CHAPTER 8
A SUMMARY OF CONCLUSIONS

Women's health can be defined as the field of practice, education and research that focuses on the physical, social, emotional, political and economical well-being of women, and encompasses women's internal and external world of reality. Most of the geographic contribution to research on women's health has been curiously sparse in comparison with other social sciences. Attention to women's health has most commonly been focused on the reproductive health. In most of the societies the majority of poor people are women and it is mainly women who are victims of health because they are dependent on others. It has been assumed that income from work bring significant health benefits to women specially to poor women and their families, because it allows them to purchase basic necessities, such as, food, clothing, medicine and housing. Elements of patriarchy play a vital role in determining the health status of women because different elements of patriarchy exert pressure separately or in combination with each other on women's health in getting necessary resources for sustaining life and promoting health. In this study it has been assumed that if women work then it helps to reduce the influence of patriarchal controls to a large extent as it helps women to be more empowered and it ultimately help women to have better health. One can arrive at such conclusion by comparing working women with non-working women who are not earning money and totally dependent on others.

The main objectives of this study were to measure the level of health status of working women with reference to anthropometric measures (BMI) and patterns of morbidity and also to examine whether work helps women to reduce patriarchal controls and to achieve greater say in decision making process and power to control resources so that it may ultimately improve their health status. Emphasis was also given on women's education, awareness and perception on health, nutrition and patterns of health care utilization. In
order to achieve objectives various research questions were formulated which examined the current health status of working women, the difference in the health status of working and non-working women, whether work have any relationship with health status or not, whether economically remunerative work help women to achieve greater say in family decision making process, power, and control of resources or not and finally whether earning prove beneficial for the health of the working women or not. For each research question, different indicators and methods were selected. To find out various aspect of morbidity prevalence rate is selected as indicator. For anthropometric measure normal BMI which varies between 18.5 to 25.0 and height more than 145cm were used as indicators. To find out absence of illness prevalence rate of absence of illness was also chosen as indicator. Decision-making power and control over money are the two most important elements of patriarchy. Therefore, it was important to see whether economic work helps women to achieve greater power in decision-making process and access to money or not. Some important indicators of empowerment such as control over money, various decisions making power and spending power were used here to fulfill research questions as well as objectives. In order to understand the relationship between women’s work and women’s health suitable statistical methods, such as, calculation of simple percentages, cross tabulations, correlation and regression analysis were used for analyzing the data. These methods enable us to understand the cause and effect relationship between the variables.

The whole research work was divided into seven chapters. Each chapter except first and last two has dealt with different aspects of socio-economic background, work, nutrition, health status and empowerment. In chapter 1 problem was introduced and various sections were devoted for overview of literature, theoretical framework, objectives and research questions, methodology, data base and chapter scheme. Chapter 2 introduced the study area and was devoted for socio-economic backgrounds and living environment of the study areas. Chapter 3 dealt with work profile of women living in slum and non-slum areas. Chapter 4 had been devoted to nutritional status of working women and non-working women of slum and non-slum areas. Chapter 5 dealt with different aspects of health. In Chapter 6 different attributes of women empowerment and awareness were
analyzes. In Chapter 7 inter-linkages between patriarchal controls, work and health were established. Chapter 8 summarizes all concluding remarks.

FINDINGS

SOCIO-ECONOMIC BACKGROUND OF HOUSEHOLDS

It is important to know the socio-economic background of the working women and non-working women in order to understand and analyze various variables.

1. It has been found that in non-slum areas 75.55% working women and 84.5% non-working women belong to non-scheduled caste whereas in slum areas majority of working women (74.5%) and non-working women (42.7%) are scheduled caste.

2. In non-slum areas maximum proportion of working women (40.0%) and non-working women (37.3%) are found in the highest age group i.e. 40 to 44 years whereas women of slums are comparatively young. In slum areas maximum proportion of working women (33.6%) are found in the age group of 30 to 34 years and majority of non-working women (43.6%) are found in the lowest age group i.e. 25 to 29 years.

3. In non-slum area little more than half of the households of working women have nuclear family and rest of the families are joint (45.5%). In contrast it has been found that family type of huge majority of non-working women of non-slum area is nuclear (71.8%). In slum area different kind of picture has emerged. Here most of the families of both working women and non-working women are of nuclear type.

4. Proportion of women got highest educational levels is found to be more among working women than non-working women. For example, educational level of 85.5% working women falls in the highest category i.e. H.S. and above but only 43.6% non-working women fall in this category. Educational levels of non-slum women are very high and women of slum areas are far behind in this case. There are many illiterate women in both the slums.

5. In non-slum area higher total household income is noticed in more number of cases among working women than non-working women. The increase in total household
income of families of working women is mainly due to the addition of working women’s income into the total household income. In slum areas also while low total household income is found to be greater among non-working women than working women but higher total household income is found to be more among working women than non-working women.

**LIVING ENVIRONMENT**

Health of communities is greatly influenced by living environment. Supply and usage of safe water, basic sanitation, quality of housing, number of rooms, location of kitchens and toilets, types of fuel used for cooking etc. determine the health of the communities to a great extent.

1. In non-slum area house type of all working women and non-working women are pucca. In slum area majority houses of all working women and non-working women are of semi pucca type. In non-slum areas of both Netaji Nagar and Malviya Nagar all the households of working women and non-working women have separate kitchen. But in both the slums, majority of households of both working women and non-working women have kitchen inside rooms.

2. In the households of all working and non-working women of non-slum areas bathing facility is located inside house but in Begampur slum majority household of working women and non-working women are located inside rooms though both working and non-working women of Harijan Basti slum prefer use of public bath more than having bath inside rooms. In non-slum areas all toilets are located inside the houses of working women and non-working women. In Harijan Basti slum not a single household has any toilet. In Begampur slum very few households have toilets.

3. Waterlogged condition was not found in any of the slum and non-slum areas. Sewage disposal facility is available in all the slums and non-slums areas. But during survey it was noticed that sewage systems of both the slums are not well maintained. In all slums and non-slum areas source of drinking water is piped one and all the households of non-
slum areas have direct taps connection but in slums all the houses are not directly connected by taps. In both slums everybody uses natural water for drinking purposes. But in non-slum areas of Netaji Nagar and Malviya Nagar a huge proportion of households use filtered water. Proportion of households use filtered water is greater among working women than non-working women.

WORK PROFILE

1. Most of the working women of the non-slum areas are found to be engaged in formal sectors. Working women of the slums are mainly engaged in unorganized informal sector. These women are mostly in low-paid, low-status jobs in unorganized sector. There are significant variations in employment and wages of women workers of slum and non-slum areas as they are engaged in different sectors of economy.

2. 80% working women of Netaji Nagar and 58.2% working women of Malviya Nagar have income which varies between 5000 to 15000 rupees but very low income and very high income are earned by a very small proportion of women. 29.1% working women of Malviya Nagar are earning high income, which varies between 15000 to 20000 rupees per month. Combined figures of these two non-slum residential areas show that majority of working women (40.9%) are earning between 10000 to 15000 rupees per month. But income of more than half of working women of Harijan Basti and Begampur slum varies between 1000 to 2000 rupees. This shows the existence of a huge gap in the monthly income of slum and non-slum women, as there are significant difference in the nature of job and the sectors where these two groups of women are working.

3. Except Malviya Nagar in all slum and non-slum areas majority of working women are in the labour market from 5 to 10 years and more than half of them have started working between the age of 20 to 25 years.

4. In non-slum areas the main reason for joining work is to be self independent and self-fulfillment, in slums financial necessity is the main reason to enter labour market. More than 90% women in slums enter labour market due to financial necessity.
5. Work status has given economic independence to more than 90% women of non-slum areas whereas this proportion is low for working women of slum areas. This indicates that patriarchal control is more prevalent in slum areas.

6. Women’s income contributes in a big way to the total household income. It has been observed that huge proportion of families of working women partially dependent on their income and this dependence is more widely noticed in slums (81.8%) than non-slum areas (58.2%).

7. About 60.9% and 74.6% working women of non-slum areas and slum areas contribute half of their income to family income respectively.

8. Majority of working women of all areas feel no stress due to job. Except Malviya Nagar considerable proportion of women feels stress sometimes. In all areas huge majority get little time for relaxation and except Harijan Basti slum in all other areas more than 90% women have job satisfaction.

NUTRITIONAL STATUS

Well-being is directly concerned with a person’s quality of life. Well-being involves three basic functioning namely being healthy, being nourished and being educated. In nutrition for adult Body Mass Index (BMI) and height are used as anthropometric measures. BMI is widely used as an indicator of nutritional status because it adjusts for stature. BMIs vary across regions and between working and non-working women of those regions and also with age.

1. In the non-slum areas 40.9% working women are having normal BMI but majority of them either overweight or obese. But among non-working women proportion of women having normal BMI is even less (36.4%). Nowadays changed lifestyle, less physical activities, food habits, introduction of electrical gadgets, which have minimized physical labour, are contributing to increase the body weight of the women.

2. In slum very different picture has emerged. In slum 71.85% working women are having normal BMI whereas among non-working women it is much less (62.75%). For
example among working women of Harijan Basti not even one-fourth women are malnourished, overweight or obese. More than 76.0% working women are having normal BMI. In slum working women are mainly involved in manual jobs where physical labour is more required than brain work. As these women are not properly fed and do lots of physical work, weight of their body does not increase. As a result most of them have BMI which fall in the normal category. But proportion of non-working women having normal BMI is much lesser than working women. This is mainly because non-working women of slum does less physical work than working women.

3. In slum proportion of women malnourished are found in greater number among non-working women than working women. In non-slum regions overweight and obesity are the major problems but in slums it is malnutrition.

4. In this study it has been established that BMI increases with increase in age. Spearman’s correlation coefficient for BMI and age groups shows that these two variables are strongly related with each other in case of working women and non-working women of non-slum areas and in 95% cases this relationship is found to be true. For working women of slum areas these two variables do not have any significant relationship but for non-working women of slum areas these two variables have strong and significant relationship in 99% cases.

MORBIDITY

1. The spectrum of health ranges from good health to morbidity to fatal ill-health or mortality. A difference in mortality and morbidity between two or more than two persons or two groups reflects a difference in their health.¹ It has been stated in the fifth chapter that conditions of the body or mind that cause pain, dysfunction, or distress to the person afflicted or those in contact with the person can be deemed an illness. It is observed that prevalence rate is lowest among working women of non-slum areas (51.8) whereas it is

highest among the non-working women (66.4) of the non-slum areas. In slum areas again this rate is found to be lower among working women (62.7) than non-working women (66.4). So it emerges that morbidity rate is lower among working women than non-working women of both slum and non-slum areas.

2. Chronic diseases are diseases that persist for long time. It has been found that in all slum and non-slum areas prevalence rates of chronic disease are very high among non-working women than working women in all areas except Harijan Basti slum. In slums prevalence rates of chronic diseases is much lower than non-slum areas for both working women and non-working women.

3. High blood pressure and thyroid are the major common chronic diseases among working women of non-slum areas. Along with high blood pressure and thyroid diabetes is another major chronic illness for non-working women of non-slum areas. Prevalence rate for diabetes is much higher among non-working women than working women in non-slum areas. For slum areas prevalence of high blood pressure is common among both working women and non-working women, but no case of diabetes is found among working women. This is probably because of the fact that working women work very hard. On one hand they go out for work on the other hand after returning from work they do all household works. In this way they burn calories more which non-working women can’t.

4. In both slum and non-slum areas proportion of women who do not receive medication is more among working women than non-working women. Most of the working women do not receive medication because medicine is not prescribed or they don’t feel like taking medicine. Non-working women who do not take medication most of them don’t feel like taking medicine.

5. Working women who do not receive regular check-ups they feel it is not required and non-working women do not go for it as they do not feel like going for check ups. One can live almost symptom free and have a good quality of life by making behavior changes and using the health care system wisely. So it has been observed that those who don’t go for check ups any of them do so due to financial reasons. In many cases they feel it’s not
required without knowing the actual condition and progression of the diseases. This is very dangerous trend as without knowing the actual condition of the diseases they may make themselves one step closer to danger line.

6. It is observed that prevalence rates of acute illnesses for working women in all slum and non-slum areas is much lower than that of non-working women in last one month. Prevalence rate of acute illness is much higher in slums than in non-slum areas. Among all acute illnesses cold related illness is the most common illness suffered by majority of both working women and non-working women of all areas. It has been also noticed that cases of urinal infection, gallstone, enlargement of liver, malaria, skin disease and slip disc are more common among non-working women than working women.

7. Everybody received treatments in both slum and non-slum areas except a few who believe in naturopathy and felt lazy to see a doctor. Working women are very prompt in receiving treatment though proportion of women who received treatment in few hours is higher for non-working women in all areas but those who received treatment in first day the proportion is much higher for working women in all areas. More than 75% working women receive treatment within 2nd day in all areas. But most of the non-working women start receiving treatments as days of illness progress.

8. It has been found that in all slums and non-slum areas private clinics are major source of treatment for working women. In all areas except Malviya Nagar non-working women seek treatment in government clinics. In non-slum areas among working women effective treatment is the main reason for preference of source of treatment. All slum women and non-working women of Netaji Nagar prefer source of treatment that is cheap and affordable.

9. Proportion of women has time to maintain health is more among non-working women than working women. But actually those who take health measures are found to be more among working women than non-working women. In slums very few women take health measures in comparison with non-slum areas.
10. Proportion of working women going for follow up is higher than non-working women in all slum and non-slum areas and proportion of both working women and non-working women go for follow up is much higher in non-slum areas than slum areas. In slums women are not educated enough and do not understand the importance of follow up visit whereas in non-slum areas women are more educated and realize that follow up visit is necessary in order to know whether the person is alright or need more medical investigations or help to be free of illness completely.

11. Many women of our society get shied away from medical help. In spite of their sufferings they pretend to be all right until it becomes serious and becomes necessary to see doctor. In all slums and non-slum areas proportion of non-working women shied away from medical help is much higher than working women. The trend of being shied away from getting medical help is quickly fading away from the mind of working women as they are having their own income. But as non-working women are dependent on others, it will take some time to remove this shyness.

12. It is well established that early the illness is reported to doctor, there is a better chance of early recovery upon taking treatment. Those who see doctor immediately have the better chance to recover quickly than those who delay in getting treatment. It has been noticed that while working women and non-working women of non slum areas wait for few days to consult doctor after symptoms of illness have appeared, w. w. in slums don’t wait and immediately consult doctor in the fear of loosing wages on the ground of their absence from work due to illness.

13. Self perception about own health is a very important determinant of health. In all slum and non-slum areas proportion of women who have perceived their health as good is higher among working women than non-working women and in all areas proportion of women who have considered their health as bad is more among non-working women than working women

14. In non-slum areas proportion of women having health problems while working is more among working women than non-working women. In slum areas it is just opposite. In non-slum areas back problem is the major health problem for working women; for
non-working women it is tiredness. In slums general weakness is the major health problems for both working women and non-working women while working.

15. Self perception about own health is one of the determinant of health. It depends upon the physical and mental condition of the person. If someone is having some permanent illness for which she has to take medicine regularly for her whole life, her self perception about her own health won’t be good. It has been found that in Netaji Nagar 76.1% working women who don’t have chronic diseases have described their health as good and 66.7% working women who are suffering from chronic diseases have described their health as bad. Among non-working women 75% women’s self-perception of their own health is good and they don’t have any chronic diseases also and 47.4% non-working women having chronic diseases have described their health as bad. Similar trends have been observed in other slum and non-slum areas. It has been noticed that perception of own health is determined by the presence or absence of having chronic diseases.

16. Absence of illness is one of the indicators of good health. Though health is more than the absence of illness, still the role of illness can’t be excluded, because it affects health in big way. In all the areas the working women have got higher prevalence of absence of illness rate than non-working women. In non-slum areas like Netaji Nagar and Malviya Nagar gap between prevalence of absence of illness rates for working and non-working women is much wider compared to the slum areas.

17. It is also found that proportion of women having absence of illness and normal BMI is greater among working women than non-working women in all areas. Proportion of women having normal BMI is found to be more among those who have absence of illness than those who do not have. So it suggests that if people have normal BMI then they tend to be free from illnesses, which is one of the most important indicators of health.

WOMEN'S EMPOWERMENT

To study health status of women and relationship between women’s health and work it was necessary to study different elements of patriarchy. Different elements of patriarchy are decision making power, control over money, approval in terms of giving permission
to spend money etc. These elements control and shape women's health, work as well as their lives. In this study it is assumed that if women work then it helps to reduce the influence of patriarchal controls to a large extent as it helps women to be more empowered, which ultimately help women to have better health.

1. Empowerment is necessary because it changes women's perception of self worth. Patriarchal controls like decision-making power, control over money, and act of approval e.g. on movement, spending of money tend to reduce when women become empowered. Women’s participation in decision making in family matters, finance, and own health and social matters shows that working women have greater share in decision making process than non-working women.

2. In both the slum and non-slum areas it has been found that proportion of women taking decision on obtaining own health care is more among working women than non-working women. It is noticed that proportion of working women who take decision on obtaining own health care are more in slums than non-slum areas. In slums most of the working women are daily wage earner. So absence for one day will mean losing wage for the day. So they want to return to work as soon as they can so that they won't lose wage.

3. Majority of working women of non-slum areas has gone alone to open bank account, whereas for non-working women this proportion is very negligible. In slums those who have gone alone to open bank account are all working women. Proportions of women who operate own account alone is found to be much higher among working women than non-working women in all slum and non-slum areas.

4. Having access to money does not guarantee that one will have control over money. Unless one has control she can't spend according to her preference and choice which means she has to depend on wish of others to get her things. It has been noticed that in all areas working women enjoy greater control over money than their non-working sisters. For example, in non-slum area of Netaji Nagar 96.4% working women have control over money but only 23.6% non-working women have control over money. In slum area of Harijan Basti 78.2% working women have control over money but only 16.4% non-working women have it.
5. In all non-slum areas huge proportion of working women (e.g. in Netaji Nagar 83.6%, in Malviya Nagar 94.5%) take decision on how their earnings are to be used. So it has been observed that majority of working women are empowered as they take decision on how their earnings are to be used. In slums this proportion is less and control of patriarchs is found to be more. Few working women in slum areas are not allowed by the patriarch of the family to take any decision on this matter. In most of the cases their husbands decide how their earnings are to be used. Except Malviya Nagar in all areas proportion of women spending money according to their choices is more among working women than non-working women.

6. In a patriarchal society, male domination is reflected in various aspects of women lives. It is not only non-working women who are dominated by the patriarch, working women who are earning money are also dominated by patriarchs in various forms. But it is important to see whether working status of woman reduces the male domination on them or not. This can be only understood by comparing working women with the non-working women on various issues where patriarch tends to dominate.

7. It has been found that proportion of women who don’t need permission to spend money is much higher among working women than non-working women in all the areas. For example, in Netaji Nagar 81.8% working women do not need any permission to spend money whereas only 14.5% non-working women do not require this permission. Proportion of working women need permission to spend money is lower in non-slum areas than slum areas and proportion of women need to take permission for the same purpose is highest among non-working women of slum areas. So male domination is least on working women of non-slum areas and it is highest on non-working women of slum areas.

8. Patriarchal controls are mostly observed when it involves spending money and movements outside the house. When it restricts the movements of women it means denial of their independence to move freely. This restriction puts control on overall movements and on movements to some special places. This restriction is imposed on women in general and on housewives in particular. Working women are also not spared.
9. It has been observed that in all areas proportion of women who need permission to go to any place is higher among non-working women than working women. For example, in non-slum area of Netaji Nagar 21.8% working women and 80.0% non-working women need permission to go to any place. This figure also indicates that patriarch of the family even controls the movements of working women who usually go to their workplace daily. These working women are allowed to go to their workplace but except that if they want to go somewhere else they need to take permission from the patriarch of the family.

10. In Harijan Basti slum patriarchal control is much more on both working women and non-working women. In this slum 58.2% working women and 85.5% non-working women need permission to go to any place. Hence again it has been found that control of patriarchs is more in the slums than in non-slum areas. Similar trends have been observed in terms of other patriarchal controls also.

11. 94.5% of working women of non-slum areas go out independently; whereas proportion of non-working women who go out independently is much lower. In Netaji nagar and in Malviya Nagar 60.0% and 65.5% non-working women go out independently. In slums patriarchal control is much stronger. For example, in Harijan Basti 67.3% working women go out independently whereas only 18.2% non-working women are allowed to go out independently. Again it also shows that control of patriarchs is more in the slums than in non-slum areas.

12. Awareness regarding health services is very essential. It is very important to have the knowledge of what kind of health care facilities and services are available and from where these services are available, whether these are free services or not etc. Awareness regarding health services gives one edge to avail it quickly whenever need arises. Proportion of women having this awareness is more among working women than non-working women in all areas. In Netaji Nagar all working women have this awareness. As expected, proportion of working women having this awareness is lower in slums compared to non-slum areas.

13. Having perception of major illness like diarrhoea, cholera, Malaria, measles, heart diseases etc. is very important as it may help to prevent or check the advent of the
disease. Perception of major illness comes not only from reading about these diseases but also from experience. Education can remove these barriers but unfortunately slum women are mostly illiterate or literate with low level of education. Proportion of working women having this knowledge is found to be more than the proportion of non-working women in all areas. Proportion of women having perception of major illnesses is more in non-slum areas than slum areas, as they are more educated.

**DYNAMICS OF PATRIARCHAL CONTROLS, WORK AND HEALTH**

It has been assumed that if women work, then it helps women to become more empowered as it reduces the influence of patriarchal controls and it ultimately helps women to have better health. Control over money is one of the most important elements of patriarchal control.

1. Women who have control over money they have better decision making power, than those who do not have it. Greater proportion of working women enjoy control over money and go alone to obtain own health care in comparison with non-working women. This indicates that working women are more empowered.

2. Proportion of women who have control over money and take decision on investment alone is found to be more among the working women than the non-working women in all areas. In non-slum areas majority of working women who have control over money take this decision jointly with their husbands. In slums it is mainly husbands of working women and non-working women who take decision on investment. So it has been observed that in slums patriarchal control is very strong as far as decision-making on investment is concerned. In all slum and non-slum areas (except non-working women of Netaji Nagar) both working women and non-working women who don’t have control over money can’t take this decision alone, and it is their husbands who take the decision.

3. Proportion of women who can spend money and also have control over money is greater among the working women than the non-working women in all areas. On the contrary, those who don’t have spending power, a huge majority of them do not have control over money. This includes both working women and non-working women.
4. Above observation proves that women who have control over money also can spend money according to their choices. So it suggests that when women are working patriarchal controls get reduced and as women are having control over money they can spend money on food, medicine etc. according to their choice.

5. If women work and have control over money then they can take decision on how their earnings are to be used. It has been observed that more than 85% (82.7% for Begampur slum) working women who have control over money can take decision on how her earnings are to be used. Some of them take joint decision too.

6. In theoretical framework it has been assumed that those who have control over money they have greater decision making power. Hence when women work they become empowered and they can spend money on food, medicine etc. according to their choices. It has been observed that in non-slum area of Netaji Nagar 85.2% working women who can spend money on food medicine etc. according to their choices also take decision on how her earnings are to be used. In Harijan Basti slum 76% working women who can spend money according to their choices, also decide how her earnings are to be used. But all the working women of Harijan Basti who can't spend money do not have any power to decide how her earnings are to be used. So even if women are working patriarchal control trickles down the strata and deny them the liberty to take decision on how their earnings are to be used. This has been found that influence of patriarch gets reduced when women are highly educated, skilled, trained and have steady income.

7. Spending power depends on income and it affects BMI. In non-slum areas spending power don't affect BMI greatly for working women and non-working women. In non-slum areas all women with spending power are more overweight than those who can't spend. In non-slum areas affordability gives women to avail luxury which reduces physical activities, and increases body weight. In slums women who have spending power and normal BMI is higher among working women than non-working women.

8. In all areas a large proportion of working women who have control over money don't need permission to spend money. In all areas proportion of women who have control over
money and therefore don’t need permission to spend money is more among working women than non-working women. So “approval” which is an element of patriarchal control becomes less when women start working and gain control over money.

9. In all areas most of the working women with normal BMI is found in the lower to medium income groups. It shows earnings prove beneficial for the health of the working women specially whose earnings are not either very low or very high. In non-slum areas proportion of overweight and obese women increase as income rises. In slums, proportion of malnourished women have been found to be more in lower level of income compared to higher level of income.

10. BMI and income are strongly related with each other and in 95% cases this relationship is found to be true. It shows that BMI increases with increase in income. As earnings of non-slum women are much more than slum women that’s why among non-slum working women the prevalence of overweight and obesity is commonly noticed in the higher and highest income groups whereas among working women of slum areas with increase in income there is an improvement in the number of women with normal BMI and decrease in the number of malnourished women.

11. Logistic regression shows that likelihood of having normal BMI is more in the low and medium level of income over highest level of income in non-slum areas. In slums when working women belong to 2nd class of income which is low level of income the odds of having normal BMI is increased by a factor of 26.906 over the highest level of income. In this case probability indicates that there are well over 65% chances of having normal BMI and this result is significant at 5% level of confidence. It has been proved beyond doubt that there is a strong and significant relationship between BMI and income and most of the women with normal BMI are found in the low and medium income levels.

12. In non-slum areas among working women logistic regression results show that working women who have no chronic diseases, whose self perception of own health is
good, who consult doctors for sickness immediately they have greater chances of having normal BMI.

13. Chances of having normal BMI is more among working women who are in the lowest and medium level of total household income as compared to those who are in the highest level of total household income. It has also emerged that if patriarchal controls are less and women can spend money without taking permission from patriarchs probability of having normal BMI is more as compared to those who need to take permission.

14. In non-slum areas it has been found that non-working women who have no chronic diseases, whose self perception of own health is good, who consult doctors for sickness after a few days they have greater chances of having normal BMI. Though these variables have an important effect on BMI yet none of them have any significance either at 1% or at 5% levels of confidence.

15. In slums-working women who have no chronic diseases, whose self perception of own health is good, who consult doctors for sickness immediately they have greater chances of having normal BMI. Likelihood of having normal BMI is more among working women who belong to 2nd class of income which is low level of income, working women who belong to low level of total household income and working women who can spend money without taking any permission from the patriarch. So these result have proved the basic assumption that if women work, then patriarchal control become less and there is a better chance of having normal BMI.

16. Many of the above results are statistically significant. Those who consult doctors immediately, those who consult doctors after a few days and those who belong to the lowest level of total household income are significant in 1% level of confidence. Those who have described their self perception of own health as good, ok and who belong to low level of income have strong and significant result at 5% level of confidence.

17. In slums among non-working women who have no chronic diseases, whose self perception of own health is good, ok, who consult doctors for sickness after a few days,
they have greater chances of having normal BMI. Likelihood of having normal BMI is more among those non-working women who belong to the lowest level of total household income as compared to those who are in the highest level of total household income.

So following conclusions can be drawn from the above discussion.

- Health status of working women is much better than non-working women in all areas.
- Proportion of women with normal BMI, less prevalence rates of both chronic diseases and acute illness, more prevalence rate of absence of illness is found to be more among working women than non-working women.
- It has been found that when women work patriarchal controls tend to reduce to a great extent.
- Patriarchal controls are very strong on non-working women in terms of decision making power, control over money and approval.
- The proportion of women taking important decisions is found to be more among working women than non-working women.
- Control over money is one of the most important elements of patriarchy, and a greater proportion of working women have this control in comparison with non-working women.
- A greater proportion of working women don't need approval of patriarchs to spend money or to go to any place – a freedom that most of the non-working women do not enjoy.
- In slum areas patriarchal controls are stronger than what it is in the non-slum areas.
- Relationship between BMI and income is very strong and significant in both slum and non-slum areas and found to be significant in 95% cases.

One can conclude by saying that work has brought many positive effects in the lives of women.
LIMITATIONS OF THE STUDY

Indicators of morbidity have some limitations. In household survey when questions are asked about illness, it depends on the perception and knowledge of the person who is reporting illness. Moreover, morbidity rates may be higher among educated people, people from higher income group etc. because they report illness more and seek more health care. Among poor, uneducated people reporting of illness is less which leads to low morbidity rates for this section of people. By considering normal BMI as main variable of heath in this research, limitations mentioned above were minimized.

FUTURE SCOPE OF THE STUDY

The work done in this research may be extended in several directions.

- In this study major emphasis was on four aspects namely, work, patriarchy, empowerment and health. Here attention was placed on private form of patriarchy where family is the main source of all patriarchal controls and in which male patriarchs of the family are the major players. But this study can be extended where both private and public form of patriarchy play major roles in limiting the resources available to women.
- BMI categories can be further sub-divided in order to find out critical level which ultimately can help to predict more realistically the chances of developing chronic illness.
- Age group of the women can be taken beyond 44 years as health effects are more prominent in the higher age groups.
- The same study can be carried out on the working women who commute a long distance to reach their workplace. For example, in Kolkata and Mumbai there are thousands of working women who commute almost 60 km. everyday by crowded bus and trains. Travel certainly has some impact on their health. It is important to see that whether travel has any adverse effect on their health in spite of being empowered and self dependent or not.
POLICY IMPLICATIONS

It has been found in this study that work has brought many positive effects including health benefits in the lives of many women. Today, women in most western nations have a right to employment which is backed up by laws against sex discrimination and by the provision of maternity leave. In India also similar law is needed.

In India women are becoming more and more educated specially in urban areas. In this study it has been found that few gave up employment when they got married and it has become increasingly normal for women to remain in employment even when their children are small.

In our society men’s contribution to housework and child care is still far from being realized. The traditional domestic division of labour remains remarkably unchanged, even when women are in paid employment. Housework and caring responsibilities should be shared more equitably with men and both men and women should be enabled to combine family responsibilities with paid employment.

Child-care is an issue which needs to be addressed. Child-care is an issue which confronts many young working mothers who leave their child behind at home when they go to work. As majority of women are main caregivers for their offspring, in the event of their being ill, child-care becomes a big issue that poses major challenges for working women. Women who want to work outside home should be enabled to do so, and that they should not be deterred by the lack of childcare provision. There is an enormous need to train child-minders and nursery school teachers in different localities in order to provide the child-care facilities that enable women to work. In non-slum areas little more than half of the families of working women are nuclear type and in slums this proportion is very high. So children of these families can’t be looked after by other family members. So any policy which encourages women’s work should incorporate policy for child-care.

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Child care also costs money. Women who are poor and are earning money to sustain their families it is difficult for them to spend extra money for child care. So, government should set up crèche which will provide service absolutely free of charge. Women who are working in formal sector they should get extra allowance for child care.

In this study it has been observed that many women specially non-working women shied away from medical help. Visit by female health workers to know the various needs of the women’s health care will be of great help. Many women feel shy to express their needs. But they can speak more frankly with the female health visitor regarding their needs. A comprehensive approach at primary health care level should identify those needs.

There is need to set up more government clinics in order to take away extra pressure from the existing clinics which will ultimately reduce doctor patients ratio and long waiting time. These clinics are often overcrowded and patients need to wait long to see doctor. Due to this reason many women prefer private clinic.

Though Government clinics are supposed to provide medicine free of charge; it was reported by many women that often medicines are not available at these clinics and they had to by medicines. So, proper public health care distribution system should be in place with proper checking system so that medicines become available only to the patients.

Improvements in the health status of women can be expected to occur if these efforts are made. Health status of women can be improved not only through health care services, but also through social reforms. It also depends greatly on political will.