crises, prolonged economic downturns, the “feminization of poverty” have all forced more and more women to take up economic activities outside the home. The generally quoted figure is that women account for 70 per cent of the absolute poor and that the percentage may be rising. Poverty is widespread among the urban and rural women and the worst affected are single and derelict women with children to support. The rural women who live below poverty line find the agricultural sector with excess of labor and thus low wages. Besides, the seasonal demand for labor in the agricultural sector deprives them of regular income. As a result, they are forced to work in construction sector to meet the dire needs in the family. Many women either commute to distant urban centers or migrate temporarily to work in construction sites (Madhok, 2005). These construction workers are one of the most numerous and vulnerable segments of the unorganized sector in India (Government of India, 2008a).

Women play multiple roles, of which ‘work’ for wages / employment / income earning is one among the most significant ones. It not only contributes to the augmentation of the household income (which in many cases is the sole income for the household), but it also determines, in a significant way, the status of women and their well being. For one, it also places women’s health on a precarious balance. Studies have observed that, women’s general health and well-being is often not a high priority for the family. This also pertains to women’s own perceived need for health which is generally below the actual need. The large majority of Indian women who work in the informal sector face several health problems emanating from the workplace and their domestic situation. They are engaged in monotonous, repetitive, back-breaking tasks, either as casual workers in the public sphere or as home based producers in the private sphere (http://www.cwds.ac.in/library/collection/elib/public_policy/pup).

Construction is one of the few industries where people can work their way to the top from the bottom level (Fisher, 2007). But women in India are denied promotional opportunities in the construction sector. In the absence of mechanization of work, many backbreaking and energy sapping jobs are
assigned to women workers who are treated no better than draught animals, so to say. It is no exaggeration that the job of a woman worker is more strenuous in the construction sector than in other manufacturing industries. In recent times, heavy machinery is replacing women workers in large construction sites (Vankar, 2005), yet the continued availability of cheap labor forces, builders and contractors to seek women laborers. Their work is naturally regarded as unskilled, and they are given no opportunity to acquire skills. Men, on the other hand, learn and up-grade construction skills while working. They start as unskilled workers and move up to work as masons and then become supervisors and some even become contractors (employers). The male dominated construction sector does not encourage women to become masons (Baruah, 2008).

Women construction workers work in dangerous conditions doing demanding physical labour, such as carrying water and cement. The lack of basic amenities leads to accidents and occupational health problems, such as respiratory tract and urinary infections, joint pain and skin irritations. The performance of a worker is usually accounted by the output. It is true that sound health is essential for proper functioning. To safeguard the benefits of the workers and their health, the Central and State Governments in India have enacted various Acts and rules (National Commission for Enterprises in the Unorganized Sector, Government of India New Delhi, 2006). For building and other construction workers, the Regulation of Employment and Conditions of Service Act, 1996, has been promulgated, for their health and welfare (Ministry of Labor and Employment, Govt. of India: Building and Other Construction Workers Regulation of Employment and working Conditions Act, 1996). But how many are propagated and how many know about it? The maximum stipulated hours of work by Factories Act 1948 is eight hours per day (Sarkar, 2008) but the workers are working 10–12 hours (Lakhani, 2004). This affects their health and they are prone to accidents. The rate of incidence of accidents is higher in the construction industry than the manufacturing industry (Jinadu, 1987) and various health hazards are also associated with the industry (Kulkarni, 2007 and Roto, 1998). Social security
for unorganized sector workers is also very meager (Tiwary and Gangopadhyay, 2011).

The link between growing informality of work and deteriorating conditions of occupational health and safety in the construction industry is difficult to prove statistically. Data on accidents are notoriously bad (Exhibit 1). In many developing countries there is no reliable data due to lack of insurance coverage, which means that reports of accidents are most likely not filed. Nevertheless, there is evidence that industrial health and safety conditions for informal construction workers are extremely bad (http://weigo.org/informal-economy/occupational-groups/construction-workers).

A worker may suffer from a broad spectrum of diseases, like those prevalent in a specific community, such as diabetes, work-related diseases such as backache and occupational diseases such as asbestosis. Occupational diseases occur as a result of exposure to physical, chemical, biological or psychosocial factors in the workplace and as a consequence of contamination of the environment. Occupational diseases are different from work-related diseases.

Health is multifactorial and helps people to live well, work well, and enjoy themselves (WHO, 1980). It is influenced by both internal and external factors of society in which people live; perhaps the hazardous work, working conditions, and environment manifest themselves in injuries to the human body. In extreme cases this also results in death or severe disability. Literature has revealed that since the 1980s, the governments have not paid major attention to the concerns regarding occupational health in developing countries, because of inadequate strategies and policies for occupational workers (Phoon, 1983; Kamuzora, 1986; Turshen, 1986; Kouabenen, 1990 and Sakari, 1993). Health promotion, hence is not given due significance.

The WHO defines Health promotion as “the process of enabling people to increase control over and to improve their health”, and is known to be one of the simplest methods of promoting health (Deacon and Smallwood, 2003).
Health at work and healthy work environment are amongst the most valuable assets of individuals, communities and countries (Chandra, 2011 and WHO, 1995). Occupational health is an important strategy not only to ensure the health of workers, but also to contribute positively to productivity, quality of products, work motivation, job satisfaction and thereby to the overall quality of life of individuals and society (WHO, 1995).

In India, public health emphasizes more on communicable diseases, malnutrition and reproductive healthcare. Majority of the population is working in industrial sector. Increasing burden of occupational hazards and changing occupational morbidity are not addressed. Still occupational health is seen as a secondary issue while formulating health policy and health-related programmes (Pandve and Bhuyar, 2008).

In India, occupational health is more than simply a health issue, which includes child labour, poor industrial legislation, vast informal sector, less attention to industrial hygiene and poor surveillance data. It is not integrated with primary healthcare, and it is the mandate of the Ministry of Labour, not the Ministry of Health. Occupational health in India has to compete with primary health and curative health for its budget.

Since 1950, the International Labour Organization (ILO) and the WHO have shared a common definition of occupational health. It was adopted by the Joint ILO/WHO Committee on Occupational Health at its first session in 1950 and revised at its twelfth session in 1995. The definition reads: Occupational health should aim at: the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological capabilities; and, to summarize, the adaptation of work to man (woman) and of each man (woman) to his/ her job” (http://www.answers.com/topic/advisory-committee-on-construction-safety-and-health).
Two die, 25 fall ill in Pallikaranai

Staff Report

Two construction workers from West Bengal died due to alleged misuse of electrical equipment.

Two construction workers killed

Special Correspondent

Report says five children orphaned as wall collapses on parents.

Construction: Five workers die in wall collapse

Construction worker falls to death

Newspaper Clippings

Exhibit 1
Decent work agenda of the ILO includes safe working, without occupational diseases and accidents. This can not be achieved without asserting **Safety and Health as a fundamental right of the workers**, irrespective of employment relations and economic conditions. It is necessary to remove the wrong belief that many occupational diseases are the necessary components and inevitable constituents of their work; that any solutions to these problems would entail high degree of technical expertise and large financial investments. This negative thinking and unhealthy attributions should be proved wrong and should be totally altered by means of appropriate training on OSHE and education at all levels. In short the goal should be to make a different industrially advancing nation - accident free, occupational disease free, pollution free and polluters free - in the era of implementing the decent work agenda (Mahadevan, 2008).

The main occupational health problems in the construction industry are injuries from carrying heavy loads, respiratory disease from inhaling dust, musculoskeletal disorders, noise-induced hearing loss and skin problems. There is a very serious risk of cancer from the handling of asbestos. Equally alarming is the number of workers who succumb to dust-related illnesses, asbestosis and silicosis mostly in the process of raw materials for construction (Ganguli, 2007 and Info change India). Except a few, most of the builders do not follow any kind of safety rules in construction sites. Most of the companies do not even provide safety belts, protection eye wears, hand gloves, shoes or helmet to their workers. The working conditions and facilities provided at the sites are far from satisfactory. In many cases the workers in order to complete the projects in a hurry have to work in night with a dim light that very often leads to accidents (http://www.mgliahd.org/download/nationalworkshophealthsafetyofconstworkers).

The latest injury statistics shows that 40 per cent of all worker deaths in construction are caused by a fall from height. Another issue linked to neo-liberal economic policies is the industrial restructuring taking place in India, which has lead to women workers ending-up without-work and sub-contracting work where they are underemployed (Ruwanpura, 2004). The increase in the practice of employing labour through sub-contractors has
also had a profound effect upon occupational safety and health and it has undermined collective bargaining agreements and training provision. Long working hours without proper rest coupled with lack of nutritional diet due to low income results in poor health of the construction workers. The workers especially women carry heavy load on back and head which would be responsible for muscular and skeletal problems in the old age. Not only do they work in harsh working conditions, their living conditions are also equally bad. Without own dwelling, they live adjacent to the construction sites or in slums without basic minimum facilities like water, electricity, toilets and so on. The poor and unhygienic living conditions also affect the health of the workers badly. As the wage received is insufficient, it is quite natural that the expenditure on health care will be much less resulting in health hazards (http://www.mgliahd.org/download/nationalworkshophealthsafetyconstructionworkers).

In the light of rapid economic growth and industrial progress in the country, it becomes imperative that safety and health at the workplace be given its due importance. However, with stress being laid on quick profits, safety aspects are generally ignored. It is only with the increase in the number of people killed and injured at workplace (Exhibit 1) that the significance of the problem has been realized. In short, no occupation is without an occupational hazard and there is no occupational hazard that is not preventable (Chandra, 2011).

Statistics for the overall incidence and prevalence of occupational disease and injuries for the country is inadequate (Joshi and Smith, 2002). According to Leigh et al., (1999) the annual incidence of occupational disease was between 924,700 and 1,902,300, leading to over 121,000 deaths in India. **Decent work is not simply employment and access to income; it is also about creating quality employment and improving conditions of work.**

The building industry is one of the major employers of women workers in India (Nathan, 1999 and http://www.unesco.org/education/uie/confintea/pdftpovety). Women can get ill as a result of the work they do. Repetitive movements, for example, may appear less dangerous than heavy lifting, yet
they can cause severe musculoskeletal problems (http://www.cwhn.ca/resources/workplace/occupational.html#1). Musculoskeletal disorders (MSDs) have been identified as one among the most serious hazards facing working women (Rosenstock and Jackson, 2000). Rosecrance (2003) explains, Ergonomics as the interaction between workers and their work environment. By knowing about ergonomics, one can better fit construction tasks and tools to the people performing them. When ergonomics is ignored, worker health can suffer. The most common result of not fitting the work environment to people is musculoskeletal disorders or MSDs. MSDs are the result of months and years of overuse of human joints and connective tissues. On the job it is called as lower back and shoulder pain, tendonitis or carpal tunnel syndrome (http://www.contractortoolsandsupplies.com/past/jobsite_safety/BattleOfBrawn.htm 22/06/03).

Box 1: Risk Factors of MSD

There are three primary risk factors for MSDs: force, frequency and posture. All three are prevalent in construction work. “Force relates to the pressure, weight or grip used during a work action,” explains Jeffrey Smagacz, director of ergonomics engineers at Humantech, a consulting firm specializing in occupational ergonomics. “Frequency is how long or how many times workers experience the force or posture. Extreme postures are the joint angles that vary from the joint’s neutral position. A combination of any two or all three increases the risk that a person can develop an MSD.” Susan Rock, a consultant for Body Logic Health Management, says, “In the construction industry, workers are required to spend time on their knees, squatting and bent over. A common task also requires repetitive use of hand-held tools. This exposes the worker to awkward wrist postures and vibration. Manual lifting also contributes to a risk of MSDs to the back.” Fulmer explains that MSDs or other ergonomic risk factors in the construction industry can be grouped into four categories:

- carrying materials that are too heavy, bulky, difficult to handle or can shift while being moved
- performing work located overhead
- doing work located under feet
- working with vibrating equipment

Source: http://www.contractortoolsandsupplies.com/past/jobsitesafety/BattleOfBrawn.htm 22/06/03

Ergonomic study in the construction industry is not common in India. Heavy physical demands are required in jobs on construction sites. The physical demands made of construction workers may be attributed to the
manual handling of constructing materials and the use of tools and machines. Awkward working postures, repetitive use of body segments, forceful movements, and vibration and long periods of standing are also sources of physical work load. Physical work load has been recognized as the cause of musculoskeletal injuries in construction workers (Way and Lung, 1999).

Construction is by its very nature a problem in ergonomics requiring work above head height and below waist level (Smallwood and Haupt, 2007). Work related musculoskeletal disorders among women in informal sectors are a major health problem in India (Nag, 2009).

A large number of female workers are engaged in building construction in India where, irrespective of technological advances, heavy manual material tasks are performed regularly (Basu et al., 2006 and Maiti, 2008). These workers, recruited on a daily basis in construction sectors and on a seasonal basis in agricultural fields (Basu et al., 2008; Sett and Sahu, 2009) neither undergo any training for manual materials handling tasks nor are aware of the health hazards related to their work (Sett et al., 2009 and Chattopadhyay et al., 2009). Can this continue? No, it is time to act. There is particularly an urgent need for an ergonomics program at the site if:

**Box 2: Goal of Ergonomics**

The following points are among the purpose/goals of ergonomics:

- Occupational injury and illness reduction
- Workers’ compensation costs containment
- Productivity improvement
- Work quality improvement
- Absenteeism reduction
- Government regulation compliance.

The methods by which these goals are obtained involve:

- Evaluation and control of work site risk factors
- Identification and quantification of existing work site risk conditions
- Recommendation of engineering and administrative controls to reduce the identified risk conditions
- Education of management and workers to risk conditions.

Injury records or workers’ compensation claims show excessive hand, arm, and shoulder problems, low back pain, or carpal tunnel syndrome.
Workers often say that some tasks are causing aches, pains, or soreness, especially if these symptoms do not go away after a night's rest.
There are jobs on the site that require forceful actions, movements that are repeated over and over, heavy lifting, overhead lifting, use of vibrating equipment, or awkward positions such as raising arms, bending over, or kneeling. (http://www.cdc.gov/niosh/docs/2007-122/).

The ethos therefore lies just not in knowing what their problems are, but to educate them on such issues which may end up detrimental to their health, safety and well being and suggest/ demonstrate measures to mitigate those adopting participative endeavours; yes, consider them as participating partners.

Need for the study

In India, majority of women in the workforce feature in the unorganized labour. The major factor impacting such women workers is their ignorance about occupational health hazards – both physical and ergonomic. Between the two, physical health atleast receives minimum priority for consideration. Ergonomic hazards are found to be beyond their knowledge domain. Construction is a physically demanding occupation, but a vital part of our nation. Unfortunately, these workers (women) basically are not aware of the physiological and subsequent psychological problems they are landing themselves to. Ergonomics impacts individual’s life, as it is defined as the Science of work. It is the interaction between workers and their work environment. Knowledge on ergonomics enables a better fit of task and tools to the people performing them while ignoring these, affects their health status. The most common result of not fitting the work environment to people is musculoskeletal disorders. Musculoskeletal disorders are the result of months and years of overuse of human joints and connective tissue. Such problems are more pronounced among women workers in the unorganized sector and the construction workers pitiably belong to the unorganized labour. Construction work is a perennial activity in the region and is totally dependent
on women labour for unskilled jobs. Lack of ergonomic consideration in these fields of activity is also quite visible. It all also depends on the smartness of the worker’s resource use pattern. Generating awareness and helping in to incorporate healthy work-life practices in the women labourers’ lifestyle can prove beneficial. These factors thus, kinded an interest in the investigator to launch on a socially-relevant study entitled “Ergonomic Analysis of Unorganized Women Construction Labourers in their Occupational Settings” with the following objectives

Objectives

- Observe workers (women) in their occupational settings for modalities of performance in the job.
- Study the work environmental impact for sources of work-related hazards and on their health status.
- Examine their socio-economic status, knowledge on occupational health hazards, work-related health disorders and access to social security systems.
- Ergonomically relate the impact of repetitive actions and the postures adopted with objective/subjective feelings of pain and perceived discomforts during performance.
- Design an ergonomic intervention programme involving them as participating partners.

Hypothesis

- Mechanization and influx of migrated labourers impacts existing labour.
- The contribution made by the women construction workers to the family and the industry at large is marginal.
- The socio-economic status of the women is satisfactory.
- The selected workers have adequate knowledge regarding occupational and work related hazards and utilization of safety measures.
- The activities related to the industry are not drudgery-prone.
Limitations of the Study

- Only women construction workers employed by promoters/contractors constructing residents, schools and University buildings were chosen for the study.

- Study was restricted to include only those construction workers settled in Coimbatore and not those who had migrated for jobs.

The aim was to throw light on the plight of women construction workers and strengthen the knowledge on health and safety at work which is an essential issue of working conditions for the workers. Equally important is to learn what hazardous agents and work processes are used by the worker’s in their workplace. The attempts, therefore, focused on locating the ergonomic problems of these workers and also identify and recommend preventive measures. Similarly the strength of this study was roping in all those who have a stake in the welfare of this group of occupation - the workers, local governing bodies, contractors, medical personnel, Ministry (Government) and the NGOs.

Hence it is hoped that the study would help throw light on the ergonomic problems faced by construction workers, at the same time pave way for participative intervention endeavours to mitigate them.

Decent work must be safe work, and there is a long way for achieving that goal

- Juan Somavia