Ensuring Occupational Health and Safety in India: Learnings from Journey of Victims of Silicosis
Workplace safety is an issue often taken for granted by those of us working in air-conditioned offices. However, for the majority of people employed in the informal economy—who comprise over 90% of India’s workforce, safety at work is often a pipe dream. In industries such as mining, chemical manufacturing, stone cutting, sand blasting, quarrying, etc., hazardous work conditions put millions of workers at risk of life-threatening injuries and debilitating diseases each year. Though the Indian Constitution articulates the right to health and safety as a fundamental right under Article 21 (the Right to Life) and under its Directive Principles of State Policy, and has legislation in place to mandate safety and health at work, the International Labour Organisation (ILO) estimates that as of 2016, only 3.4% of the country’s workforce was eligible to receive social security benefits in the event of a workplace injury.¹

In this context, the work by civil society organisations (CSOs) like PRIA and others has been crucial in bridging the gaps between workers and their entitlements to safety and health at the workplace. Sustained work and engagement at the grassroots, local, state and national levels over the decades has generated rich insights into who is most affected by the lack of provision of occupational safety, how it can have community wide impacts, and how workers have organised to petition the establishment and secure their due compensation. In particular, the struggles faced by workers at risk of or suffering from a preventable, yet widespread condition called silicosis, have been instructive in highlighting the macro and micro level gaps in India’s occupational health and safety landscape. This paper will present a synopsis of the insights into the occupational health and safety landscape of India through the lens of PRIA’s work with communities affected by silicosis. Beginning with a brief overview of the role of civil society in the occupational health and safety landscape, it then presents a bird’s eye overview of what occupational health and safety in India looks like. This will be followed by understanding the impacts of silicosis, and who it affects at both individual and community level. Blending experiences of diverse civil society stakeholders, the paper goes on to lay out the gaps in India’s occupational health and safety landscape as highlighted by silicosis incidents. The paper concludes with the latest labour codes proposed in India, highlighting the scope of the work that civil society continues to do to ensure workers’ rights to a safe and healthy workplace are secured.


Civil society is the “sum total of all individual and collective initiatives for public good” (Tandon, 1999). The role of civil society and CSOs comprises a wide-ranging plethora of diverse activities. Associations of civil society that pursue common purpose/deliver a public good include Traditional Associations, Religious Associations, Social Movements, Membership based (representational, professional, socio-cultural, self-help) and Intermediary Organisations (service delivery, mobilizing, support, philanthropic, advocacy, network). Various types of organisations engage at various levels.² The nature of CSO activities can range from policy influencing to achieve certain goals (including evidence and agenda setting, policy development, advocacy, mobilization, consensus building, policy and accountability monitoring/watchdog work), to direct service provision (such as education, health, etc), to technical standard-setting, self-regulation through the creation and enforcement of best practices, and partnerships with the government to enhance their capacity to deliver essential services. This holds true of CSOs

working on Occupational Health and Safety (OHS) and labour rights with the goal of securing workers’ rights to compensation. Often, these efforts take place within larger movements to secure health for all persons nationally. All CSOs have a different guiding ethos driving their efforts and espouse different theories of change to effect those changes in the long term. For example, PRIA’s theory of change, involving efforts at the micro, meso and macro levels, as a CSO is depicted in Figure 1. PRIA’s efforts are grounded in its ethos of participatory research, action and development. Enabling the excluded and the marginalised to gain and then exercise their agency, and informing, capacitating and empowering communities to incorporate their knowledge into solutions for themselves forms the bedrock of PRIA’s efforts.²

Figure 1: PRIA’s Theory of Change

Information Dissemination | Capacity Building
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Types of Interventions Practised By PRIA
Monitoring | Advocacy

Information Dissemination: One of the most crucial aspects towards ensuring workers’ health and safety is building awareness about occupational hazards and existing provisions enabling workers’ rights. PRIA has carried this out by spreading information about the occupational hazards of silicosis among not just workers, but also medical professionals, local and national government officials, and communities at large. Seminars and campaigns were organised to help increase knowledge and awareness about the disease and how it could be dealt with at the workplace.

Capacity Building: Knowledge and information dissemination is also an essential part of overall capacity building that PRIA undertook with workers. Workers were made aware of information and strategies they could use to secure their rights. This included building the skills they needed and the awareness of the need to unionise and demand better working conditions at their workplaces.

Monitoring: PRIA monitored and evaluated the implementation of specific projects, programs and policies to see how effective they were in actually effecting a change in the conditions of the workers.

Advocacy: PRIA also engaged in various advocacy initiatives to influence policies and changes that were made in the working conditions of the individuals suffering from silicosis, and ensuring proper diagnosis and treatment.

Workers’ rights are also actively championed through activism on the ground and now increasingly on social media. Several organisations are engaged in this, along with awareness

²To know more about PRIA, and PRIA’s theory of change, visit: [https://www.pria.org/about-us-2-0](https://www.pria.org/about-us-2-0)
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raising. Another key role CSOs play in securing occupational safety is in enabling legal recourse and compensation through filing public interest litigations and cases against violators of labour laws. At a broader level, network building, movement building and ongoing campaigns facilitate knowledge sharing, sustained activism, awareness generation and coalition building among organisations that help strengthen overall efforts to secure workers’ rights and occupational health.

In the realm of OHS, knowledge institutions like PRIA also play a key role in bringing all stakeholders together. PRIA enabled direct access of workers to amplify their voice and demands to stakeholders across government, industry and academia, at the local, state and national level. In the OHS landscape, stakeholders can consist of workers’ collectives, government bodies and officials at different levels, employers’ associations, union representatives, activists, multi-lateral global governance bodies like the ILO or WHO and many more. Multi-stakeholder dialogues are crucial mechanisms that PRIA uses to collectively share knowledge and insights to bridge gaps in understanding between various stakeholders. Multi-stakeholder dialogues enhance levels of trust, discussion and collective problem solving amongst different stakeholder groups.

CSOs thus play a crucial role in India’s OHS landscape, serving as crucial platform providers, dialogue facilitators and change agents towards systemically achieving inclusive, rights-based changes in occupational health and safety. Ensuring workers’ right to OHS through standards and proper precautions to prevent occupational injury, disease and related death are also mandatory from moral, ethical and productivity standpoints.

A Bird’s Eye View of Occupational Health and Safety in India

According to the World Health Organisation (WHO) occupational health and safety deals with all aspects of health and safety at the workplace, with a strong focus on prevention of hazards. Workers’ health has several determinants, including risk factors at the workplace. These risk factors can be said to stem from two major causes:

1) **Hazards at the workplace** - such as equipment, chemicals, furniture and other environmental factors that make work dangerous

2) **Lack of regulatory standards and awareness on safe workplace practices** - A lack of training and guidelines on safe workplace conduct and proper use of equipment can lead to various dangers for workers. These workplace level guidelines are drafted based on both task level specifics as well as overarching regulatory frameworks that accord workers’ rights to safety and health at the workplace.

When these risk factors are inadequately addressed, workers end up suffering from various types of occupational hazards, such as accidental injuries, as well as diseases such as cancers, musculoskeletal diseases, respiratory diseases, hearing loss, circulatory diseases, stress related disorders, communicable diseases and many others.

Ensuring working environments that prioritise workers’ health and secure their rights is an enduring challenge. In terms of overarching guidelines to ensure workers’ rights in India, there are over 16 labour laws that provide for various types of OHS measures in India, provided through a range of laws enacted. Some of these laws are: The Employee’s Compensation Act, 1923 (previously the Workmen’s Compensation Act); The Employees State Insurance Act of 1948; The Factories Act, 1948; Mines Act, 1952; Dock Workers Act, 1986; Contract Labour Act, 1970; and Inter-State Migrant Workers Act, 1979. The two key acts that denote the most detailed OHS provisions are The Factories Act, 1948 and The Mines Act, 1952. As Rajat Kumar Saha outlines in his paper on “Occupational Health in India”,

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The Factories Act was amended in 1987 and stipulates pre-employment examination as a pre-placement procedure, statutory periodic medical examination for job in hazardous areas. In India, occupational health is under two ministries: 1) Labour and 2) Health and Family Welfare. The Ministry of Labour and the labour departments of the states and union territories are mainly responsible for health and safety of workers. The Ministry of Health and Family Welfare is responsible for providing health and medical care to workers through its facilities. The DGMS (Directorate General of Mines Safety) and the DGFASLI (Directorate General – Factory Advisory Services and Labour Institutes) assist the Ministry in technical aspects of occupational health and safety in mines, ports and factories respectively.4

There are two other key legislations that provide crucial provisions for workers’ OHS. These are:

a) The Employee’s Compensation Act of 1923: The Employee’s Compensation Act (previously the Workmen’s Compensation Act) of 1923 is the oldest regulation that continues to be applicable and enforced throughout the country. This act provides all workers working in legally registered entities (aka the formal sector/ the formal economy) the right to compensation for workplace injuries and occupational diseases due to the condition of the workplace, and lays out the conditions under which workers must be compensated by employers. In case a worker dies, compensation is owed to his/her dependents (which are classified under the act). The act also lays down rules for the processes to be followed and the officials responsible for overseeing the implementation of the act.

b) The Employees State Insurance Act of 1948 (ESIA): This act established the Employees State Insurance (ESI)—a self-financing social security and health insurance scheme for Indian workers—and the Employees’ State Insurance Corporation (ESIC) which is an autonomous corporation under the Ministry of Labour and Employment in India. The ESIC manages the funds collected according to rules and regulations stipulated in the act. The scheme’s finances are drawn from compulsory monthly payments by employers and employees in the organised sector. In addition to other responsibilities, the ESIC must provide workers in the organised sector and their families monetary benefits in case of sickness, maternity and employment injury. In case of employment-related disablement or death, there is provision for a disablement benefit and a family pension. In addition to the 22 diseases classified under the Factories Act, the ESIA adds 4 more categories of illness for which workers are owed insurance benefits under the act. The ESIC has also established many hospitals and dispensaries across the country where beneficiaries under the act can obtain affordable and subsidized treatment.

Other provisions that provide guidelines on occupational health include the Plantation Labour Act, 1951; The Contract Labour Act, 1970; The Inter State Migrant Women Act, 1979; The Beedi and Cigars Act, 1966; and The Employment of Children Act, 1938.

Thus, at the legal and regulatory level, India does ensure OHS for its workers. However, an important and crucial caveat is that these provisions are only applicable to workers in the formal sector. This leaves at least 90% of India’s workforce (which works in the informal economy)

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without OHS. Informal sector workers continue to work in unregulated environments, and thus denied of crucial rights.

There are several key gaps in these legislations:

- Within the Factories Act, the Chief Inspector of Factories in a state has the powers to relax the provisions of the Factories Act as and when they wish to. This dilutes the provisions of the act, as the key enforcing officials are very susceptible to undue influence and prone to misusing their power.
- Some of the acts’ provisions are contradictory in nature. For example, byssinosis is mentioned as a notifiable disease under the Factories Act but not as a compensable disease under the Employee's Compensation Act.
- The implementation of these Acts is ineffective and irregular.
- They exclude a large number of diseases on which technical information is available.

The nature of work performed is a major factor that dictates the level of hazards workers face. It is in this context that a closer look at how workers affected with silicosis (and other related diseases) have struggled to secure their rights in India is relevant – as the very nature of their work entails exposure to harmful substances that cause the disease, and preventing exposure is an essential part of securing their right to OHS.

Silicosis and its Biological Effects on Workers

Silicosis is one of the most prevalent and deadly occupational diseases in India. It is caused by the inhalation of crystalline silica dust, which scars lung tissue. It is most commonly seen in workers engaged in work that exposes them to crushed silicates, such as sandblasting for surface preparation; crushing and drilling rock and concrete; the masonry and cement industry; mining/tunnelling; quarrying; slate and pencil industries; and demolition work. Silicosis is a progressive, disabling and often fatal lung disease. Symptoms of this disease include shortness of breath, fever, fatigue, loss of appetite, chest pains accompanied with dry and non-productive cough; which eventually leads to respiratory failure and in most cases, death. Silicosis can develop within a few weeks to even decades after the exposure, and the damage done to the lungs cannot be reversed, making it an incurable disease.

Silicosis disproportionately affects people from low-income and disadvantaged socio-economic backgrounds – who constitute the majority of unskilled labour in the industries where this disease is most prevalent. Crucially, silicosis is also prevalent in communities in the vicinity of activities that generate crystalline silica dust in the surrounding air. It also affects child and maternal mortality rates among workers exposed. Women workers, in addition to paid work at factories and mines, perform demanding jobs like cooking, maintaining the household as well as childbirth and child-rearing. These extended hours of work put tremendous pressure on women’s bodies. Due to working in the same uncomfortable positions for longer durations, women are more prone to developing additional muscular-skeletal disorders. Women workers in silicosis associated occupations are often not provided basic entitlements like maternity leave, medical health benefits, washrooms at work and provisions for rest and change during menstruation.

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Higher child mortalities to silicosis or other diseases increases as women’s immunity is further compromised.9

At a national level, according to the National Health Portal of India, silicosis is most prevalent among workers of construction and mining in states like Gujarat, Rajasthan, Pondicherry, Haryana, Uttar Pradesh, Bihar, Chhattisgarh, Jharkhand, Odisha and West Bengal. The prevalence of silicosis in India ranges widely from 3.5% (in the ordnance industry) to 54.6% (in the slate-pencil industry). This variation in the prevalence of this disease is due to different silica concentrations in different work environments and different durations of exposure to the silica dust. Estimates indicate that as of 2018, more than 10 million Indians are at risk of contracting silicosis.10

Silicosis is among a whole host of diseases workers can suffer from as a result of exposure to harmful biological, physical and chemical agents, which include substances like poisonous chemical fumes, asbestos, cotton dust and many more that cause harm upon ingestion or physical contact with the body. As many of these substances including crystalline silica can cause irreversible damage, preventing exposure through proper protective equipment and safe operational procedures is often the only way to ensure workers’ safety. However, as the next section will highlight, despite being preventable if not curable, silicosis is extremely prevalent in India due to a host of factors stemming from improper implementation of OHS policies. Most occupational diseases are preventable through proper safety precautions, yet millions are still at risk. The next section will highlight some reasons for this.

Explaining the Prevalence of Silicosis and Other Occupational Diseases: Evidence from Grassroots Work by Civil Society Organisations

Though silicosis is preventable, it is still widespread in India for many reasons. A major factor perpetuating its prevalence is a combination of a lack of knowledge about the disease among workers, and enduring cases of misdiagnosis. As PRIA and other CSOs have documented, in numerous instances, silicosis is misdiagnosed as tuberculosis (TB). As part of its study on the “State of workers in the mines of Rajasthan” in 1997, PRIA (in partnership with the Mine Labour Protection Campaign) was able to document the prevalence of silicosis among sandstone mine workers in areas within Jodhpur and Udaipur districts. Of 280 workers surveyed and tested through Lung Function Tests (LFTs), 98.5% of the workers tested positive for silicosis, and most of them had been diagnosed as having tuberculosis by medical authorities. For many years, they had been treated for tuberculosis, and a further confounding factor was that their silicosis made them susceptible to contracting tuberculosis, resulting in instances of silico-tuberculosis.11 Other studies PRIA conducted in the 1990s in Mandsaur12 in Madhya Pradesh and Renukoot13 in Uttar Pradesh yielded similar insights related to misdiagnosis of silicosis as tuberculosis – workers with silicosis were often misdiagnosed with tuberculosis and treated incorrectly for years. This had direct implications on their ability to seek compensation and redressal from their employers, since tuberculosis could not be proved as an occupational health hazard.

11 Centre for Occupational and Environmental Health, Society for Participatory Research in Asia(PRIA), "State Of Workers In The Mines Of Rajasthan" (repr., New Delhi: Society for Participatory Research in Asia(PRIA), 1997).
12 "State Pencil Workers Of Mandsaur, Madhya Pradesh" (New Delhi: Society for Participatory Research in Asia (PRIA), n.d.).
13 Participatory Research in Asia (PRIA), "Occupational And Environmental Health Problems In Renukoot - A Retrospective Of The Visit Made By PRIA To The Area" (repr., New Delhi: Participatory Research in Asia (PRIA), 1998).
Despite increased knowledge of silicosis over the years and gradually increasing awareness, the problem of misdiagnosis persists. A large-scale incidence of misdiagnosis was recorded in 2019 in Karauli\textsuperscript{14}, a district of Rajasthan known for large-scale unregulated sandstone mining. Out of 250 silicosis affected workers, 68% were wrongly treated for tuberculosis prior to their diagnosis of silicosis, and more than 50% of them had gone out of the state or to larger cities within the state for better treatment. Further, 60% of the workers had not received their compensation from the government. Solving the issue of misdiagnosis is thus a long-standing challenge. This is compounded by the realities of the state of India’s healthcare infrastructure, wherein the presence of a doctor in each village cannot be guaranteed, let alone an occupational health specialist with the ability to distinguish between similarly presenting diseases.

A second crucial factor enabling the prevalence of silicosis and other occupational diseases is the lack of awareness among workers of their condition, as well as of their rights. In most studies and interventions conducted by PRIA for silicosis and other OHS related grassroots work, a common thread afflicting workers has been the lack of awareness of their rights to safety and health, as well as compensation. Educating workers as to their rights, and building their capacities to collectivise their concerns through measures such as unionisation, joining group insurance schemes and self-help groups, have been crucial in enabling them to negotiate with their employers as well as the government. Such measures are essential to secure their legally enshrined rights to safe work environments and monetary compensation. Without awareness of their rights and of the nature of the disease, workers could not demand that they be recorded and reflected on the employer’s records, demand protective gear, ventilation and other needs that would help ensure their rights and prevent the contraction of diseases. Employers, unless held to account, also have no economic incentive to invest in mechanisms to enable compliance with OHS guidelines and prioritise health of their workers. Management can often be unresponsive to workers’ needs and concerns. In many cases, especially in industries where heavy machinery is used, productivity concerns and costs take precedence over workers’ safety. This often results in workers removing safety guards from equipment to increase operation speeds and efficiency. When workers’ collectivise their concerns, it provides them greater negotiating power with their management on OHS matters, in addition to conventionally conceptualised wage negotiations.

The prevalence of occupational diseases and hazards stems from the disconnect between workers’ needs and the use of protections, including legal recourse, available to them. Civil society organisations’ grassroots experiences and knowledge sharing also reveal more granular, situational and behavioural insights explaining the prevalence of occupational hazards. For example, in Bombay\textsuperscript{15}, unions had worked hard to ensure employers provided protective footwear in an engineering industry when the use of heavy machinery was required. However, workers refused to wear them, as they were heavy, steel tipped boots which were extremely uncomfortable in the heat that characterized local weather, and had no utility outside of the workplace. In the case of a fertilizer factory\textsuperscript{16} in Maharashtra, where nitric acid was being produced, activists in the factories and other supporters decided to go to the courts for the redressal of their concerns and the affect the acid had on their health. However, they later withdrew their case under pressure from the workers. The workers were uncertain about how the


\textsuperscript{16} Ibid.
judges would react. They feared that rather than considering their grievances, the court would just completely shut down the plant due to non-compliance and thus deprive them of their income. They also believed that, unlike in a court, they had some power at the shop floor to make their voices heard and demands met. They collectively preferred to take that route to solve their problems than go to the courts which did not have the specific knowledge to deal with their occupational health concern.

Opening up and globalisation of the Indian economy, has resulted in increasing informalisation of labour, which has resulted in further erosion of workers’ OHS rights. Contractual and informal daily wage workers working in hazardous occupations (including silicosis causing occupations) have virtually no legally mandated OHS protections as compared to full time workers on the payroll of factories and businesses. Thousands of workers thus cannot access ESIC subsidised public healthcare and compensation enabled through various labour laws for financial support during illness.

Workers in occupations that expose them to silicosis and other occupational hazards tend to come from socio-economically disadvantaged backgrounds. Delays in diagnosis of silicosis result in higher costs of treatment which many cannot afford. Lack of other locally available employment options often forces workers’ families to send other family members to replace them in the same hazardous job. Thus a vicious, inter-generational cycle of continued affliction from occupational diseases gets perpetuated.

PRIA’s work in Renukoot\textsuperscript{17}, Uttar Pradesh in 1998 highlighted how industrial clusters and associated pollution resulted in occupational diseases affecting not just workers but also nearby communities. Renukoot and the adjoining areas had one aluminium factory, more than six chemical factories, six thermal power plants within a diameter of 80 kms, one cement factory and many stone crushers. The pollution created by these units had widespread impact. Workers at the aluminium factory were not being provided their benefits and reported that serious accidents were a frequent occurrence. Majority of the population living in Renukoot got their drinking water supply from a reservoir where three thermal plants also dumped their waste, and thus resulted in community wide gastric issues. In the village of Dala, approximately 30 kms away from Renukoot, villagers faced serious problems due to a cluster of stone crushing units in the area. With more than 360 stone crushers spread over a radius of 10 kms, huge quantities of dust caused health problems not only to workers but also to their families and surrounding community. Majority of the workers there suffered from respiratory problems and many of them were diagnosed with tuberculosis, which was later suspected to be silicosis. While the villagers wished for proper safety precautions and regulations to be implemented at the factories and desired the closure of some units, the owners of those crushers were affluent people with strong political backing and any kind of opposition was curbed.

Other broader factors perpetuating silicosis and other occupational health hazards include improper enforcement of central and state level legislation. For example, in the case of the Factories Act, while the central legislation lays the regulatory framework for the types of governance authorities and agencies, states must implement the act. States have discretion on the number of staff they hire and the monetary allocations made to enforcement and oversight bodies. However, relying largely on states for implementation has often resulted in under-staffed

\textsuperscript{17} Participatory Research in Asia (PRIA), "Occupational And Environmental Health Problems In Renukoot - A Retrospective Of The Visit Made By PRIA To The Area" (repr., New Delhi: Society for Participatory Research in Asia [PRIA], 1998).
and underpaid government workers overseeing implementation of the Factories Act. Collusion and bribery between factory owners and oversight officials also play a role in poor levels of compliance — all of which harm the worker. PRIA’s own research in Maharashtra in the 1980s highlighted, in an asbestos factory, the management of the factory and inspection officials colluded to pass of cases of asbestosis among the workers as tuberculosis and other non-occupation related lung ailments. This enabled the factory management to evade punitive legal action and avoid paying compensation amounts to workers affected by asbestosis due to exposure at the factory.  

There is still a long way to go towards universalising workers’ rights to occupational safe and healthy in India. However, gradual progress has been made in the right direction — in part due to sustained activism and engagement towards ensuring universal OHS, as well as overall increases in awareness and education levels among workers. Governments have also taken incremental, if incomplete, steps towards strengthening the OHS landscape in India — such as the creation of a “National Policy on Safety, Health and Environment at the Work Place” in 2009. A landmark moment in this journey was the Supreme Court judgement on the People’s Rights and Social Research Centre (PRASAR) vs the Union of India case. In 2006, PRASAR had filed a petition asking for compensation and rehabilitation for the families of migrant tribal workers from Madhya Pradesh who contracted silicosis as labourers in Godhra and Balasinor in Gujarat died of the disease. The petition also asked to protect workers in eight different states. Due to sustained advocacy by PRASAR, PRIA and several other CSOs, The National Human Rights Commission (NHRC) conducted its own studies on the prevalence of silicosis, and in a report submitted in 2010 directed the state of Madhya Pradesh to take appropriate steps to rehabilitate 304 people identified as having silicosis. Further, the NHRC in 2010 informed the apex court about its findings regarding the prevalence of silicosis in the country, and sought permission to be included as a party in the case initiated by PRASAR. The Supreme Court asked the NHRC not only to pursue the matter but also directed the government (through the Ministry of Health) to provide the necessary assistance to the NHRC. In 2016, the Supreme Court delivered a verdict in favour of the workers, and directed the State of Gujarat to pay an amount of Rs. 1 lakh each to the kin of the 238 migrants identified by the NHRC, and also arrange to deposit an amount of Rs. 2 lakhs each in their names in fixed deposits, so that the monthly interest accruing there could also be availed by the kin of the deceased. The court further ordered the government to make sure that working environments are not hazardous for the workers employed.

This judgement is thus a crucial marker of the success of sustained activism and engagement on part of various stakeholders on the issue of OHS. However, the need for CSOs to continue advocacy for the rights of workers to safe workplace environment and to receive legally mandated compensation claims remains.

In 2019, the central government proposed the unification of the existing gamut of labour laws into 4 national labour codes through 4 bills in Parliament. While the Code on Wages Bill, 2019

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was passed by Parliament in 2019, in 2020 the government reintroduced 3 new bills for the remaining codes on Industrial Relations, Social Security and Occupational Health, Safety and Working Conditions. These four codes collectively replace and consolidate almost 29 different existing labour laws.

Labour rights experts and organisations have criticised these codes for being more pro-employer than pro-worker, especially in the wake of various state governments using their discretion to unilaterally extend factory working hours, without any consultation or dialogue with trade and labour unions. Key criticisms levelled include:

- The Code Occupational Health, Safety and Working Conditions (COSH) does not address protections for most workers in the unorganised sector due to a lack of specific legal stipulations for workers in agriculture and small businesses.
- Migrant workers are also short changed as provisions in the earlier Inter-State Migrant Workmen Act related to providing an employee passbook detailing key employment terms, and provisions requiring employers to register details of workers’ home and destination states with the government are no longer present in COSH.
- In COSH, daily hour limits for work have been left to the discretion of “the appropriate government,” thus making a key labour right contingent on government discretion. Under the Factories Act, 1948, they are strictly defined at 8 hours a day. Making working hours subject to government discretion turns a core right of the worker to a reasonable workday into a privilege.
- The codes do not address the specific needs of women workers to ensure their health and safety concerns at the workplace.

The efforts of several CSOs including PRIA and PRASAR ensure meaningful provisions of OHS and workers’ rights continue, involving:

- Awareness generation among workers about the hazards presented by their work and the rights and redressal mechanisms available to them.
- Training of government workers on up to date OHS protocols, aligned with global standards.
- Monitoring of maintenance of proper employment records and compulsory recording of the workers’ attendance towards enabling compliance with labour law regulations and ensuring workers’ rights.
- Monitoring governments at all levels to ensure the rigorous implementation of all the laws and acts made for workers, including providing for clean working spaces, safe drinking water, toilets, first aid kits, regular medical check-ups, housing to all the permanent staff, and tracking where migrant workers come from.
- Ensuring proper equipment is provided to the workers so that they do not go through injuries while working; and factory and mine owners provide wage compensation to those workers who are suffering from silicosis, silico-tuberculosis or any other forms of pneumoconiosis.

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- Ensuring gender-based workers’ rights, such as maternal health leave and prevention of sexual harassment at the workplace against women, and elimination of instances of child labour.
- Ensuring orientation and training of medical professionals at local and national levels in the various occupational diseases prevalent in the country is essential towards ensuring the availability of correct treatment for workers.
- Awareness generation of occupational health related issues among all stakeholders such as employers, employees, lawmakers, workers’ organisations (e.g. trade unions), and the general public.

As the government reviews the new proposed labour codes, existing labour laws, occupational health related legislations, and compliance facilities and frameworks need to be fairly evaluated. Provisions protecting workers’ interests need to be retained, and the expansion of protections to workers in the unorganised sector needs to be commenced with urgency. Moreover, these codes need to be periodically reviewed. Adequate investments and improvement in the nation’s healthcare infrastructure is essential to ensure universal OHS nationwide at scale.

In the process of ensuring workers’ rights and designing solutions to ensure OHS for them, workers’ must be active stakeholders whose voice and perspectives are sought, heard, acknowledged and implemented in designing further interventions and regulation.
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