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Occupational health status among women workers: a study in food industry

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Abstract: The launch of 'Make in India' and 'Skill India' initiatives envisages establishment of high-class manufacturing facilities and enhancement of skills. Although this will lead to improved manufacturing production, human resources could also be covered by enhancing the occupational health scenario. The present study was conducted to know the level of awareness about occupational health and hygiene among employees and to ascertain impact of occupational health and hygiene on productivity of women employees. Since the study was descriptive in nature hence descriptive research design was adopted to describe the occupational health Status of women employees. 40 samples were drawn from 350 women employees of Neo Foods Private Limited, Tumkur by adopting simple random sampling technique (Lottery method). From this study it was found that, occupational health and hygiene of working women was deteriorated due to not following proper measures in the industry.

Keywords: occupational health, hygiene, productivity, awareness, manufacturing industry

INTRODUCTION

A significant role of human resource management is to select workers and provide them with safe working environments in order to improve and sustain their performance and productivity while reducing absenteeism and turnover. The topic of occupational health is divided into two parts: occupational or health hazards and occupational diseases (Kohli, 2006). Physical health is defined as the absence of any physical ailment or unhealthy condition in the body, while mental health is defined as the absence of stress, tension, concern, negative thoughts, and so on. Emotional wellbeing is a healthy state of absence of rage, greed, pride, hate, and so on. Spiritual wellbeing is the ability to live in ourselves with consistency and harmony. Spiritual health is also described as having faith in your religion and accepting and seeing other people's religions with equal harmony. Public health is the art and science of preserving and enhancing people's health through coordinated community activities (NOIS, 2012).

In 1985, the International Labour Organization (ILO) adopted the Convention on Occupational Health Services (No. 161) and the ILO guidelines on Occupational Health Services (No. 171). The following description was given at the convention: The term 'occupational health services' refers to services tasked with primarily preventive roles and responsible for advising the employer, staff, and their members in the undertaking on occupational health and safety (ILO, 1985).

Wellness programs improve employee wellness by providing health education, promoting lifestyle improvements to minimize the risk of infection, or providing early notice of emerging health problems by screening for conditions such as high blood pressure, high cholesterol, blood sugar levels, HIV/AIDS, and other illnesses. Employee productivity and work satisfaction are improved by such services. Furthermore, health services enable workers to make lifestyle improvements such as healthy diet, daily exercise, and abstinence from smoking and alcohol use, as well as stress therapy and periodic physical exams (Gupta, 2009). Organizational stressors play a major role in ill health and low organizational commitment. Job-security stress led to both physical and psychological illness. Five stressors, namely work-life balance, overload, power, job aspects, and pay, predicted low individual commitment to the organization (Viljoen & Rothmann, 2009).

In 2011–12, the National Sample Survey (NSSO) reported that 115 million people were working in the manufacturing sector, 10.1 million as the manpower employed in the manufacturing sector is an underestimation by the Labour Bureau since the formal sector employs just 10% of India's total workforce (NSSO, 2014).

Health hazards

They found 20 studies that addressed the health risks faced by manufacturing employees. Not every manufacturing industry has been studied or reported on. Chemical industry, metal and allied, plastic and rubber,

leather, asbestos, textiles and allied, car and allied, and ship building are among the large categories of industries surveyed (Ambreen, Khan, Bhadauria, & Kumar, 2014).

Incidence of occupational injuries/accidents

Accidents are classified as fatal or complete by the Directorate General of Factory Advice Service (DGFASLI) (i.e. fatal as well as nonfatal). While the prevalence in both groups has decreased over time, from 65.59 per 1000 people in 1980 to 2.41 in 2006 and 0.90 in 2011, the proportion of fatal accidents has risen from 0.2 percent in 1980 to 5.4 percent in 2006 and 10% in 2011 (MinistryofLabourandEmployment, Report of the working group on Occupational safety and health for the Twelfth Fiveyear Plan (2012–17)., 2011).

Notifying Occupational Hazards

According to the 3rd Schedule of the Factories Act, 1948, twenty-nine requirements are notifiable, according to the Report of the Working Group on Occupational Safety and Health for the Twelfth Fiveyear Plan (2012–17) by the Ministry of Labour and Employment. Occupational lung infections, poisonings, contact dermatitis, occupational cancers, and noise-induced hearing loss are among them. There have been several reports that have published data on notifiable diseases. Silicosis was the most frequent perpetrator, accounting for 38%–54.5 percent of the prevalence in slate pencil and precious/semi-precious stone manufacturing. Byssinosis was the second most widespread, with a prevalence of 30–48.8 percent in textile and jute manufacturing. The prevalence of asbestosis has been reported to be 3%–9% among workers involved in its manufacture (MinistryofLabourandEmployment, Report of the working group on Occupational safety and health for the Twelfth Fiveyear Plan (2012–17)., 2011).

Vulnerable groups involved in manufacturing

Women and children working in manufacturing are more likely to be adversely affected by occupational exposures because neither the activities they perform nor the equipment they use are built with their build and physiology in mind (Perera FP, 2012). This is in addition to lower salaries, less decision-making authority, and the possibility of sexual harassment. According to Tiwari and Saha, children employed in the manufacturing sector work for 6 hours or more a day. The work atmosphere is often poorly ventilated and illuminated, unsanitary, and often contains respirable dust, making it dangerous (Tiwari & A., 2014). Workers from the informal sector form another important vulnerable group but in spite of their higher occupational as well as non-occupational morbidity, healthcare and social security for them is meagre, if not completely absent (Mandal, 2009).

Existing laws/programmes and their implementation

In India, there are 44 labor-related laws/programs for the welfare of workers; ten of these have provisions for occupational health and safety. There are the Factories Act 1948, the Employees' State Insurance (ESI) Act 1948, the Child Labour (Prohibition and Regulation) Act 1986, the Maternity Benefit Act 1961, the Workmen's Compensation Act 1923, the Contract Labour (Regulation and Abolition) Act 1970, the Unorganized Workers' Social Security Act 2008, the Bonded Labour System (Abolition) Act 1976, the Fatal Accidents Act 1855, and the Unorganized Workers' Social Security Act 2008 (MinistryofLabourandEmployment, Annual Report 2012–13, 2013). Just two of these, the Factories Act and the ESI Act, are specifically applicable and provide sufficient protection for workers. The Factories Act, which is enforced by DGFASLI under the Ministry of Labour, covers the execution of multidisciplinary surveys in industry, as well as the training of factory inspectors, among other items (Ministry of Labour and Employment, The Factories Act,1948, 2013).33 The ESI Act, on the other hand, is an integrated social security scheme for workers and their dependants to cover for sickness, death or disablement, and maternity. It is administered through the ESI dispensaries and hospitals (Ministry of Labour and Employment, The Employees' State Insurance Act, 1948, 2014).

Rationale of the Study

The manufacturing sector contributed 15% to the gross domestic product (GDP) of India in 2014. The launch of 'Make in India' and 'Skill India' initiatives envisages establishment of high-class manufacturing facilities and enhancement of skills (Industry, 2014). Although this will lead to improved manufacturing production, human resources could also be covered by enhancing the occupational health scenario.

The Directive Principles of the Indian Constitution aim to protect the health and strength of its workers, to provide just and humane working conditions, and to promote the establishment and provision of occupational health services (Employment, 2015). Yet the occupational health scenario in the manufacturing sector in India leaves much to be desired. This could be attributed to the multitude of new industries and new units being added every year (MinistryofLabourandEmployment, Report of the working group on Occupational safety and health for the Twelfth Five-year Plan (2012-17), 2011) (Kulkarni, 2012). More importantly, if the health of workers

who comprise about 10% of our population could be ensured, it would improve our GDP and contribute to achieving the goal of Health for All (MinistryofLabourandEmployment, Annual Report 2014-15. , 2015).

OBJECTIVES OF THE STUDY

- To know the level of awareness about occupational health and hygiene among employees.
- To ascertain impact of occupational health and hygiene on productivity of employee.

METHODS AND MATERIAL

The present study was descriptive in nature hence descriptive research design was adopted. The study population constitutes of 350 women employees of ―Neo foods Private Ltd, Tumkur among them 40 women employees were drawn as sample, with the help of simple random sample technique by using Lottery method to arrive sample selection from the research population. Primary data was collected with the help of interview schedule and observation methods. Secondary data were reviewed by various journals, books and project works.

RESULT AND DISCUSSION

The Socio-demographic composition of the respondents shows that, 52.5 per cent (21) of the respondents were have "Primary education" (1^{st} to 7^{th} standard education), followed by 25 per cent (10) of the respondents were having "PUC education" (11^{th} to 12^{th} Standard), and remaining 22.5 per cent (09) of the respondents were having secondary (8^{th} to 10^{th} standard) Education level. 82.5 per cent (33) of the respondents were got "Married", and remaining 17.5 per cent (7) of the respondents were "Unmarried" from which were taken for the study purpose. 42.5 per cent (17) of the respondents were have "2 to 3" years of work experience, followed by 27.5 per cent (11) of the respondents were have "above 5 years" experience, 22.5 per cent (9) of the respondents were have "04 to 05" years of experience, and remaining 7.5 per cent (3) of the respondents were have "0 to 01" years of experience.

Table 1: Showing the opinion of the respondents towards the attention to maintain a good health.

Particulars		Rarely	Sometimes	Always	Total	Mean
Attention to maintain a good health	F	02	07	31	40	2.72
	P	5.00	17.50	77.50	100	
Importance for their regular meal planning	F	02	13	25	40	2.57
	P	5.00	32.50	62.50	100	
The poor health of working women repercussion on their children and their family members.	F	05	20	15	40	2.25
	P	12.05	50.00	37.50	100	
	Mean score					2.51

Source: Primary

The Above table shows that, 77.50 per cent (31) of the respondents opinioned that "Always" they are given attention to maintain a good health, 17.50 per cent (07) of the respondents opinioned that "Sometimes" they were given attention to maintain a good health, and remaining only 5 per cent (02) of the respondents were "Rarely" they are given attention to maintain a good health. Majority of the respondents were opined that always they used maintained a good health. It clearly shows majority of the respondents had conscious about their health even though moderate percentage of the respondents sometime neglect their health conscious may be their education background created some ignorance about their health. 62.50 per cent (25) of the respondents opinioned that "Always" they are given importance for their regular meal planning, followed by 32.50 per cent (13) of the respondents opinioned that "Sometimes" They are given importance for their regular meal planning and remaining 5 per cent (2) of the respondents opinioned that "Rarely" they are given importance for their regular meal planning. Majority of the respondents opined always they use to give attention to there regular meal planning. However moderate percent of respondents use to give attention sometime for their regular meal planning. It shows skipping meal awareness about nutrition hood be low among few respondents.

50 per cent (20) of the respondents "Sometimes" felt that the poor health of working women repercussion of their children and their family members, followed by 37.50 per cent (15) of the respondents "Always" and remaining 12.50 per cent (5) of the respondents "Rarely" felt that the poor health of working women repercussion of their children and their family members. Majority of the respondents were opined that sometime they used to poor health of working women repercussion of their children and their family members. It clearly shows majority of the respondents had conscious about their statement, moderate percentage of the respondents always neglect their statement.

Table 2: Delineates impact of occupation on general health

Particulars		Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree	Total	Mean
The occupational risk factors and reproductive health of married working women.	F	01	02	11	19	07	40	3.65
	P	2.50	5.00	27.50	47.50	17.50	100	
Spousal support for working women is have a direct connection diminishes mental health.	F	-	03	12	19	06	40	3.70
	P	-	7.50	30.00	47.50	15.00	100	
Social support in the work environment helps to improve mental health	F	-	04	07	23	06	40	3.77
	P		10.00	17.50	57.50	15.00	100	
Mean Score		3.70						

Source: Primary

The above table number 2 shows that, 47.50 per cent (19) of the respondents "Agreed" they feel that the occupational risk factors on reproductive health of married working women. Fallowed by 27.50 per cent (11) of the respondents were have stayed "Neutral", followed by 17.50 per cent (07) of the respondents "Strongly agree" and remaining 5 per cent of the (2) respondents "Disagree" and remaining 2.50 per cent of the respondents "Strongly disagree" for the statement of the occupational risk factors on reproductive health of working women. Majority of the respondents were agreed for the statement of the occupational risk factors on reproductive health of married working women. But moderate percent of the respondent stayed neutral and strongly agreed for the statement. It shows that clearly occupational risk factors have impact on reproductive health of working women.

47.50 per cent (19) of the respondents "Agreed" they feel that the occupational risk factors on reproductive health of married working women. Fallowed by 27.50 per cent (11) of the respondents were have stayed "Neutral", followed by 17.50 per cent (07) of the respondents "Strongly agree" and remaining 5 per cent of the (2) respondents "Disagree" and remaining 2.50 per cent of the respondents "Strongly disagree" for the statement of the occupational risk factors on reproductive health of working women. 57.5 per cent of the respondents "Agreed" that the social support in the work environment will help to improve their mental health, followed by 17.50 per cent (7) of the respondents stayed "neutral" to the statement. 15 per cent (6) of the respondents "Strongly agree" to the statement and remaining 10 per cent (4) of the respondents "disagreed" with the statement.

Sum mean value of above table is 3.70 it clearly shows respondents agreed that, there is a hazards with regard to occupational health and hygiene.

Table 3: Depicts opinion about industry's facilities

Opinion		Average	Good	Excellent	Total	Mean
Opinion about sanitary facility.	F	8	32	-	40	
	P	20	80	-	100	1.20
Medical facility getting by the company.	F	6	32	2	40	1.40
	P	15	80	05	100	
Industrial health programme.	F	6	34	-	40	1.25
	P	15	85	-	100	
Total Mean		1.28				

80 per cent (32) of the respondents opined that "Good", remaining 20 per cent (8) respondents opinion that "Average" of sanitary facility provided at company. It reveals that sanitary facility was good in the industry.

80 per cent (32) of the respondents opinion that "Good", fallowed by 15 per cent (06) of the respondents opined that "Average" and remaining only 5 per cent (2) respondents opined that "Excellent" of medical facilities getting by the company. Majority of the respondents opined good for the medical facility provided by the company. 85 percent (34) of the respondents opined "good" and remaining 15 per cent (6) respondents opined "Average" of the industrial health programme.

Sum mean 1.28 of the above table delineates slightly good (satisfactory) with existing health and hygiene facilities in the industry.

CONCLUSION

From the study it was found that, working condition is not favourable for the cause of their reproductive health and hygiene. The environment where they work because suffocating humidity they sweat and lose there ability to work hence it would affect on productivity. There is no air condition inside, moreover it is food industry, hence they have to stand for long time there is no proper sitting arrangement given, and sometimes even a pregnant woman finds it hard to mange a sitting place for completing her task. The fact is that there poor girls do not understand the importance of their reproductive health and hygiene. They think that their employers are not bound to provide them with the facilities they require during their childbirth period. Hence they feel shy to inform their employees about their problems during their pregnancy period. Their employees are not bothered to address the issue properly. The Neo foods 'workers have failed to realize properly the gravity and importance of their reproductive health and hygiene issue and hence they have failed to raise their voice against their employers. India, in the millennium set goals to minimize women health problems after the ICPD (International conference on population and development, 1994, cairo). AS far as women health and hygiene is concerned, mainly in the developing countries. Including India, the situation is very depressing. Women have disproportionately paid the price of fertility regulation. The wide variation in cultures, religions, and levels of development among Indian states and territories, it is not unusual and starting that women's health also varies immensely form state to state. A many of the health problems of Indian women are related to or exacerbated by high levels of fertility. The health of Indian women is intrinsically linked to their status in society. The contributions Indian women make to families often are overlooked and instead they are viewed as economic burdens. Health and hygiene status is no longer considered on out come solely of lifestyle choices, It is now believed that health and hygiene is also influenced by social, political and economic factors. The sum-total of these factors called the determinants of health and hygiene. The current understanding of women's health and hygiene has gone beyond singular, individual, biomedical perspectives to include diverse factors such as the family, community, population, psychosocial, and cultural understandings social determinants of health and hygiene also include such factors as education, income, employment, working conditions. Environment, health services, and social support care giving and family responsibilities, economic insecurity and experiences of violence and abuse are common for working women.

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