Chapter 8

TO CONCLUDE:
CONTEXTUALISING WOMEN’S HEALTH
AND WELL BEING
To Conclude: Contextualising Women’s Health and Well Being

Human health and well being and its relation to the conditions of life has always been present. From prehistory through the first agricultural revolution and the modern industrial revolution, the conditions of life have determined the health or ill health of human beings. The living and working conditions of people during the industrial revolution in the eighteenth century England were visible in a number of factors: “Overcrowding, creation of slums and accumulation of filth in the cities and towns, high sickness and death rates, especially among women and children, infectious diseases like tuberculosis, industrial and social problems which deteriorated the health of the people to the lowest ebb” (Park 1995).

The ‘great sanitary awakening’ that followed gave birth to the concept of public health and asserted that the state was responsible for the health of its people. McKeown (1979) observed that most of the decline in death rates for almost all the major infectious diseases occurred well before the discovery and availability of modern medicine. He acknowledged that clean water supply and sewage systems in the final decades of the nineteenth century contributed in the reduction of exposure to water- and food-borne diseases, such as diarrhoea, dysentery and typhoid.

In India, the significance of physical environment as well as social and economic circumstances for health and well being was recognized in 1946 by the Bhore Committee. It stated: “The maintenance of public health requires the fulfillment of certain fundamental conditions which include the provision of an environment conducive to healthful living, adequate nutrition, the availability of health protection to all members of the community, irrespective of their ability to pay for it, and the active cooperation of the people in the maintenance of their own health” (Bhore Committee Report 1946).
Also, the existence of socio-economic inequalities in health has been acknowledged by a number of studies (Banerji 1982, Zurbrigg 1984, Djurfelt and Lindberg 1976). These studies demonstrate that health problems cannot be solved by means of medical technology alone, and that socio-economic changes are required as a means to bring about a transformation in poor people's health. Further, among the poor, the health status of women has been found to be the cause of concern due to certain factors located within the social, cultural and economic network interlaced with the fabric of their lives (Doyal 1995, Sagar 1999, Gopal 1997, Soman 1997, Nair 1999). The National Population Policy 2000 explicitly stated the fact that complex socio-cultural determinants of women's health and nutrition have cumulative effects over a lifetime. It also accepted women's over-representation among the poor and that "interventions for improving women's health and nutrition are critical for poverty reduction" (Government of India, Ministry of Health and Family Welfare, 2000). However, policy attention to women's health seems to have overlooked the social reality, over emphasizing instead on their reproductive health. Such a "uterocentric" and fragmentary approach fails to recognize that women's health outcomes are inextricably linked to various social and economic factors. The understanding of the dynamics of gender and ill health requires an understanding of the social and economic realities.

The present study was carried out in the chikan industry of Lucknow in Uttar Pradesh. Chikan is a kind of hand-embroidered clothing, the history of which lies in the Muslim culture associated with the former

1 Term used by Anindita Datta (2003) to mean 'centered on the uterus' or confined only to the reproductive aspect of women's health.
state of Awadh. Chikan embroidered goods are produced in a large-scale, low technology industry where hand-powered labour predominates and piece wages are paid. Embroidered garments are made in stages starting with fabric cutting and tailoring, followed by block printing and embroidering, and finally laundering. In all stages but one male specialists predominate. However, the embroidery stage is completely ‘dominated’ by women, overwhelmingly Muslim, almost all of them poor, with few other job opportunities. While most of the women in the industry work as ‘home-based workers’, there are a relatively small proportion of them who are ‘centre-based’, working more or less as employees in private chikan production centres. The women do embroidery out of sheer necessity, not as a hobby or as a means to achieve empowerment. The wages they make from chikan, are for some, the only resource they have against utter destitution. The plight of the embroiderers stems largely from an ideology in which their work is regarded as leisure-time activity, unworthy of serious attention and appropriate wages. This study focuses on the embroiderers, the conditions of their lives as wage earners and homemakers, predisposed to capitalism and patriarchy. Our study has attempted to explore the linkages between their social, economic and ecological conditions and their implications on the perceived health and well being of the women embroiderers. For this it was necessary to study the structure and evolution of the chikan industry as well as to analyse its terms and conditions for the embroiderers. To pursue the objective further, the social, economic and ecological conditions of the home-based workers were compared with those of the centre-based embroiderers. This was done by seeking women’s own perceptions of their working and living conditions and how they related these to their health and well being. The main features of health
issues among the embroiderers as they emerge out of our data throw up some very relevant information about the various aspects of their lives.

The Basic Needs

As Mckeown (1988) puts it, life must be possible before it can be pleasant. For the chikan embroiderers and their families, life is about barely filling their stomachs and continuing to work because, for most of them, there are no resources for anything else. Their individual earnings together with their family incomes are indicators of their conditions of poverty. Our study shows that nearly 60 per cent of the embroiderers earn only upto Rs. 900 per month, while almost 10 per cent earn even less than Rs. 300. To add to the burden, in quite a few families, the husband's occupations provide not only low but also irregular earnings. Other members of the families, including children are also required to contribute to the family income. Most of the income, in some cases almost all of it, is spent on the most basic requirement – food, often inadequate food. The survival strategy of the poorer families ensures that women take on themselves the extra burden of hunger, with its resultant load of ill health. It is understandable then that for other mandatory household expenditures or unforeseen emergencies, they need to incur heavy debts. A life of poverty and debt creates the inevitable cycle of malnutrition and ill health. Such a situation arises notwithstanding the current medical and historical understanding of the relationship between nutritional status and ill health. Households slip into destitution through sudden loss of work, illness or death of individual breadwinners. This may lead to chronic hunger (undernourishment) which takes its toll on young children and is intimately linked with conditions of women's work, conditions which preclude
adequate feeding and care of themselves and their children (Zurbrigg 2001).

Here, it is important to note that the inadequacy of food among poorer families means their inability to buy food rather than unavailability of it. The reason is that the available food is very inequitably distributed between different areas and population groups (McKeown 1988).

Further, data in our study show that water and sanitary facilities are available in their houses only to nearly 28 per cent and 48 per cent embroiderers’ families respectively. Fetching water from some distance meant a lot of physical labour for the women. Though installation of new community hand pumps reduced the distance as well as the labour of the women. It did not however, take care of the requirement of clean potable water either in the rural or urban areas. Our study shows that unsanitary conditions and poor waste disposal are posing a constant threat to the health of the urban and rural populations.

Working Conditions

The World Development Report (1993) addresses the health risks in the occupational environments within and outside the home. It enumerated the illnesses arising from the exposure to toxic chemicals, noise, stress and physically debilitating work patterns. Further, for alleviating such occupational risk, it suggested solutions such as “safety education for workers and managers, use of appropriate equipment and technology and sound management practices.” Governments have been advised to “encourage these initiatives through legislation and regulation, financial initiatives, investment in education, and research and development” (World Bank 1993). When more than 90 per cent of the
workforce in India is in the unorganized sector, such ideas seem completely misplaced and unconnected to reality. The World Development Report, therefore, tries to remedy the social and economic circumstances of such a workforce with technological and managerial interventions! Amongst women, about 96 per cent worked within the unorganized sector in 1991. Women’s presence in the unorganized sector thus, is not only extremely high but is on a steady rise over the years (it was 94 per cent in the seventies) (Gopalan 1995).

This study has tried to analyze the terms and conditions of the chikan industry along with the socio-economic conditions of the embroiderers with the purpose of understanding their joint impact on the perceived health and well being of the embroiderers. The problems most commonly faced by the women in the chikan industry are those of 'subcontracting' and 'devalued work'. It was found that two kinds of subcontracting systems exist in the industry. One in which men act as intermediaries or 'agents', and the other, in which women embroiderers themselves operate as agents to give out work to other embroiderers in order to maximize their earnings as embroiderers and also as agents. Wage payment is through piece-rate system and the workers have no control over the terms and conditions of work. In such situation, women fare badly as they are pushed into the worst forms of unorganized production process. Such problems, however were not faced by center-based embroiderers who were paid on a monthly basis.

The mahajans (traders) and agents, who ‘control the threads’ in the industry tend to believe that embroidery is women’s work, and therefore, treat it as an extension of women’s domestic role. This is most interesting
as well as ironic, especially when historically men worked as embroiderers in this industry which flourished under the Nawabs of Awadh. Their leaving chikan completely in the hands of women can be equated to the "proverbial abandoning of the sinking ship". Men left a dying craft to look for better remunerative options elsewhere as wages in the chikan industry got depressed when the Nawabs lost power to the British. Such a feminisation of the work force in the industry led more and more women to compete for work, and consequently, get paid lesser and lesser.

**Chikan Embroiderers: The Socially and Economically devalued artisans**

It becomes clear from our study that embroiderers' experiences as piece-wage workers are powerfully shaped by their gender. Constraints upon women's behaviour, opportunity, and the devaluation of women's productivity all contribute to this state of affairs. Both women and men subscribe to the ideal that women's primary task is the care of the family and the maintenance of the home. Waged work contradicts this ideal since it challenges the complementary notion that men and not women bring earnings into the household. Besides, their absorption in domestic duties, limitations on mobility and action outside home (caused by purdah observation among Muslim women) force the physical isolation of women and limit their knowledge of the market.

As mentioned earlier, embroidery is regarded by men as easy and undemanding work for a woman. With increasing economic pressures to find a source of money, many women (including Hindu women) find themselves in competition with each other for the meager
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rewards of an unreliable form of waged work. The restructuring of the labour force that has created a female dominated embroidery stage has occurred along side an overall decline in the quality of chikan available in the market. The devaluation (both socially, and in terms of wages paid) of occupations as women enter them is not unique to chikan and has been illustrated in the cases of other unorganized sector industries as well (Mies 1982, Gopal 1997). Despite such pathetic circumstances, the embroiderers 'retire' only when either their financial stringency ends or if they become physically incapable of doing embroidery, the former being a highly unlikely and rare occurrence. This fact leads us to appreciate that:

1. Chikan work is done by women due to a dire need for money, and not necessarily for the sake of empowerment, independence or self-esteem.

2. Their deteriorating health, especially degenerating eyesight, sometimes to the point of blindness, is not a serious enough reason for them to give up chikan embroidery when a few hundred rupees that they earn are vital to fire the hearth.

Thus, along with the meager wages, women earned headaches, backaches, body aches, numb fingers and the very rampant eye-problems. To add to these, the anxiety of turning in the finished product on time or face wage deductions was a part of their lives.

In the light of these issues, it is noteworthy that centre-based workers are generally relieved of a lot of problems faced by the home-based or piece-wage workers, both in the city as well as in the villages. The center-based embroiderers are thus the better lot of the exploited workers in this unorganized industry. Although they are not the targets of the evils
of subcontracting, even a nine-to-six kind of work setting, the center owners, in effect their employers, do not take any responsibility of or provide any kind of concessions to them. The Uttar Pradesh Government, through its agencies like U.P. Export Corporation, District Industries Centre and the U.P. Mahila Kalyan Nigam has time and again come up with training programmes for the embroiderers. But, in a bid to improve their working conditions, the government production schemes attempted to cut out female agents, the same embroiderers who were lauded as national and state awardees. It seems thus, that the socio-economic base of fine work has not been fully understood. We understand through this study that fine work exists only because cheap work exists, and fine embroiderers exist through subcontracting cheap work. The decline in government production schemes in 1994 as well as the subsequent shutting down of the government production centers in 1999-2000 (due to paucity of funds) indicate the lapses on the part of the government and the withdrawal of the state from its commitment to chikan. This had a negative impact on the earnings of the less skilled embroiderers who had been getting work from the government centers. SEWA Lucknow has also been taking steps to reduce agent activities and in the process, had eliminated many of the most accomplished and fine embroiderers (and subcontractors). Simultaneously, SEWA Lucknow is explicit in its aim to achieve ‘female empowerment’ without reference to the divergent interests among the embroiderers. This brings us to a very vital question: Does being a woman eliminate all other social differences?

Our study highlights that female embroiderers cannot be regarded as a uniform group whether in terms of the skills they posses or their status as workers. Using their locale (rural/urban) and mode of employment
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(home-based/center-based), it has been studied that female embroiderers diverge along important lines such as degree of skill, wages and their position in the chain of relationship linking the *mahajans* with workers.

**Women’s Perceptions of their Health and Well being**

The present study has sought to focus on the value of the embroiderers’ own perceptions regarding their health and well being. Since perceptions and experiences are regarded as ‘subjective’, they are often questioned and labeled as ‘skewed’ or ‘biased’. But, the purpose of studying the perceptions of the embroiderers was to be able to view their circumstances and problems from their point of reference. Hence, perceptions have been used in the study to explore:

1. The embroiderers’ awareness of their circumstances and milieu (objective realities) in the past
2. Their understanding of the same in the present with reference to the past
3. Their expectations from, or anticipation of, the future with reference to the present
4. Their comparisons of their conditions of life with those of ‘the others’, who belong to a different socio-economic group.

Perceptions were also useful in attributing causes to their health problems as well as to their own behaviours as outcomes of their circumstances. Women’s denial of their illness or delaying access to health care, for example, may not signify their inability to perceive such a need. Instead, it might convey their prioritization of the needs of their family as they have been socially schooled to do. It is in such a perspective that
socio-economic needs should be understood and acknowledged in order to provide them with the quality of social services that have as yet been denied to them.

Social Dynamics of Women’s Health and Well being

Among the health problems perceived by the women workers, aches and pains stand out as the most prominent symptoms of ill health. Firstly apart from being an outcome of weakness, aches and pains say a lot about women’s continuous physical activity with little rest and inadequate nutrition. Secondly, it was observed that pain was one of the symptoms accompanying most health problems expressed by them. Finally, since chikan embroidery work required adopting a particular posture and continuous working with the needle and thread, usually for long hours, backache, neck ache, shoulder pain, arm pain, leg pain and most prominently headache and eye pain together with other eye problems are specifically work related maladies. Nevertheless, the embroiderers considered aches and pains as an inevitable part of their lives. Also, most women attributed digestive disorders to ‘sitting in a particular posture for hours while embroidering’ as well as their ‘inability to consume anything but tea till midday’. A large number of women in the study reported reproductive health problems, white discharge being the most prevalent symptom. It was also found that reproductive illnesses including menstrual disorders were usually endured silently by the women without seeking treatment, since they ‘felt ashamed of discussing such problems with the doctor’. Along with the economic or work related aspect of women’s lives, the study brings into focus, the social and familial dynamics of health. The reason for this is that for any interventions in the ill health of people,
especially women, gender relations play an important role. Women's access to health care was determined by their own as well as the significant others' (authority figures in the family) recognition of an illness as serious enough to merit medical/health interventions. Though the delay in taking initiative was mostly due to their economic insecurity, women's own notions of severity of an illness sprang from the level of hindrance it created in their ability to perform remunerative as well as domestic activities. Further, their utilisation of health services was based on a few vital factors:

1. Past experiences, whether good or bad;
2. Severity of illness and the urgency of treatment required;

The larger picture that emerged showed the embroiderers' preference for the 'nearby private practitioners', who were considered both socially and economically viable than the primary health centre or government hospital where 'nobody cared'. Traditional healers were consulted along with the medical intervention and were not solely relied upon. In order to understand the various factors influencing their access to and utilisation of health care it was mandatory to look at women in their social perspective. The social norms that shape women's and men's behaviour patterns also decide the course of action as also who will initiate action. Further, the capability of a family to initiate action depends upon its resource base.
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THE MILIEU OF CHIKAN EMBROIDERERS’ LIVES

- Intra-familial power relations
- Traditional and cultural norms

- Feminization of labour
- Not recognized as ‘workers’
- Improper working conditions

- Inadequate nutrition
- Pregnancy and child care
- Physically taxing labour

- Improper housing
- Lack of drinking water
- Lack of proper sanitation

- Misdirected health policies
- Improper PDS
- Inadequate empowerment policies

- Domestic burden
- Devalued Image
- Discrimination

- Inadequate wages
- Poverty

- Weakness
- Reproductive Health Problems
- Eye Problems
- Aches & Pains

- Domestic work
- Cultural devaluation
- Discrimination

- Inaccessibility to Health & Services
- Undernourishment
- Subordination and low status of women

DECLINE IN HEALTH AND WELL-BEING

Figure 8.1 The Milieu of Chikan Embroiders’ Lives

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The structure and nature of a patriarchal society like ours forces women not only to accept their inferior position, and to conform to their devalued self-image, but also to pass on the same legacy of ‘sacrifice’ and ‘selflessness’ to their daughters. The physical survival of the household and the society depends, to a marked extent on their labour. As earning members and household workers, women perform the vital role of sustaining their families. The collective principles of the household as a unit warrant that productivity or reproductivity are not the criteria for allocation of resources. The needs of the non-productive children or aged or those of men take precedence over the needs of women. The use of health care for them is therefore minimal, and poverty aggravates this deprivation further. Here it is important to note that these women who earn money, in most cases do not have any control over it within the household. None of the women were free to decide whether or not to work and also how their wages would be spent. Kabeer (1997) has cited examples from various parts of the world to show that as male income increases more personal forms of consumption increases. They consist of “alcohol, meals eaten out, cigarettes and female companionship”. On the contrary, women spend their income on children and their nutrition, and on items of collective household consumption. This shows that intra-household power relations require women to carry out a variety of economic activities and yet continue to be allocated responsibility for the daily tasks of cooking, cleaning, and caring for children and other dependents, often at the considerable cost of their own health. Most importantly, there is no end to the working day, so many women found it difficult to separate work from leisure. Home-based workers in the study often stated that for them taking a break from embroidery work meant finishing pending household work,
preparing a meal for the day or looking after children. Such a punishing burden of both mental and physical labour signified 'rest intervals' or 'leisure'!

In addition to this, 50 per cent of the women in the study said their families relied on an alternative source of income to cope with the financial stringency. This amounted to a 'triple burden' for women – a small piece of land to be cultivated, working as an agricultural labourer, taking care of animals, stitching clothes or working as a housemaid. It was thus noted that women often carried the additional burden of the family occupation along with their own embroidery work and household responsibilities. Yet, none of these were recognized as women's indispensable contribution by their families. This is because traditionally much of this work is 'invisible' and is 'naturally expected' of women. To meet these expectations women often deny themselves any rest or leisure, even meals, predisposing themselves to illness. What is more, they are even conditioned to deny the existence of illness, since the illnesses of the children and the men are always more significant than their own.

Emerging Issues and Policy Implications

The Uttar Pradesh government launched training and employment programmes for the chikan embroiderers immediately after independence in 1947-48. Even after five decades of policy implementations (during which period, various programmes were initiated and suspended due to financial stringency), the condition of the embroiderers has not improved. In fact, it has worsened owing to the overcrowding of women workers in the industry; their competition for
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work has led to further depressed wages. Whether the chikan production scheme of 1978 or the STEP scheme launched twice in 1995 as well as in 2000 have concentrated more on the training and enrolment of workers with the U.P. Export Corporation (UPEC) instead of organizing them to make them self-sufficient. The workers who had come to rely on the UPEC production schemes exclusively for work were affected drastically when the schemes were suspended and the Government Production Centres shut down. Latest in the line of schemes is the centrally sponsored Baba Saheb Ambedkar Hastshilp Vikas Yojana introduced by the Development Commissioner (Handicrafts), Government of India for a three-year period in 2001. Working through authorized agencies the scheme aims at 'promoting Indian handicrafts by developing artisans' clusters into professionally managed community enterprises'. The outcome of this effort remains to be seen.

Apart from government efforts, NGOs have also entered the 'arena' of chikankari with an 'empowerment agenda' for the workers. The most prominent among them is SEWA Lucknow, an affiliate of SEWA Bharat. With a belief that women workers need 'special support in the form of health care, child care, skills training, legal aid, reliable work supplies and, in general, assistance in dealing with the public world', it has had limited outreach among women. The government, as manufacturers, affected more embroiderers with varying skills than SEWA Lucknow has. Bringing about an aesthetic shift in the craft and introducing it to the 'elite metropolitan fashion market' have been SEWA's achievements, rather than contributions to the chikan workers. Though registered as a Trade Union now, SEWA claims to have taken 'another step towards empowering the embroiderers', for most embroiderers, both SEWA Lucknow and the
government schemes have paled into insignificance next to the larger and more powerful commercial sector. Women still depend on the mahajans for the core of their employment. Authority in the NGO or government schemes is concentrated at administrative centres, and little is devolved among embroiderers themselves. Women are still outworkers, working for piece-wages, just as they would in the commercial sector. The commercial sector, in turn, is a lasting source of work, however poorly paid it may be for women who cannot live on the limited amount of work that is available to them through the government or the NGOs. Because neither organisation has genuinely transformed women's working lives, yet perpetuates chikan as a major source of wages, the government or NGO activities, in a perverse way, tend to entrench the arrangements of the commercial sector.

What the workers need therefore, is a reliable lasting source of work. Government policies and schemes have failed to offer this reliability and so have NGOs whose concentration to 'their achievements' is more than any real and lasting contribution to the women working in this vast industry.

It has been realized through this study that it is impossible to understand the organization of the embroidery process or the relationship of embroiderers to merchants without reference to their social and economic realities. Any policies or programmes would have to work on such lines in order to make any conspicuous difference in their lives as workers as also as women.
This study points to the poverty, social and economic backwardness and the inequitable social structures of the chikan embroiderers and also reveals that the very nature and organization of the industry has played a big role in throwing them further into destitution. We see that the Structural Adjustment Policies, by pressurizing the state to withdraw from the social sector are enhancing inequalities, so that the poor and the underprivileged get additionally marginalized and continue to be denied the basic amenities. Also, instead of concentrating on their childbearing years and being otherwise gender-blind, here is a need to focus on women's social, economic and environmental conditions to improve all aspects of their lives. Moreover, the understanding that poverty itself is a cause for ill health is completely lacking. Therefore, the it is required to step up the social and economic measures through developmental programmes that appreciate the actual conditions of poor people's lives and address their needs accordingly.

Feminist research has increasingly taken account of some of the issues addressed in this study. For understanding the problems regarding women's health and well being and the combined lethal effect of patriarchy, capitalism and the dubious "reconstruction and development" of the Structural Adjustment Programmes on their lives, the research problems in women's studies need to be refocused. While women's work merits study in its totality (since all women work), there is need particularly to understand the kinds of relations among women that waged work creates.
References


