Chapter 3

CONCEPTUALISATION
AND
METHODOLOGY
After developing the perspective on women workers in the preceding chapter, we will now formulate the conceptual framework of the study. This chapter has been divided into two sections. In the first section, we deal with the conceptualisation of the problem to be studied. Based on the conceptualization, in the second section, the objectives of the study have been framed and the methodology formulated.

Conceptualisation of the Problem

Women's health and well being is an outcome of certain factors embedded in a network of various socio-cultural, economic and political forces that form the entire milieu of their lives.

**Women's Cultural Devaluation and Social Roles**

Women's identity is created within the framework of culturally constructed definitions of womanhood. They are considered the weaker sex – physically, mentally and socially inferior to men. They are forced to accept their inferior position in the society and to conform to their *devalued self-image*. Right from girlhood it is obligatory for them to internalize this self-image. It is this image that defines the *power-relations within the family*. It is expected of them to defer their needs in favour of the needs of the family, especially where there are limited resources. Further, in most societies of the world, the physical survival and well being of the household is entirely the responsibility of the women. Through generations, societies have thrust upon women the *roles of production and reproduction*, and an inability to fulfill either of them 'appropriately' results in a further decline of their position within the family and the society. Additionally, to improve the financial conditions of the family and to shield the family from destitution, they take
up waged work. The *physical and mental rigors* of the various roles assumed by the women weigh down heavily upon them. In this context, it is questionable how empowering waged work can be for them. Women's struggles to make the lives of their families better can thus be read in their social existence as well as their health. As earning members and household workers, women perform the vital role of caretakers and are responsible for all the work that is required to sustain the household. The *lopsided variance of health* as it stands against women appears to be set in stone.

Feminisation of Labour and Material Discrimination

The proportion of women in waged work, especially in the informal sector of the economy has been on a rapid rise over the last few decades. Within each area of work there is a *concentration of women in the jobs with lowest pay and least status*. Data fails to capture the extent and nature of female participation in economic activities. Women are progressively marginalized from production in the process of industrialization and economic development. Capitalism and patriarchy force women's confinement to homes and to inferior jobs. It has been assumed that for women living in poverty, income from waged work may bring significant health benefits since it will allow them to purchase the basic necessities of life. However, the effects may be contradictory since lack of food combined with overwork may damage their health, though it may improve that of their dependents. Income from work outside home is expected to enhance women's autonomy and hence, well being by reducing their economic and social dependence on the male partner. Throughout the world, women work more than men, yet their labour is seen to be of less value. They continue to be denied their rights to autonomy and self-
determination despite their economic contribution. As a result they have to struggle more in order to acquire the basic resources of life.

**Health Care and Social Services**

The health care and social services are meant to provide the basic services to the people. Apart from medical services, these include food and nutrition, availability of drinking water and sanitary services as well as education. This however does not ensure their equitable distribution among all sections of the population. The socially and economically disadvantaged groups, who need these services most, are the ones deprived of them.

Women’s health, therefore, is a product of the multifarious factors discussed above. The social and economic circumstances of women’s lives have an impact on their health. The dual burden of work borne by women together with their low social status predisposes them to poor health conditions. Economic deprivation means lack of adequate food. Further, having to pay for health care and other social services means that their social and economic disadvantage gets translated into further marginalisation in terms of health and well being.

**Objectives of the Study**

On the basis of the above understanding, the study proposed to explore linkages between the social, economic and ecological conditions of women embroidery workers in the chikan industry of Lucknow and their implications on their perceived health and well being.

This objective has been broken up into the following specific objectives:
1. To study the structure and evolution of the chikan industry.
2. To analyse the terms and conditions of the industry for home-based embroiderers.
3. To examine the working conditions of the embroiderers.
4. To analyse their social circumstances.
5. To study the physical environment of the embroidery workers.
6. To compare the social, economic and ecological conditions of the home-based embroiderers with those of the centre-based workers.
7. To compare the social, economic and ecological conditions of the rural embroiderers with those of the urban embroiderers.
8. To study the embroiderers' preference for and availability of health care services.
9. To study the women's perceptions of their working and living conditions and the linkages thereof with their health.
10. To understand the embroiderers' perceptions of their well being in relation to their working and living conditions.

The Study Area and its Population

The district of Lucknow in Uttar Pradesh (Map 1) was selected for the study in accordance with our objectives. Our earlier exploratory study on the workers in the chikan industry was also conducted in Lucknow during the years 1996-97. The previous study helped to develop significant insights into the social and economic conditions of the workers and also how their health was affected by these conditions. The health problems owing to working conditions as well as social causes were found

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1 Private chikan production centres are commonly referred to as 'centres' by those associated to the chikan industry of Lucknow.
to be striking among the embroidery workers, predominantly women. Therefore, a need was felt to further explore the dynamics between the socio-economic conditions and the health and well being of the women embroiderers. The present study thus, was an outcome of this need.

The district of Lucknow, apart from Lucknow city, comprises of 8 rural blocks. The population of Lucknow as recorded in 2001 census was 3,681,416. Most of the activity related to the chikan industry is concentrated in the older sections of the city or in the villages adjacent to the city. In keeping with the objectives of the study, therefore, it was proposed to select the study population from the urban as well as rural areas of Lucknow district.

**Urban Areas of Study**

In order to study the urban embroiderers, the *muhallas* (traditional neighbourhoods) with maximum concentration of the embroiderers were chosen in five areas of the city. These were Daliganj, Chowk, Qaiserbagh, Khadra and Banarsi Tola (Map 2). Daliganj is one of the areas where our previous exploratory study was also carried out. It is a large area made up of several *muhallas* with old, but mostly *pucca* houses interspersed with small general stores, sewing workshops, vegetable stands etc. The narrow, uneven, often brick lined or *kachcha galis* (lanes and by-lanes) were bounded by open drains, covered at some places with stone slabs, and garbage dumps could often be encountered at street corners. Khadra is located very close to Daliganj. Most houses in Khadra are partly *pucca*, although some are entirely *kachcha*. The bigger agents and embroiderers usually have larger *pucca* houses in comparison to those of...
MAP 1

UTTAR PRADESH
STUDY AREA

KILometres
0 20 40 60 80 100

BOUNDARIES:

INTERNATIONAL
STATE
DISTRICT

H.P. HIMACHAL PRADESH

LUCKNOW

HARYANA H.P. UTTARANCHAL UTTAR PRADESH
RAJASTHAN
DELHI
HARYANA
LUCKNOW NAGAR NIGAM
STUDY POPULATION — URBAN
(NOTIONAL)

MAP.2

LOCATION OF STUDY POPULATION
HOSPITAL/MEDICAL COLLEGE
BANK
HIGH SCHOOL/ENTER COLLEGE
DEGREE COLLEGE/UNIVERSITY
TECHNICAL INSTITUTION
PARK/GARDEN/PLAY GROUND/STADIUM
GOVERNMENT OFFICE
RAILWAY STATION/BUS STAND
HISTORICAL PLACES
BOUNDARY— NAGAR NIGAM
VILLAGE
RAILWAY LONG-THRESH GAUGE
METRE GAUGE
IMPORTANT ROAD
RIVER AND STREAM
CANAL
people, which were single roomed *kachcha* dwellings, covered with a
disintegrating thatch and a few sackcloths or tarpaulin sheets. While
Daliganj and Khadra are located north of the river Gomti, Chowk is
situated across the river towards the south. Apart from the high density of
chikan embroiderers in this area, most of the city’s chikan businesses are
also located in the Chowk bazaar. In terms of physical profile the
residential areas of the embroiderers are quite similar to those of Khadra
and Daliganj — *kachcha* as well as *pucca* houses, narrow dirt lanes and paths,
open drains and garbage dumps. It lies in close vicinity to the King
George’s Medical College Hospital. Qaiserbagh falls between two main
market places of Lucknow — Aminabad and Hazratganj. The main bus
stand of the city and the Balrampur Government Hospital lie in the same
area. Banarsi Tola is situated in the north of the city and is the only area of
the study that does not fall in the old city. It lies close to Aliganj, is
characterized by densely packed houses, and has all the features similar to
the old city areas mentioned above.

*Rural Areas of Study*

For studying the rural embroiderers, two of the blocks with
concentration of chikan embroiderers were chosen. Further, two census
villages were chosen from each block respectively on the basis of the
criteria that concentration of both home-based and center-based
embroiderers was required in the same village. The Kakori block lies
towards the west and north west of Lucknow urban agglomeration,
whereas the Chinhat block is divided in two parts. While one part bounds
the city towards the north, the other adjoins the eastern boundary of the
urban agglomeration (Map 3). The two villages selected in Kakori are
Sikrauri and Pahia ajampur. Sikrauri is situated in the closest proximity to
the city boundary and the state highway, Hardoi Road, while Pahia ajampur is situated a little further from the city on the same state highway. In the Chinhat Block, the villages selected for the study were Sarai Sheikh and Malhaur. These villages were located close to the National highway, Faizabad Road. The health facilities available in these two blocks are given in Table 3.1.

### Table 3.1 Block PHCs, new PHCs, Sub-Centers and Mahila Hospital in the Study Blocks, District Lucknow

<table>
<thead>
<tr>
<th>Name of Block PHC</th>
<th>No. of Beds</th>
<th>Name of new PHC</th>
<th>No. of Beds Sanctioned</th>
<th>Main/ Sub-Centre</th>
<th>Mahila Hospital</th>
<th>Nearest Referral Hospital (Emergency)</th>
<th>Villages Covered</th>
<th>Distance From HQtrs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kakori</td>
<td>4</td>
<td>Baragaon</td>
<td>4</td>
<td>23</td>
<td>Kakori Town</td>
<td>K.G.M.C. Hospital</td>
<td>83</td>
<td>16 KM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fatehganj</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinhat</td>
<td>4</td>
<td>Purabgaon</td>
<td>4</td>
<td>17</td>
<td></td>
<td>R.M.L. Hospital</td>
<td>57</td>
<td>8 KM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Juggor</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Sampling Procedure

The study was conducted on a sample of 400 embroiderers. Out of these, for the purpose of preparing case studies, a sample of 24 embroiderers was chosen which consisted women belonging to all the four categories. The sampling procedure adopted for the study was as follows:

As a starting point, a list of organisations and individuals managing the chikan production centres in the Lucknow city and the rural areas was obtained from the office of the Development Commissioner (Handicrafts). As a result of the earlier exploratory study and information collected during the pre-pilot study, areas with a high concentration of chikan embroiderers were recognized. On the basis of this knowledge, the centre-owners were contacted in those areas. After acquiring the consent of
the centre-owners, centres in five urban and four rural areas were identified to conduct the study. This constituted 50 per cent of the sample of the study – centre-based embroiderers, both in the urban and rural areas of Lucknow.

As mentioned earlier, centres in areas with high concentration of chikan embroiderers were selected. This enabled the selection of home-based workers from the same areas. It was considered mandatory to select centre-based as well as home-based workers from the same areas in order to control the ecological and physical variables, and accessibility to social and health services across all categories in the sample. Table 3.2(a) and Table 3.2(b) show the distribution of the sample across all categories.

Table 3.2(a) Distribution of Sample in Urban areas of Lucknow

<table>
<thead>
<tr>
<th>Category</th>
<th>Lucknow City</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Daliganj</td>
<td>Khadra</td>
</tr>
<tr>
<td>Home-based</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>Centre-based</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>36</td>
</tr>
</tbody>
</table>

Table 3.2(b) Distribution of Sample in Rural areas of Lucknow

<table>
<thead>
<tr>
<th>Category</th>
<th>Villages in Kakori Block</th>
<th>Villages in Chinhat Block</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sikrauri</td>
<td>Pahia ajampur</td>
<td>Sarai Sheikh</td>
</tr>
<tr>
<td>Home-based</td>
<td>26</td>
<td>24</td>
<td>32</td>
</tr>
<tr>
<td>Centre-based</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>49</td>
<td>57</td>
</tr>
</tbody>
</table>

Traditional and cultural constraints on women meant a restricted degree of access to strangers in general, and men in particular. For this reason, despite being a woman, the researcher was precluded from gaining
access to the embroiderers' houses. Also, the unspoken resistance put up by the mahajans and the presence of the agents created difficulties. Therefore, for contacting home-based workers, help was sought from centre-based embroiderers to introduce and familiarize the researcher to the women and families in the area. It was in this manner that, gradually, the home-based workers were contacted; one home-based embroiderer introduced the researcher to others in the neighbourhood.

Thus, while a purposive sample has been used for the study, for the home-based embroiderers, an approach similar to snowballing technique was adopted. This also provided the researcher with time and opportunity to gradually, get familiarized with the community. This familiarity was instrumental in helping the researcher gain acceptance in the community and also in holding focused group discussions of home-based as well as centre-based workers in all areas.

Data Collection

*Type of Data Collected*

It was necessary to collect extensive and comprehensive information in order to fulfill the objectives of the study. Therefore, both qualitative as well as quantitative data was collected on different aspects of the embroiderers' lives.

*Quantitative Data*

With the aim of quantifying certain aspects of the embroiderers' lives, quantitative information was collected. These aspects were:
1. Socio-economic background of the embroiderers and their families, which included family structure, educational levels, occupational patterns of family members, religion, patterns of family income and expenditure, land ownership etc.

2. Availability and condition of amenities such as housing, water supply, sanitary facilities and electricity.

3. Details of working conditions, taking into account their place of work, mode of payment, information about workdays and workweeks, availability of work, training received, if any, overtime, rest intervals and work-related problems.

4. Patterns of food consumption of the embroiderers and their families.

5. Occurrence of illnesses including reproductive health problems as perceived by the embroiderers during the previous year.

6. Preference for health care services and their availability.

7. Details of pregnancy and childbirth including indicators of maternal and child ill health, as well as place and type of assistance during pregnancy and childbirth.

8. Family planning practices of the women including types of contraceptives used or reasons for not using them.

9. Embroiderers’ perceptions about the parameters of their well being taking into account the various dimensions of time.

Qualitative Information

Qualitative information was collected not only from the embroiderers but also from other key informants on a number of issues. These were:
1. Women's daily routine and their workload in managing the household and earning a living.

2. Their perceptions of their value as social and economic beings i.e. in the society, at home as well as at work.

3. Women's abilities to take important decisions regarding their lives and that of their children and opportunities to do the same.

4. Women's opinions about different forms of embroidery work and subcontracting in the industry and about the regard or disregard towards them and their work.

5. Embroiderers' opinions about the government and non-governmental interventions for the upgradation of the industry and the changes perceived by them over the last ten years.

6. Opinions of others involved in the chikan industry about the embroidery stage and the women who do it.

7. Women's and their families' beliefs and customs regarding the causes and effects of health and ill health.

8. Women's reasons for choosing private practitioners, government hospitals or traditional healers for seeking health care.

9. Also, regarding pregnancy and childbirth, their reasons for deciding between a hospital (private/government) delivery and home delivery.

10. Their perceptions about their access to or delays in seeking health care.

11. Embroiderers' perceptions and views about the different issues related to their well being as also their aspirations for and expectations from the future.
Tools of Data Collection

Having listed out the variety of data to be collected, and keeping in mind the multidimensional nature of the problem, an assortment of tools was employed in order to procure the data.

**Bibliographical Studies**

These included:

1. Published and unpublished reports and data from government agencies such as the U.P. Export Corporation, District Industries' Centre, National Small Industries Corporation, District Urban Development Agency, District Rural Development Agency, District Statistics Office, Development Commissioner's (Handicrafts) Office, State Institute of Health and Family Welfare, Chief Medical Officer's Office.

2. Study reports of non-governmental organisations and individual researchers on various aspects of Lucknow, chikan workers and issues related to their condition, training, empowerment etc.

3. Reports and articles from newspapers and local periodicals.

**Informal Discussions and Interviews**

Informal discussions acted not only as data collecting devices, but went a long way in helping to build a rapport with the embroiderers as these were more conducive to lengthy conversations as compared to structured interview schedules. Information regarding women's routine work, their families, availability of basic needs, terms and conditions of doing chikan work etc. was obtained through such discussions. Apart from the embroiderers, discussions and informal interviews were also carried out
with other key informants such as the women’s family members, gram pradhans, school teachers, NGO workers, government community development workers, health workers and traditional healers, chikan agents, traders (mahajans), chikan centre owners etc. Issues that appeared recurrently during such discussions and interviews were taken a note of and were used later in the Focused Group Discussions.

**Focused Group Discussions**

At least two focused group discussions were held with the women in each category, depending upon their strength in a given area. The groups usually did not exceed ten embroiderers at a time. It was easier to hold such discussions in the centres because the embroiderers were present there throughout the day. In case of home-based workers, groups had to be organised at a time convenient for most women, which was usually at forenoon when the men had gone for work, and the women had just finished the tasks of cooking, cleaning, fetching water and washing. The focused group discussions were used to obtain information from the women about:

1. Their work, the nature of the chikan industry and the government and non-governmental interventions for their welfare.

2. Decision making on matters of significance, like household expenditure, their own health, children’s health and education etc.

3. Health and ill health and its relation to their socio-economic circumstances and working conditions.
It was often noticed that the discussion drifted from one topic to the other without the researcher's intervention, pointing to the interwoven nature of such issues in the women's lives.

**Observation**

Observation provides the kind of insight into a particular setting and the behaviour of the people belonging to it that cannot be acquired merely by holding discussions and carrying out interviews. Listening to the women talk about their daily workload and their problems in balancing housework and remunerative work, for example, was very different from observing them go through it on a daily basis. This became possible when the researcher was no longer viewed as a stranger by the women and their families, and they went about their daily tasks without being disturbed by the researcher's presence. Apart from observing the women in their socio-cultural milieu, observation of their surroundings, housing and sanitation patterns, their food intake, their interactions with, and often threats of chikan agents etc. provided an obvious improvement in the researcher's understanding of their lives.

**Case Studies**

Case studies of embroiderers belonging to each of the four categories of workers were prepared in order to understand comprehensively their lives as part of their particular social and economic realities. These were prepared not only on the basis of information received from the women themselves, but also from their family members, relatives, neighbours, social workers etc. Thus, a very useful profile of the workers'
lives was obtained by accounts of various people as well as by the researcher's observation.

**Interview Schedule**

In order to collect the quantitative information regarding various aspects of the embroiderers' lives, a detailed interview schedule was prepared. Our familiarity with the area and the industry as a result of our earlier exploratory study proved valuable in this respect. The interview schedule was prepared in order to cover the following aspects:

1. Socio-economic background of the embroiderers.
2. Details of availability of basic amenities.
3. Information regarding their working conditions.
4. Their patterns of food consumption, perceptions of their illnesses and their health care seeking patterns.

Care was taken to ask the general questions seeking personal and family details in the beginning, followed by the more specific questions on working conditions, health and well being\(^2\). The questions were presented before the embroiderers in the local language, i.e. a mix of Hindi and Urdu, but later, the coding was carried out in English. Also, the interview schedule was pre-tested for reliability during the pilot study.

**Ladder Rating Scale**

The ladder rating scale was used for studying the embroiderers' perceptions of their well being with respect to four essential parameters, viz. income, physical health, working conditions and living conditions. The

\(^2\) The Interview Schedule has been given in the Appendix.
11-point ladder from 0 to 10 represented well being, with 0 standing for the worst condition and 10 for the best. The embroiderers were asked to rate their lives in terms of individual parameters on the scale. In order to explore any changes that might have occurred over time in their lives, the four parameters were studied in terms of three basic dimensions of time: their past, present and future. While first two were meant to comprehend their perceptions of the quality of their life, the last one was supposed to be a reflection of their expectations from the future.

Study Design and Process of Data Collection

The present study required an understanding of women's health and well being in the context of their social, cultural and economic circumstances. It was designed, therefore, with the purpose of developing insights into the various aspects of the lives of chikan embroidery workers. It was considered necessary to investigate the pressures of women's social existence (including their family dynamics) and waged work. Further, a combined affect of these circumstances on women's health and well being was required to be studied. To study these interlinkages, women's own perceptions of their health and well being, the reasons thereof, and the actions taken to deal with them were considered indispensable. To meet this requirement, both qualitative as well as quantitative information was sought.

Our earlier exploratory study on chikan workers was conducted in the Daliganj and Nishatganj wards of Lucknow city (Gulati 1999). This study illustrated the relationship between the working and living conditions of chikan workers and their health and well being. The present study was
carried out in the city as well as villages of Lucknow in three phases: pre-pilot study, pilot study, and the final field study.

**Pre-pilot Study**

As mentioned earlier, the information gathered during the exploratory study and the pre-pilot phase helped the researcher get familiarized not only with the study area, but also with their broad characteristics and problems. During the pre-pilot study, the political history of Lucknow and its impact on chikan production and its economy was studied. Data pertaining to the general population as well as specific to chikan workers was acquired from government documents and NGO reports. Also, literature on the city spanning the Nawabi and Colonial period to contemporary Lucknow was consulted.

The Office of the Development Commissioner (Handicrafts) was contacted and a list of organisations and individuals managing the chikan production centres in the Lucknow city and the rural areas was obtained. These were agencies working for the artisans under the Ambedkar Hastshilp Vikas Yojana and the National and State awardees for excellence in the handicraft respectively. On the basis of information obtained from government sources as well as from informal discussions and interviews with the chikan traders, agents, NGOs, and embroiderers themselves, areas with maximum concentration of chikan embroidery workers were selected. Subsequently, the agencies and individuals running their centres in these areas were contacted in order to get their consent for conducting the study in their respective centres. After identifying the respective study areas, the researcher visited each of the areas. Informal discussions were held with
the embroiderers, centre-owners and ‘neighbourhood doctors’. This was helpful in providing an idea about the general as well as area-specific problems, including health problems of the workers.

Separate notebooks were maintained to record the observations and information collected during visits to study areas and also to keep an account of the data obtained from various official sources. On the basis of this background information, the interview schedule and the ladder rating scale were developed. The questions were formulated in English as well as in Hindi. Care was taken to use the terminology that was as close as possible to the embroiderers’ dialect.

**Pilot Study**

During the pilot study, the interview schedule and the ladder rating scale were pre-tested for reliability. For this purpose, a small sample of workers belonging to all the four categories to be tested was selected. These were rural home-based and centre-based, and urban home-based and centre-based embroiderers. The sample for pre-testing was selected from the Daliganj area of Lucknow city and Mahipatmau village of Kakori block.

Some of the questions needed to be rephrased or presented in a manner that increased the likelihood of a more unambiguous and clear response. E.g. the questions on availability of leisure (*fursah*), and how the women used it, received vague and unclear responses. It was realized that most women did not have any leisure for themselves, and any free time that they could manage to get was spent in finishing pending household work. It was also realized that the ladder rating scale had to be drawn in front of the
embroiderers each time, while explaining its purpose in order that they understood it properly and replied accordingly.

**Final Field Study**

The field study entailed the collection of data by employing the pre-tested interview schedule and the ladder rating scale along with other research techniques discussed earlier. The responses of the women were recorded at the time of the interview. Often, in the process of answering questions in the interview schedule, the women wanted to describe certain experiences in detail. They were encouraged to do so and such information was recorded after the interview. Similarly, other qualitative information collected during the field study was also noted down at the end of a day's fieldwork if it was not possible to do so 'on the spot'. Along with the progress in exploration, new categories, other than those that were formulated, emerged from the embroiderers' responses. Keeping this in mind, the coding system was evolved only at a later stage in order to incorporate all the responses received from the embroiderers.

**Time Schedule of the Field Work**

The field work for the study was initiated in May 2002 and lasted for a period of a thirteen months. Between each of the phases of data collection, two breaks were taken with the purpose of articulating the observations and findings. The per-pilot phase was carried out during the first two months. Following this, time was taken off for preparing the interview schedule and the ladder rating scale, and also for finalizing other research tools. Subsequently, in the pilot study, the tools were pre-tested on a small sample. This was followed by a second break during which the
operational features of the study tools were identified and retained, and the necessary changes made. The remaining period of the field work was utilized for the final field study.

Limitations of the Study

For the purpose of the study, lists of centres or number of women embroiderers employed in the industry were available. A census of chikan workers and specific areas would have facilitated in finalizing the sample by using conventional sampling techniques. Conducting such a census was beyond the capacity of one person.

Also, this study has concentrated on the perceptions of women regarding their health and well being. Though self-perceived illness is significant as a social phenomenon, it is different from the actual classifiable disease. While studying women as embroidery workers, the biomedical aspect of their health would have helped us attribute their illnesses to their circumstances, especially working conditions with much more certainty. In this context, we are aware that some of our important deductions from the study are based on research methods that are qualitative in nature.
Reference