CHAPTER 1
INTRODUCTION

1.1. STATEMENT OF THE PROBLEM

Health is perhaps the most crucial aspect of human well-being. Women’s health assumes significance because they form about half the population. Women’s health is often shaped by the physiological hormonal milieu and environmental, societal and economic circumstances. The human experiences of physical illness are socially constructed, and quite often women’s and men’s experiences are different because elements of patriarchy play a vital role in determining the health status of women irrespective of whether the women are working or not. 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. Even if women are working, patriarchal controls work actively to restricting them of the freedom to spend according to their choices. Therefore, it becomes necessary to examine whether women’s work plays an important role in limiting the patriarchal controls so that work enables them to have better health status.

It is important to study women’s health because it 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. The study of women’s health is necessary because women are different from men. There are differences among women’s and men’s health in every system, as for

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example, cardiovascular, gastro intestinal, immune, musculoskeletal, urology and psychological health.

Health is foremost determined by a variety of economic and social factors, which assure access to sufficient food, drinking water, shelter and other necessary resources for sustaining life and promoting health. Millions of persons do not have access to these basic life-sustaining resources. It is mainly women who are the victims of poor health because in most of the societies the majority of poor people are women and they are dependent on others. In many developing countries the economic pressure and poverty force women to enter labour market and income is the prime motivation to enter the labour market. Income from wage work offer significant health benefits to poor women and their families, because it allows them to purchase basic necessities, such as, food, clothing, medicine and housing. It can be said that women’s work at any level will have some kind of positive association with health. Having a paid job outside the home usually enhances women’s physical and mental health.

In this study attempts have been made to examine health status of working women. As different elements of patriarchy restrict women from the freedom to spend on food and medicine according to their choices it is important to examine whether women’s work plays an important role in limiting the patriarchal control, i.e. whether patriarchal control becomes less when women start working or not. It is assumed that if women work then patriarchal control becomes less and work enables them to have better health. This relation can be observed if the proportion of working women and non-working women taking decision on different matters, having access and control over money and investing resources according to their choices are compared. NFHS report No. 8, 1998 shows that mother’s work brings negative effects on child’s survival. In India majority of women who work are extremely poor and that is why they enter labour market. Without their


economic contribution few families among them will be able to sustain themselves. This report, therefore, recommends that mother’s work should not be held responsible for this negative impact and emphasis should be given to the need for viable alternative child care for working women.

In this study it is important to examine effects of women’s work on their own health. Comparison between working women and non-working women will be made not only about their health status, but also about their socio-economic backgrounds, their living environment, awareness and perception about health and nutrition, and their health care utilization. Systematic study of all these is very much needed for overall growth of the society, as health of women is a crucial component in the health of a nation and as important as that of men.

1.2. AN OVER VIEW OF LITERATURE

Health is a very dynamic concept. It is determined by biological, physical, social, economical, cultural, environmental, political and historical factors. Recently, concept of women’s health is emerging as a separate branch of knowledge, which will bring justification to a long awaited field of research. Women’s health and men’s health are not similar and also not determined by the same factors. In this section many studies related to this research are reviewed. The whole review of literature is classified on the basis of various themes. These themes are: concepts of health; patriarchy and culture; poverty, work and women’s health; domestic work, paid work and health; food nutrition and health; illness behaviour, perception and health. Literature on concepts of health dates back to 1946 and covered up to 1994. A wide range of period starting from 1947 to 1996 is covered in the section that deals with patriarchy and culture. Literature reviewed on poverty, work and women’s health is relatively of recent origin which has started from 1983 and covered till 2001. These research works deal with different aspects of life that have direct or indirect links with women’s health. Literature concentrating on domestic work, paid work and health ranges from 1967 to 1999. Time period covered on food,
nutrition and health is from 1985 to 1999. The literature reviewed on illness behaviour, perception and health covered the period from 1951 to 1979. Studies reviewed here provide a comprehensive summary of research findings.

1.2.1. CONCEPT OF HEALTH

Different concepts of health and illness exist both within and between different societies. Different researchers conceptualized health in different ways. According to Dan\(^4\) health is determined by the interaction of economic, political and social forces. On the other hand, d'Houland and Field\(^5\) felt that a state of good mental and physical equilibrium represents health. WHO\(^6\) has also defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Calnan\(^7\) thought that being able to maintain normal role functioning, being fit, being able to cope with crisis and stress indicates the health of a person. The first and most immediate need of the people is to survive and be physically healthy. Definitions of health also vary with age and gender. Jones\(^8\) reported that women were most likely to define health in terms of ability to cope with household tasks.

1.2.2. PATRIARCHY AND CULTURE

Many scholars have tried to view patriarchy, as a universal phenomenon. Patriarchy is viewed as a world system and the two processes of colonization and house-wife-isation are closely and causally interlinked. Without the ongoing exploitation of external colonies, today within the new international division of labour the establishment of internal colony

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that is nuclear family and woman maintained by male bread-winner, would not have been possible. Mies 9 identifies various structures including systematic violence to domestic violence that maintains women’s oppression. Reflecting on the phenomenon of patriarchy Walby 10 theorizes patriarchy as a cross-cultural phenomenon of oppression, even if it may change forms with the change capital, a shift from relatively privatized form of patriarchy, in which woman is primarily a labour in home unpaid to a relatively public form of patriarchy in which do wage work. According to Giddens 11 over the most of the course of history patriarchy has never been sustained mainly through the use of violence. It has been legitimized on the basis of differential gender roles, values associated with these, and sexual separation between public and private spheres. One of the first radical feminists to insist that the roots of women’s oppression are buried deep in patriarchy’s sex/gender system was Kate Millet 12. In her sexual politics (1970) she argued that sex is political primarily because the male-female relationship is paradigm for all power relationship. Social hierarchy supercedes all other forms of inegalitarianism, racial, political, or economic, and unless the clinging to male supremacy as a birth right is finally forgone. Patriarchal ideology, according to Millet, exaggerates biological difference between men and women, making certain that man always have dominant or masculine roles, and that women always have subordinate or feminine ones. Men do this through institutions such as, academy, church, temple, mosque and the family.

Structuring of gender relations has always been reflected in the division of labour between the sexes. With the development of industrial societies in the eighteenth and nineteenth centuries, this was manifested in the development of ideology of “separate spheres” in which women specialized in domestic work and men in market work;

9 Mies, Maria (1980) Indian Women and Patriarchy: Conflicts and Dilemmas of Students and Working Women, Concept, New Delhi.


women's sphere is the home, men's public life. This ideology was uncritically reflected in the writings of early sociologists. For example, Durkheim argued "today among cultivated people the woman leads a completely different existence from that of men ... the two great functions of the psychic life are dissociated, that one of the sexes takes care of effective functions and the other of intellectual functions".

1.2.3. POVERTY, WORK AND WOMEN'S HEALTH

Women's health has been reported to be poor in low income countries. According to Jacobson though some affluent women are as healthy as those in developed countries it is clear that millions of others live in a state of chronic debility afflicted by the diseases of poverty and the hazards of child bearing. According to WHO report in some African countries Gonorrhea is estimated to affect as many as 40 percent of women. These diseases are not just distressing but most of the time produce chronic infections which have serious effects on women's health. Paltiel examined women's health in the context of poverty and noted that the relationship between women's work and women's worth has profound consequences for their mental worth. She has found that the poor are exposed to more environmental health hazards in their homes, and in unrewarding, depersonalizing jobs. Women's dependent status as housewives, mothers, and dutiful daughters is not absolute, but is conditional upon their being simultaneously dependent upon by others.


Medjuck and Tozer\textsuperscript{17} are of the opinion that women are tainted with economic dependency throughout their lives as a result of the domestic division of labour, which accords a discounted value to women's paid work, and no value to women's domestic labour. Basu\textsuperscript{18} says that there are many dimensions to poverty, and that the relative of disadvantage of women is more severe on some matters than on others, and also varies according to the larger context. It is true that poverty is bad for health. Recent research findings make it increasingly clear that poverty is a dynamic, not a static, concept. According to Benzeval and Judge\textsuperscript{19} some people face long period of sustained financial hardship, a large number of others move in or out of poverty in various ways, and for different periods of time. In a study they have found that long run income and persistent poverty are key determinants of health, and that short-term falls in income can have a detrimental effect on health. Duncan\textsuperscript{20} thinks one needs to consider the reason for the change in income and its timing.

The effects on individual's health could be compounded by the lack of social integration and low store of some forms of social capital on the estate, or buffered by its greater stock on other. Cattell, Vicky\textsuperscript{21} is of the opinion that social capital - essentially an individual and neighbourhood resource produced when people cooperate - is a helpful construct for identifying conditions, which contribute to the quality of life. As a concept which bridges structural and approaches to poverty social capital is a useful heuristic tool.

\textsuperscript{17} Medjuck, S., O'Brien, and Tozer, C. (1992) "From private responsibility to public policy: Women and the cost of care giving to elderly kin," Atlantis; A Women's Studies Journal, 17(2), p 45.


\textsuperscript{19} Benzeval, Michaela and Ken Judge (2001) 'Income and Health : The time dimension', Social Science and Medicine, 52, p 1388.


\textsuperscript{21} Cattell, Vicky (2001) 'Poor people, poor places and poor health: the mediating role of social networks and social capital', Social Science and Medicine, 52, p 1514.
in understanding the relationship between poverty, place of residence, and health and well-being.

According to Buvinic and Lycettle\textsuperscript{22} in developing countries like Indonesia and Peru, it is the poor women who are more likely to work for pay. The two reasons most often cited to explain this pattern are economic need and gender inequality. It is argued that poor women are more likely to be in the labour force due to sheer necessity and demands for survival. In a study Malhotra and Degraff\textsuperscript{23} have found that among poor families both daughters and wives and daughter-in-laws contribute towards household strategies for survival by getting jobs. Another study conducted by Ramu\textsuperscript{24} in Bangalore shows that about sixty percent of the dual earner wives reported economic need as the reason that led them into the labour force. However, Ramanamna and Bambawale\textsuperscript{25} found few women industrial workers in Pune and Bombay consider the right to work or the improvement of their social status as reasons for entering the labour force. In a sample drawn from Bombay and Ahmedabad, Papola\textsuperscript{26} observed that rising prices and increasing family size compelled some women to work in order to supplement family income. NFHS report No. 8, 1998\textsuperscript{27} shows that mother’s work brings negative effects on child’s survival. In India majority of women who work are extremely poor and that is why they enter labour market. Without their economic contribution few families among them will be able to sustain themselves. Therefore, mother’s work should not be held responsible for this negative impact.


Emphasis should be given to the need for viable alternative child care for working women.

According to Bartley and Montgomery in England women who are either unemployed or keeping house fulltime are likely to describe their health as generally “fair” or “poor”. This study shows that more than 80 percent of the employed women describe their health as “good”, and about 10 percent describe their health as “poor”. Whereas it has been found that about 30 percent unemployed women and about 10 percent women who are keeping house have described their health as “poor”. However, they feel that physical health does not necessarily decline during a spell of unemployment. Indeed it has been found that physical health may actively improve during a period of unemployment.

Poverty was putting back into the centre of the enquiry while arguing for the relationship between unemployment and ill-health. Many studies link the health effects of unemployment directly to financial problems. White has shown that unemployed people who are obliged to borrow are also more likely to report deterioration in physical health. Stable employment contributes to building up skills, work experience, and social network.

Workplace, working environment, workload and working hours – all these have great impact on the health of the workers. Workplace or organization is made up of much more than the building and its environments. Job satisfaction, happiness, joy, emotional and spiritual well being and physical fitness indicate the health of employees and workers. For employees discharging responsibilities attracts much more attention than well-being of the workers. If one is not healthy, he or she is unable to perform, participate, act or fulfill the needs of the organization. Wilkinson thinks that the concept of social determinants of workplace health is a position developed from the understanding that


health potential can be maximized through the recognition of individual and organizational needs. The wellness-illness dictionary can be balanced if needs of both are balanced in terms of desires and expectations.

1.2.4. DOMESTIC WORK, PAID WORK AND HEALTH

The issue of workload and its impact on the individuals’ predisposition to illness has been the subject of study for many years. Garfield 31 told that work and work process rather than combined home and work pressure is the central subject. According to Boserup.32 the caring labour, mainly done by women for children, the ill and elderly; indicated the community work contributed by women beyond household boundaries; and profoundly changed the ways work and values are conceptualized. However, the content of the work itself varies significantly between rich and poor countries, between rural and urban areas, and between industrialized and non-industrialized modes of production. In the late 1980’s combined effects of home and work pressures became main focus as a result of increasing roles of women in the workplace and in service sector, changes in work process and technology took place. Excessive workload or overwork leads to coronary heart disease. Hall33 has reported that occupational stress may be considered as a more important risk factor than diet, smoking, lack of exercise and family medical history.

Relationship between working hours, length of work time, and illness had been established long back. It has been found that irregular working hours and two-shift systems affect the bodily functions like temperature, heart rate, and various hormones that regulate the activity level of the brain. Sleeping problems, gastro-intestinal disturbances are found among these workers. Before going and after coming from work,


working women take care of their children, and domestic chores, and thus find very little
time for relaxing at home.

Some sociologists feel that notions of work are socially constructed, and the same can be
said regarding the concept of health and risk. Berger and Luckman34 said that everyday
knowledge about reality is created through the interactions and interpretations of
individuals rather than reflecting pre-existing facts. Hence the meanings attached to
health and work are constantly negotiated rather than given. After studying various
research Weindling35 has found that occupational health research and practice have
indeed frequently served the interest of employers at the expense of workers by limiting
compensation cost, prioritizing the maintenance of production over the protection of
health, ignoring and devaluing workers' experience of occupational ill-health, and
focusing on individual behaviour in explaining work-related illness. According to
Messing36 in Quebec women workers have more industrial diseases than men. Men are
having more accidents compared to women. Women are working in those areas where
the dangers are less obvious, but health damage builds up over time.

For almost all of the women domestic labour takes up a major part of their lives. But
relatively little about how these effects their health is known. In a study Norboo37 has
found that women who are spending time near the cooking stoves are exposed to serious
pollutants which can cause acute bronchitis. In an article Kettle38 has emphasized the

37 Norboo, T., Yahya, M., Bruce, N., Heady, J. and Ball, K. (1991) “Domestic pollution and respiratory
need to explore both the bio-physical and social environments in which women do their work. In developing countries women collect, lift and carry water and fuel which cause them back injuries and complications during late pregnancy. Doyal\(^39\) thinks that measuring household labour is difficult. However, demographic statistics give us some indications of the volume of household work, but it will be a partial picture, unless one takes a closer look inside the family to determine the type of work being done, and its allocation between household members. The nature of household work differs from developed countries to developing countries. In the poor countries women have to grapple directly with the natural world to provide necessary things for their families. Thus the health impact of household work needs to be much more carefully delineated in different social and economic context.

1.2.5. FOOD, NUTRITION AND HEALTH

The links between diet and range of diseases are incontrovertible. WHO’s “Health for all” policy recommends that member states focus on the determinants of health, and two of the main determinants of health are food and nutrition. Generally, nutrition is linked to problems of deficiencies of nutrients, such as, energy, protein, vitamin or minerals. According to Robertson, Brunner and Sheihamp\(^40\) relationship between food, nutrition and health is more than just a matter of nutrients. They think food and health are affected by globalization, macro economics, social values, and culture. They are of the opinion that social class differences in health are seen at all ages with lower socio economic groups having greater incidence of premature and low birth-weight babies, heart disease, and stroke in adults. The diet of low income groups in the U.K. provides low-cost energy from foods, such as meat products, but lacks vegetables and fruits that are costly. This

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type of diet is lower in essential nutrients, such as calcium, iron, magnesium, folate, and vitamin C.

Diet-related diseases can be grouped into two categories: those due to under nutrition, such as iron deficiency, and those due to over nutrition such as cardio-vascular disease. The extent of under nutrition in girls and women, which is a direct result of poverty, leads to the incidence of anaemia. According to WHO\textsuperscript{41} report at least 44% of all women in third-world countries are anaemic, compared with about 12% in the developed countries. According to World Bank report\textsuperscript{42} in India the figure is as high as 88%.

The common use of nutritional status as the indicator of health points to an underlying assumption that poor nutritional status arises primarily from inadequate food intake. But Maxwell\textsuperscript{43} opines that this concept of food insecurity ignores other definitions such as poverty or vulnerability to food shortage with or without overt malnutrition. A specific concern for urban nutrition is how nutritional status interacts with exposure to environmental pollutant and industrial toxicants. It has been found from the literature on industrial toxicants and nutritional states that poor status in any of a number of nutrients can increases susceptibility to toxicity of substances. Sutphin,\textsuperscript{44} had cited the example of the Soviet Union where the states explicitly incorporated a concern for nutritional status into occupational health services by providing workers with food high in those nutrients indicated by research to be protective.

\textsuperscript{41} World Health Organisation (1992) op. cit., p 62.


\textsuperscript{43} Maxwell, Simon ed. (19991) To Cure All Hunger: Food Policy and Food Security in Sudan, IT Publication, London, p 51.

1.2.6. ILLNESS BEHAVIOUR, PERCEPTION AND HEALTH

Each aspect of the social system is related with each other, and thus produces some consequences which affect health, and consequently people become ill. According to Parsons this sick role treats sickness as a form of social deviance, which has violated a norm of behaviour and is dysfunctional to society. Norms are socially important because they help to define the boundaries of a social system, and the sick role is conceptualized as a social niche where people who are ill are given chance to recover in order to return to their normal social roles. On the other hand, doctors play an important role as they legitimize the status of sickness. Parsons was the first scientist to describe the social control function of medicine within a social system. His concept of sick role, however, has some flaws. It did not take into account of the variation of the variation in human behaviour and cultural norms confronted by illness. Sick role behaviour is very much dependent on illness behaviour. Kasl and Cobb defined illness behaviour as behaviour aimed at seeking treatment, e.g. consulting a doctor, and they define sick role behaviour as activity at recovery, e.g. taking medicine. Mechanic defined illness behaviour more broadly in relation to the perceptions and evaluation of symptoms and action taken or not when one is experiencing ill health. Unless behaviour differs from person to person as illness or deviation from standard from normality is perceived differently.

Apart from perception two main approaches have to be understood before analyzing health-seeking behaviour or illness behaviour. Firstly, social and structural influence such as social class, age, gender, etc. which determine people's decision on health and illness secondly, psychological characteristics of people which is expressed in terms of


coping with illness and triggering actions. According to Nathanson\textsuperscript{48} theories of illness behaviour postulate to report distress and to seek help. Health-seeking behaviour varies according to socio-economic status. People in the lower social classes are most at risk of ill health, but least likely to use preventive services, and adopt healthier life styles. Mckinlay and Mckinlay\textsuperscript{49} were of the opinion that communities which experience poverty and low status placed little importance to health in the face of other like problems related to poverty. The poor people are less knowledgeable than middle class patients about how to gain access to services and communicate with doctors. According to Parkin\textsuperscript{50} poor people continue to work though they are ill because they do not want to lose wages.

1.3. RESEARCH GAPS

About twenty six years ago Stellman\textsuperscript{51} published Women’s work, Women’s Health (1978). Since then not much research has been carried out in this field except for some research on women’s occupational health problems. In 90’s research on women’s health issues and gender differences in health have got higher priority in U.S.A. and U.K. Though there are studies concentrating on poverty, work and health but gap exists in social arena in relation to patriarchy, work and empowerment of women. Research gaps are found in bringing out the relationship between patriarchy and women’s work and its effect on women’s health. This aspect of women’s health has been overlooked, though several studies on reproductive health have been carried out in different parts of the world.

That’s why this research is aimed at bringing out the relationship between women’s work,

\textsuperscript{48} Nathanson, C.A. (1975) “Illness and the feminine role”, \textit{Social Science and Medicine} , 9, p 58.

\textsuperscript{49} Mckinlay, J.B. and Mckinlay, S.M. (1972) “Some social characteristics of lower working class utilities and under-utilisers of maternity care services”, \textit{Journal of Health and Social Behaviour} , 13, p 371.


patriarchy and its effects on women's health. This study is a novel attempt which will create awareness and knowledge about how elements of patriarchal controls are influenced when women work and how it enables women to have better health status.

1.4. THE THEORETICAL FRAMEWORK

Patriarchy is defined as a system of social structures and practices, in which men dominate, oppress and exploit women. It is simply perceived as male domination over women. To study the relationship between women's health and work, one needs to study different definitions of workers and non-workers also.

The Census of India defines work as participation in any economically productive activity with or without compensation, wages or profit. Work involves not only actual work but also includes effective supervision and direction of work. It even includes part-time help or unpaid work on farm, family enterprise or in any other economic activities. In census a person is categorized as a worker if she/he had participated in any economically productive activity at any time during the reference period, which is normally one year preceding the date of enumeration. A person, who did not work at all during the last year preceding the date of enumeration, is termed as non-worker. The non-economic activities of non-workers were grouped into following six categories:

(i) Student (ii) Household duties (iii) Dependents (iv) Pensioner (v) Beggar (vi) Others.

A woman attending to daily household chores like cooking, cleaning utensils, looking after children, fetching water, collecting fire wood, going to market etc. is treated as doing household duties. Women who fall in this category are considered as non-working.

NSSO defines work as any activity resulting in production of good and services that add value to national product was considered as an economic activity. Such activities

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included production of all goods and services for market (market activities), i.e. production for pay or profit, and the production of primary commodities for own consumption and own account production of fixed assets, among the non-market activities.

For this study the definitions of worker and non-worker as specified by NSSO is followed. NSSO follows three broad activity statuses. These are the following:

(i) working or being engaged in economic activity
(ii) being engaged in economic activity but either making tangible efforts to seek work, or being available for work if the work is available, and
(iii) being not engaged in economic activity and also not available for work.

In this study activity status no. (i) and (iii) will be considered.

NSSO has specified detailed activity categories under each of the broad activity statuses. From activity status no. (i) above, following categories will be considered for this study.

a) worked in household enterprise (self-employed) as own account worker
b) worked in household enterprise (self-employed) as employer
c) worked as regular salaried/wage employee
d) worked as casual wage labour

Women who are in these categories will constitute working group for this study.

From activity status no. (iii) following activity categories will be considered.

a) attended domestic duties only.
b) attended domestic duties and was also engaged in free collection of goods, sewing tailoring, weaving, etc. for household use.

Women who fall in the above two categories will form non-working group.

After defining patriarchy, worker and non-worker need arise to study elements of patriarchy, such as, decision making power, approval in terms of giving permission to spend money and go out and control over money because these elements always control
and shape women’s life. Women throughout the world are united by their common experience of oppression and subordination, but at the same time there is division among the women based on class, race, and society. Norms, culture and practices of patriarchal households and societies get embedded in both men and women since they start interacting with the outer world. Women often fail to understand that the principle of capitalism, which is divisive in nature, often separates themselves from privileged class to oppressed class.\textsuperscript{53} Not only women at large, even women belonging to the privileged class too do not share same status with men, and are not treated equally. Women, in general, also get so habituated with the patriarchal system that they often do not realize that they are denied the right, status and respect that they should get at par with men. Women also often fail to understand that they are exploited, suppressed within the household, and also in the society, unless it crosses certain limits. Many attempts have been made to divide women in classes, such as, belonging to privileged class and under privileged class, or developed and under developed nations, or urban and rural areas, or industrialized and non-industrialized nations. But problems of women resulting out of patriarchal systems still remain same, though nature and types of problems change.

Patriarchal structure of society is characterized by male domination, and female subordination. Social conditioning of women ensures that they remain inferior to men in different spheres of decision-making. Women are socially conditioned to be submissive and docile. Sex role distinction and allocations are evident both within and outside the family, and reflect the patriarchal structure of society. Division of labour, which identifies women with the domestic sphere and men with the outside world leads to the domestication of women, is an integral part of patriarchal system.

Inequalities in the social and economic status of men and women disproportionately deprive women and their children of good health.\textsuperscript{54} Women worldwide tend to earn less

\textsuperscript{53} Mies, Maria, (1982) ‘Women’s Struggle and Research: An Introductory Note’ in Maria Mies (ed.) Fighting on Two Fronts: Women’s Struggles and Research, Institute of Social Studies, Netherlands p. 6

money and are economically dependent. Compared to men, women attain a lower educational level and enjoy fewer legal rights. This inequality leads to a power imbalance between genders, which leave women with inferior status. Though women live longer than men and females outnumber males in most regions of the world, less than half of the world's population is composed of women. This is because women face various health risks due to differential treatment they receive at home since childhood. In some regions where the social value of women is little, abortion of female fetuses is practiced even by the educated and rich people as they are unwanted. Female babies become the victims of selective malnourishment, which results in various health problems in future.

In this study, it is necessary to examine how different elements of patriarchy, such as, decision making power, control over money, approval in terms of giving permission to go out or spending money influence women's own health. All these patriarchal practices affect women's employment, which in turn influence women's health in various ways. Here a diagrammatical representation of the theoretical framework formulated for this study has been provided.
PATRIARCHY AND SPHERE OF WOMEN'S WORK AND HEALTH

PATRIARCHAL ELEMENTS

DOMESTIC WORK
- Joining work after a brief leave
- Earning Money
- Control Over money
- Decision Making Power
- Spending on Food, Medicine Etc.

APPROVAL
- Joining work after a gap
- Time Management
- Spatial strategy

CHILD REARING
- Not Working
- Decision Making Power
- Can't spend on medicine, food etc. acc. to her choices

DECISION MAKING POWER
- Can't spend on Food, Medicine etc. acc. to her choices

CONTROL OVER MONEY
- Part-time Work
- Downward Occupational Mobility

LESS INCOME
- Earn Money

EARNING MONEY
- Less Money

DOMESTICATION and Discrimination
- Restriction of Education and other opportunities to girls.

No Spending Power
- No Control Over Money

HEALTH

Dependent upon Husband's/ Family Income
- No Control Over Money

Restriction of Education and other opportunities to girls.
- Domestication and Discrimination

Domestication and Discrimination
- Joining work after a brief leave
- Earning Money
- Control Over money
- Decision Making Power
- Spending on Food, Medicine Etc.
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, which ultimately help women to have better health. One can only come to such conclusion if working women are compared with non-working women who are not earning money and totally dependent on others. Other than work education is one of the most important factors, which creates perception and knowledge of nutritious food and illnesses and awareness of health services. So along with different patriarchal elements like control over money, decision-making power, etc., education, exposure to mass media, perception and knowledge of nutritious food and illnesses and awareness of health services are some important explanatory variables, which determines health. Inter-linkages between these variables will help to reach the conclusion.

1.5. OBJECTIVES OF THE STUDY

Objectives of this research have been drawn after a thorough review of the relevant body of literature on women's health and associated factors. Objectives of this study are:

(1) To measure the level of health status of working women with reference to anthropometric measures (BMI) and patterns of morbidity.

(2) As elements of patriarchy influence women's life as well as health it is necessary to examine whether work helps women to achieve greater say in decision making process and power to control resources so that it may ultimately improve their health status.

(3) To examine the women's awareness and perception on health, hygiene, nutrition and patterns of health care utilization.

1.6. RESEARCH QUESTIONS

In order to achieve the above objectives the following research questions have been examined.

1. What is the current health status of working women?
2. What is the difference in the health status of working and non-working women?
3. Does work have any relationship with health status?
4. Does economically remunerative work help women to achieve greater say in family decision making process, power, and control of resources?
5. Does the earning prove beneficial for the health of the working women?
6. Does work other than domestic labour generate more awareness about health care services?
7. Is there any significant difference in healthcare utilization of working and non-working women?

1.7. THE PLAN OF THE STUDY

In order to achieve various objectives research questions have been designed for each objective. For each research question, indicators and methods are also selected. Objectives of this study are:

(1) To measure the level of health status of working women with reference to anthropometric measures (BMI) and absence of diseases and pattern of morbidity.

Research questions:

a) What is the current health status of working women?

**Health Status:** As long as a person is alive, good health is generally perceived as absence of illness. Health status is seen as BMI, absence of diseases morbidity pattern and access to health care. Aggregation of all these four will constitute health status. While considering morbidity pattern chronic ailments will be considered and not the acute one. Diarrhoea, Malaria, Tuberculosis etc. are examples of acute illness. Diabetes, Hyper tension, Cardio-vascular diseases are few examples of chronic illness.

Nutrition may be defined as the science of food in relationship to health. Good nutrition means maintaining a nutritional status that enables us to grow well and enjoy good health. Nutritional deficiency states of varying degrees in regard to protein, calories, vitamin A, and iodine deficiency, and anaemia are prevalent in a wide section of the population.
As absence of illness reflects the good health of the population, in this study rate of absence of illness will be calculated.

**Method.** In order to know the health status of working and non-working women, absence of illness rate for particular time will be calculated. The method is:

\[
\text{Person not affected by any disease for particular time} \times 100
\]
\[
\text{Total population at that time}
\]

**Limitation:** In household survey when questions are asked about illness or absence of illness it depends on the perception and knowledge of the person who is reporting it. Data gathered through questionnaires tend to suffer from some major bias (e.g. gender bias).

**Indicator:** Absence of illness rates will be used as indicator.

**Nutritional Status.**

**Method:** 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. There are various functional consequences of low BMI for women. For women conception ceases at low BMI. Also, low BMI leads to low birth-weight babies. The effects of low BMI on health is connected to more days of illness. BMI is calculated as follows:

\[
\frac{\text{Weight in k.g.}}{\text{Height in meters}^2}
\]

The height of an adult is an outcome of several factors including nutrition during childhood and adolescence. A woman’s height can be used to identify women at risk of having a difficult delivery, since small stature is often related to small pelvic size. Although BMI and height of a woman are the two best indicators of nutritional status, they have some limitations too. Anthropometric measurements are affected by nutrition as well as the public health environment, prevalence of infections and availability of health care. Despite these disadvantages anthropometrics approach is
more direct, and simple, and easier to collect data on height and weight than the dietary approach.

*Indicators:*  
i) women with BMI 18.5-25 kg/m².  
   (this range of BMI is considered to be ideal)  
ii) women with BMI < 18.5 kg/m².  
   (Below this level a woman can be identified as nutritionally at risk.)  
iii) women with height < 145 cm.

An enquiry into morbidity pattern is essential to know the health profile of the people.  
*Method:* In order to know the morbidity pattern of working and non-working women, prevalence rates of both acute and chronic illness for particular time have been calculated. The method is:

\[
\frac{\text{Person affected by diseases for particular time}}{\text{Total population at that time}} \times 100
\]

It should be noted that in this study total population in the denominator has been replaced by total number of women considered for this study of that area at that time. Numerator and denominator are multiplied by 100, as total number of women of all the areas is 440. So it is basically percentage.  
*Limitation:* 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. Morbidity data gathered through questionnaires tend to suffer from some major bias (e.g. gender bias). 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.  
*Indicator:* Two separate prevalence rates for working and non-working women will be used as indicator.

b) What is the difference in the health status of working and non-working women?
Method: Difference in health status will be calculated by using indicators of health status as stated earlier. Comparison will be made across age groups, income and also between working and non-working women. In this study non-working women acts as controls.

c) Does work have any relationship with health status?
To see whether work has any relationship with health status it is important to calculate how many working women are there with BMI between 18.5-25 and <18.5 and absence of illness rates of working women. Same calculation will be done in case of non-working women.

Indicators:
   i) Number of women with BMI 18.5-25 and < 18.5
   ii) Number of women having no diseases.

(2) As elements of patriarchy influence women’s life as well as health it is necessary to examine whether work helps women to achieve greater say in decision making process and power to control resources so that it may ultimately improve their health status.

Research questions:

a) Does economically remunerative work help women to achieve greater say in family decision making process, power and control of resources?

Decision-making power and control over money are the two most important elements of patriarchy. Therefore, it is important to see whether economic work helps women to achieve greater power in decision-making process and access to money.

Method: In order to meet the research questions it is important to find out that how many working women having say in different decision making matters and power to control money. In order to see whether working women exercise significantly more decision making power on different matters than non-working women, the difference will be found out.
**Indicators:**

i) women who take decision on—
   own health care, opening bank / P.O. account, on monthly budget, investment etc.

ii) women taking decision on how the money she earns will be used.

iii) women who have control over money or can spend money according to their choices and preferences.

b) Does the earning prove beneficial for the health of the working women?

**Method:** Here the relationship between women’s income and indicators of health status will be observed carefully.

i) women with very high income level

ii) women with higher income level

iii) women with medium income level.

iv) women with low income level.

v) women with very low income level.

BMI has been calculated for each income level

(3) To examine the women’s awareness and perception on health, nutrition and their health care utilization.

**Research questions**

a) Does work other than domestic labour generate more awareness about health care services?

**Method:** Here it is important to see whether working women are more aware about health care services than non-working women by simple comparison.

**Indicators:**

i) women aware of various health care services

ii) women having perception of major illness.

iii) women having knowledge of nutritious and healthy foods for different stages of life.
iv) women who are relatively prompt in getting treatment
Variables of exposure to mass media and education will be used as explanatory variables.

b) Is there any significant difference in healthcare utilization of working and non-working women?

*Method:* For each indicator of health care utilization the difference between working and non-working women will be worked out.

*Indicators:*

i) number of women seeking treatment for major and minor illness

ii) number of women getting treatment from primary health centre / govt. hospitals / private clinics.

iii) number of women getting different types of treatment.

iv) expenditure on medical treatment by women.

1.8. METHODOLOGY

1.8.1. SAMPLING DESIGN

The sample areas are selected from the MCD and NDMC areas of Delhi. We have selected two residential areas representing women engaged in various activities: (i) women living in slums and (ii) women living in non-slum residential areas. A sample of 110 working women from each of these localities (group of localities) is drawn as per the characteristics given below. For purposes of controls 110 households of non-working women from each of these two localities were also selected. In total 440 women were considered. Working women’s and non-working women’s households have been identified with following characteristics:

1) Age of working women is between 25 and 44 years.

2) Working women should not be pregnant currently, and the youngest child should be at least two years old.

3) Working women who are living in family set up for considerable time.
In order to see the relationship between women’s work and women’s health different variables will be examined. Suitable statistical methods, such as, calculation of simple percentages, cross tabulations, correlation and regression analysis will be used for analyzing the data. These methods will enable us to understand the cause and effect relationship between the variables.

1.8.2. CHOICE OF SAMPLE AREAS

Two non-slum and two slum areas surrounding these non-slum areas have been surveyed. The slums and non-slum areas were essentially chosen on the basis of their location and the availability of working women. According to NFHS 2 19.7 percent women are currently working in Delhi. These working women are scattered all over Delhi and it is very difficult to find out sufficient number of working women in one residential area. Because of this limitation Netaji Nagar has been selected as our non-slum residential area, which is a government colony and located in NDMC area. Finding out working women was somewhat easier here, as considerable numbers of women employees of various governmental departments are residing in the government quarters along with their families. Harijan Basti, which is located just behind Netaji Nagar have been selected as slum area.

Malviya Nagar from MCD area has been selected as another non-slum area where again the possibility of getting working women was higher and this area is considered, as this non-slum area is characteristically different from that of Netaji Nagar. Begampur slum, which is located in one corner of Malviya Nagar, has also been selected as slum area.

1.9. DATA BASE

Primary Data and Field Survey

Data used for this study is primary and collected from field survey. All the tables generated for this study have been prepared using the data collected from the field survey. Some figures have taken from NFHS 2 and NFHS 3. In this study firstly working women and non-working women of each residential area are compared separately. As mentioned
earlier two non-slums and two slum areas surrounding these non-slum areas have been surveyed. As it is a comparative study between slum and non-slum residential areas of Delhi so comparison has been made at micro level between Netaji Nagar and Harijan Basti slum and between Malviya Nagar and Begampur slum so that all characteristics can be analyzed in detail as they characteristically differ from each other. Finally, for some major variables comparison has been made between slum and non-slum areas after pooling data of two non-slum and two slum areas.

1.10. CHAPTER SCHEME

Chapter 1 introduces the problem and various sections are devoted for overview of literature, theoretical framework, objectives and research questions, methodology, data base and chapter scheme. Chapter 2 introduces the study area and is devoted for socio-economic backgrounds and living environment of the study areas. Chapter 3 deals with work profile of women living in slum and non-slum areas. This chapter analyzes occupational profile, background of work, work, income and its implications, conditions of work and finally work and its effects. Chapter 4 has been devoted to nutritional status of working women and non-working women of slum and non-slum areas. This chapter has been divided into various sections which look into the anthropometric measures, consumption pattern of various food items, meals and related issues. Chapter 5 deals with different aspects of health such as morbidity, health care utilization, health care behaviour, accessibility of health care, taking care of own health, perception of own health, health problems. Relationship between the different variables of health has been discussed here. Chapter 6 analyzes the different attributes of women empowerment and awareness. In this chapter comparisons have been made between working women and non-working women of both slum and non-slum areas on different aspects of empowerment to show how various patriarchal elements work differently on them and which group have become more empowered or able to reduce the controls of patriarch on them. Chapter 7 deals with the inter-linkage between patriarchal controls, work and health. In this chapter discussions have been made on the determinants of health with the help of logistic regression. Chapter 8 includes all concluding remarks.