1.1 Introduction

Good health is an important factor for the provision of regular supply of labour as it avoids the disruptions caused by sickness and the resulting absenteeism. Good health not only promotes high morale and labour productivity but also produces a positive environment of economic growth. Health has been declared as a fundamental human right. This implies that the State has the responsibility for the health of its people. National Governments all over the world are striving to expand and improve their health care services. People constitute the valuable human resources needed for the development of any country. It is needless to say that the development of the national economy rests on the health, ability and well being of the people. The people's strength is the nation's strength and nation's strength is its people's strength. In assessing a country's resources for economic development, the health of the people should be reckoned with. Health is the most basic and primary need of an individual that enables the nation to progress in the socio-economic, scientific, literacy and cultural spheres. A long life and good health are about the greatest blessings that human beings can pray for. Health is an important input in any process of development.

Health is both an input and output and is linked with development, and therefore, should not be viewed in isolation from the overall goals of development. It is human beings who make a society. Healthy human beings make a healthy society. However, every society has its share of unhealthy human beings. The promotion and protection of health of the people is essential for sustained economic and social development. It should be a national objective to attain the highest possible standard of health, as good health is the basic foundation for the promotion of creativeness, self-discipline, self-confidence and dynamism in people, which are necessary to increase the productive capacity of the nation. The domain
of the term 'Health' is as large and complex as the entire scope of human activities. Good health is a pre-requisite to human productivity and development process. A healthy community constitutes the infrastructure needed for building economically viable society. The World Health Organization defines health as "A state of complete physical, mental and social well being and not merely an absence of disease or infirmity." Health has found an important place in the constitutions of all countries. Of the thirty articles of the Universal Declaration of Human Rights, Article 25 is particularly concerned with the right to health. A healthy society is a strong society (Ramanujam, 2009).

1.2 Health Status

Health status is multidimensional in nature and difficult to measure precisely. It is captured through a range of indicators such as mortality, morbidity, anthropometric measures (study of origins and development of human beings), nutritional status or calorie intake, and life expectancy at birth. Among these, mortality and life expectancy at birth are widely used to measure the health status of a population, as they are easily observed, objective and less prone to measurement errors. However, morbidity may be a more useful indicator than mortality, since it is related to the pain and sufferings of the people, while mortality is a terminal event (Amartya Sen, 2000).

Health status, in general, and morbidity in particular, are primarily influenced by the behavioural decisions of the individuals or family, besides genetically inherited health endowments and the health environment in which they reside. Thus, illness is not a random event, but one that is systematically related to the household- and community-level factors. In the event of an illness, a majority of individuals seek some form of treatment. The choice of curative healthcare (public, private, self-treatment and no treatment) depends upon the type of illness, access to service provider, information about the provider, economic status of the individual/household, among others (Duraisamy, 2001).

Health and health services have major influence on the well being of the individuals and the societies, and are an important part of a nation’s politics and economy. Ill health and poor health services are increasingly recognized as major dimensions of poverty in their own right, so that efforts to combat poverty ought to consider the role of health. It is now widely recognized that health is both an input and an
outcome of broader social and economic development. It is also well known that achievements in health do not simply depend on the health sector, but arise out of improvements in standard of living, social stability, education, housing, water supply, sanitation, and other environmental factors. These are amenable to change by actions taken by households, communities and governments, and are usually outside the domain of the health system. Good health also improves educational attainment, and fosters economic growth and political participation. Yet unhealthy behaviour, sickness, malnutrition, and high fertility are also significant causes of poverty (Marilyn Bergner, 1985).

1.3 Investment on Health and Economic Development

There is a close link between rise in the reach of education and health, through higher rates of social provisioning, and rise of happiness, welfare and fall in poverty percentage. Health and poverty or vice versa (poverty and health) is closely related. Deprivation means, something taken away from people so as to maintain them in a state of poverty to which they will never become accustomed. To break or overcome such situation particularly for the poor, the intervention of the government is very essential so as to ensure higher provisioning for health and education sectors for securing decent and quality life (Jeremy Sea Brook, 2006).

Health is an important determinant of economic and social development because ill health creates vicious circle by depleting human energy, leading to low productivity and earning capacity; deteriorating quality and quality of consumption and standard of living. Therefore, a nation ought to give adequate attention to the healthcare of its people. Health is an important aspect of human resource development. Good healthcare facilities and services are essential for creating healthy citizens and society that can effectively contribute to social and economic development. With increased urbanization, industrialization and the changing environment, health related issues and problems are being emphasized and have become a great concern for the contemporary world. Little attention has been paid to the micro aspects of health economics by the researchers, government, policy makers and the development planners. Health is the essence of productive life. It is an integral part of development.
Human health has come to be regarded as a prerequisite for optimum socio economic development. Human resource development, of which health is an important aspect, has been instrumental in accelerating economic development. Health of the people is really the foundation upon which all their happiness and all their powers of a State depend. Low income, poverty and illiteracy prevent many people in developing countries neglect giving due importance to the primitive and preventive aspects of healthcare. There are many social and economic factors that influence the provision of healthcare services in developing countries. The problem of under-development in ‘health’ in developing countries like India is not only an economic but also a technical problem. The Government's efforts at providing healthcare services free of cost or at low cost and making those easily accessible have their impact on the health status of the country. It could also be a reflection of the greater awareness of the people of their rights in getting healthcare services. Health should be considered as a fundamental human right and therefore the attainment of the highest level of health should be the most important goal (Sagaya Doss, 2008).

Economic growth and development affect the health of the people by increasing their level of income, and hence in the consumption - increasing goods and services. It means, there is a positive relationship between health and stages of economic growth and development, but it is not always true. In this connection it is useful to note two important consequences of the improvement of health: demographic transition and epidemiological transition. As population becomes healthier, they live long which is known as demographic transition. It occurs due to two reasons. Firstly, when health status of the individual improves, they live longer. Assuming given birth rate, the net addition to the population each year increases, increasing the share of older people in the total population. Secondly, the fertility rate (the average number of children born to a representative woman in her life) may tend to decline (which may not be always true) due to better health and greater economic security. Of course, this has more indirect effect of the change in health status (Himanshu Sekhar Rout and Bhabesh Sen, 2007).

In order to explain the relationship between health and economic growth, it is necessary to understand the concept of health in a broad sense. Health is not only the absence of illnesses; it is also the ability of people to develop their potential during their entire lives. In that sense, health is an asset individuals possess, which has intrinsic value (being healthy is
a very important source of well-being) as well as instrumental value. In instrumental terms, health impacts economic growth in a number of ways. For example, it reduces production losses due to worker illness, it increases the productivity of adult as a result of better nutrition, and it lowers absenteeism rates and improves learning among school children. Health also allows for the use of natural resources that are used to be totally or partially inaccessible due to illnesses. Finally, it permits the different use of financial resources that might normally be destined for the treatment of ill health.

In order to strengthen the beneficial relationship between healthcare and economic development, it is necessary to establish mechanisms that solve the problems of lower income population groups in the face of adverse health shocks. These mechanisms should not only improve the average level of health but also reduce the marked lags in health levels in certain areas. There are several mechanisms that can be used to deal with each one of these points; among others, financial actions to compensate those expenses incurred by a population in order to pay for medical attention. Nevertheless, in order to comply simultaneously with the goals of equity and efficiency, the most appropriate option is that of adopting an insurance plan for the population.

1.4 Importance of Women – As a Human Resource

Women who constitute half of the world’s population are not fully harnessed as a human resource. Any society cannot go ahead if at least 50 per cent of the populations do not participate in its developmental activities. Indira Gandhi, the former Prime Minister of India observed that neglect of women would be criminal since humanity had been deprived of half of the energy and creative talents. Right through history, in all religions and cultures women have been assigned a secondary status (Shakuntala Balaraman, 1986).

The world wars proved to be a turning point in the history of mankind. The participation of women in the work force stated increasing since then. This trend is observed in developing nations (Kalpana Sharma, 1988). In tune with world wide trend, Indian women are marching towards self-development. In India, women played a secondary role for centuries together. During the colonial rule, women lived a miserable and horrible life in diverse situations (Krishnamurthy, 1990). Mahatma Gandhi, Father of
Indian Nation, helped women to find a new dignity in public life, a new place in the national mainstream, a new confidence and a consciousness that they could act against oppression (Madhu Kishwar, 1985).

The socio-economic changes, that were set in motion in India after independence provided women with better educational and employment opportunities. Besides, a series of laws such as the Special Marriage Act (1954), the Hindu Marriage Act (1955), Equal Remuneration Act (1976) passed by the government of India helped to improve a lot of women. Today educated Indian women have made a landmark in the non-conventional fields like consultancy, marketing, advertising, garment exporting, interior decoration, beauty parlors, road and building construction etc. Women have started coming forward in considerable number in certain spheres of higher category jobs like civil service, judiciary, Foreign Service, medicine and architecture. In organized sectors like banking, insurance, communication and air transport women’s share in employment has recently doubled over the decade and government’s intervention played an important role in this regard (Nirmala Banerjee, 2000).

1.5 Women and Health during Five Year Plans in India

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<tr>
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<th>Five Year Plan</th>
<th>Focus on Women</th>
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<tr>
<td>1.</td>
<td>First Plan (1951-1956)</td>
<td>Introduction of Central Social Welfare Board in 1953 to promote welfare through organizations and charitable trusts</td>
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<td>2.</td>
<td>Second Plan (1956-1961)</td>
<td>Focus and support the development of Mahila Mandals to work at the grass-root levels.</td>
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<td>4.</td>
<td>Fifth Plan (1974-1979)</td>
<td>Major shift of approach from welfare to development</td>
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<td>5.</td>
<td>Sixth Plan (1980-1985)</td>
<td>Women’s development as a separate economic agenda and took a multi-disciplinary approach with three thrust areas on health, education and employment</td>
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<td>6.</td>
<td>Seventh Plan (1986-1990)</td>
<td>The main objective was to bring women into the mainstream of national development</td>
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<td>7.</td>
<td>Eighth Plan (1992-1997)</td>
<td>There was a paradigm shift from development to empowerment and benefits to women in core sector of education, health and employment and outlay for women rose from Rs.4 crore in the First Plan to Rs.2000 crore in the Eight. Promote social welfare services like improved health care, sanitation etc.</td>
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<td>8.</td>
<td>Ninth Plan (1997-2002)</td>
<td>The main strategic objective was on empowerment of women and accepted the concept of a women’s component plan to assure that at least 30% of funds and benefits from all development sector flow to women. To provide basic infrastructure facility of health, safe drinking water, primary health care etc.</td>
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<td>9</td>
<td>Tenth Plan (2002-2007)</td>
<td>It suggests specific strategies, policies and programmes for the empowerment of women.</td>
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<td>10.</td>
<td>Eleventh Plan (2007-2012)</td>
<td>Strengthen the general hospitals-efforts is taken to ensure that pregnant women would get at least for antenatal check up during the pregnancy. Reduce total fertility rate to 2. Reduce Anemia among women and girls by 50%. Proper implementation of programmes for health, water supply, gender equity bridging divides.</td>
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Source: Sanjoy Roy (2010) p. 79

### 1.6 The Role of Women in Health Care

Most of the gender-related and health related demographic researchers agree over ‘women’s pivotal role in health’, as they are the keepers of a nation’s health and development. When woman is healthy, the family is healthy, the society is healthy and the nation is healthy. Women particularly in Indian society, take care of children’s health, family health as well as their own health. By empowering women through education, especially health education, the health and the mortality of the people as a whole could be improved.
A research study shows that education in general and the women’s education in particular has a positive impact on the attainment of better quality of life. Women’s education is interrelated with number of health determinants like age at marriage, delay in first child birth, immunization, better household hygiene, utilization of available health services. Thus the policy emphasis now is mainly on its responsibilities for promoting good health through indirect means such as female education and empowerment as an educated mother is more likely to take her sick child for treatment, she is more likely to follow doctor’s instruction accurately. One study says that in south India, the educated mothers are more serious about their children’s sickness and use more children’s health services (Dhanlaxmi Dash, 2005).

At the close of the 20th century, the life expectancy of women exceeded that of men in every country. This is attributed to biological differences, but interactions between these differences and the physical and social environment are of major importance. Demand for health and healthcare services are very high for women as compared to men. Women were recognized to be ill by family members only when they were bedridden or unable to perform their daily tasks. The women felt that most illnesses would get cured by themselves. Those who sought care for general illnesses first tried home medicine. If this was not successful they approached traditional healers. If they were still sick, those who were able to access care visited the nearest health institution (Ram Lakhani, 2007).

1.7 Women and Health

Among the human rights, right to health is the basic and essential right and it must not be a target of any discrimination. Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well being and their ability to participate in all areas of public and private life. Health is the state of complete physical, mental, social well-being and not merely the absence of disease or infirmity. Women’s health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology. But the irony is that women themselves are
many times denied of this basic right. This situation is due to women’s vulnerability which arises from the physio-social environment in which they live in addition to various other factors (Suguna and Sandhya Rani, 2008).

For the past so many years, many studies have shown the importance of women’s health. It is now well accepted that women’s health status has got an impact on the health of the children, family and community. In spite of several studies and rapid technology advances many women still suffer preventable mortality and morbidity. While some improvements have been recorded in physical quality of life indicators, health status of women remained precarious, rather it is worsening. After numerous conferences, meetings, and symposia framed on women’s health, worldwide programmes have been initiated from 1987 onwards specially to reduce the maternal mortality and morbidity.

To highlight certain outcomes of inequity and discrimination, women’s life span in total is found to be important. Various phases which are important due to a number of reasons include: pre-natal period, adolescence, reproductive period and elderly phase. Women’s health status affects their proportion in the population, working hours, income, and their overall contribution in the work place as well in the society.

In women, nutrition forms the critical part of their overall health status. It is stated that the food intake in the lifetime comprises of the following:

- Their energy output and workload
- Their control over resource for household food security and
- Their roles in the food chain etc.

The main causes of poor health conditions of Indian women are:

1) Illiteracy and ignorance
2) Lack of knowledge and information regarding health facilities and health education and government programmes and schemes especially, in rural areas
3) Sex discrimination
4) Less importance and opportunity to girl child in the family
5) Social stigma
6) Subordination and patriarchal attitude towards women by the own parents and as well as in the in-laws house after marriage

7) Burden of household work, child caring and rearing and earning of livelihood also another reason of poor health of women (Suguna and Sandhya Rani, 2008).

1.8 Women Work Force in the Labor Market

Traditionally, women’s occupational status has always been closely associated with the home and family. She has only a secondary status because she is economically dependent on her father or husband (Mary Billington, 1978). In order to improve the status and position of women at home and in the society at large, it is necessary to achieve economic independence for women.

Freedom depends on economic condition even more than political. If a woman is not economically free, without self-employment and self-earnings she has to depend on her husband or some one else (Azad Singh Gulab, 1988). For a woman, an opportunity to productive work is not merely a means to higher income but also to self respect, to the development of her personality and to a sense of participation in the common cause of the society. The low status of women in large segments of Indian society cannot be raised without the opening up of opportunity of independent employment and income. Economic independence makes women conscious of their rights. By working outside the home and coming into contact with other people they have broadened their outlook and mental horizon (Margret Cormack, 1976).

The image of women in society is fast changing. But it is difficult to define clearly the changing shape of the image. One thing is clear; women are entering the labor force in a large number (Devaki Jain, 1975). Employment is considered to be an important indicator of women’s achievements in the economic sphere. In the organized and industrial sectors employment of women has gone up rapidly. A similar increase could be seen in the unorganized sectors which are outside the reach of public regulation, labor laws and other forms of public control. They are employed in considerable numbers in public services in several countries. They are employed in all services not in the same proportion as that of western countries. The labor force participation rates particularly of women and teenagers are very sensitive to the general level economic activity.
The impact of economic conditions on female labor force participation can take two forms. In times of economic down turn, the wife or other members of the household may enter the labor force to supplement the family income. These additional workers often leave the labour force once the major breadwinner is reemployed on a regular basis. If an employed woman loses her job, and cannot find a new one after a prolonged search, she may become discouraged and leave the labour force. Despite the rapid growth of the female labour force in recent years, women still primarily confine themselves to certain sector of the economy. In the secondary and tertiary sectors the female working force is much less as compared to male employed in transport, storage and communications (Subba Rao, 2000). The phrase ‘working women’ is generally understood to mean women who take up jobs usually outside the home, the work being mostly of a remunerative nature. The term is however a misnomer in so far as it implies that the housewife is not a ‘working woman’. It is indeed surprising that housewives all over the world have not taken exception to this usage (Annapa Gupta, 1971).

Women are employed in all fields. They are shouldering official, family and social burdens. While working in the mixed group, their need to keep up with the status, which can be higher, compared with non-working housewives. Working women can be defined as the employed women ranging from those who are employed in small scale industries and organisation to those who, possesses ownership, and authority in organizations, in government, private and quasi-government (Lawrence Marry, 1996). Working women could be brought under three categories on socio economic basis.

- The first category includes agricultural workers and those engaged in traditional menial services, construction work and domestic works such as cleaning, cooking and washing.
- The second category mostly consists of those women who work in offices or in factories. They can be called the blue-collar women workers.
- The third category of women workers is well educated. They are quite well off in life. They have both vertical and horizontal mobility (Gangrade, 1993).

The employment of women under the next three types of industries, electricity, gas and water supply, construction and trade and commerce reveals downward trend.
These three categories of industries seem to provide the largest avenue of employment to women job-seekers in India. Under the division of transport, storage and commerce, there was a substantial increase both in the number of workers as well as in their proportion.

The majorities of women under these divisions take up the white-collar jobs and work as clerks, typists, steno, telephone operators, secretaries, assistants etc. Women workers are preferred in these jobs because of their docile nature. They do not take in general active part in strikes and other trade union activities. This is an important feature of women workers (Kulshrestha, 1999).

1.9 Unorganised Labour and their Characteristics in India

Indian economy is characterised by the existence of high level of informal or unorganized labour employment. The workers in the organised sector constitute about 7 per cent of the country’s total work force and the rest (93 per cent) comprises of subsistence farmers, agricultural workers, fisherfolk, dairy workers and those working in traditional manufacturing like handlooms are grouped under unorganised sector. The term unorganised sector or employment is defined as “unorganised workers consist of those working in the unorganised enterprises or households, excluding regular workers with social security benefits and the workers in the informal sector without any employment / social security benefits provided by the employer” (National Commission for Women, 2004).

Ministry of Labour has categorised the unorganised labour force under four groups in terms of occupation, nature of employment, especially distressed categories and service categories.

- In terms of occupation, it includes small and marginal farmers, landless agricultural labourers, sharecroppers, fishermen and those engaged in animal husbandry, beedi rolling, labeling and packing, building and construction workers, leather workers, weavers, artisans, salt workers, workers in brick kilns and stone quarries, workers in saw mills, oil mills etc.,

- In terms of nature of employment, they are attached to agricultural labourers, bounded labourers, migrant workers, contract and casual labourers.
• Toddy tappers, scavengers, carriers of head loads, drivers of animal driven vehicles, loaders and unloaders, belong to the especially distressed category.

• While midwives, domestic workers, fishermen and women, barbers, vegetable and fruit vendors, newspaper vendors etc. come under the service category. In addition to the above categories, there exists a large section of unorganised labor force such as cobblers, handicraft artisans, handloom weavers, lady tailors, physically handicapped self-employed persons, rickshaw pullers / auto drivers, sericulture workers, carpenters, leather and tannery workers, power loom workers and urban poor. (Government of India, Ministry of Labour 2006-2007). The extent of unorganised workers is significantly high among agricultural workers, building and other construction workers, and among home based workers. But, the availability of statistical information on its intensity and accuracy vary significantly.

The major characteristics of unorganised workers could be listed as below:

• The unorganised labour is overwhelming in terms of its number range and therefore, they are omnipresent throughout India.

• As the unorganised sector suffers from cycles of excessive seasonality of employment, majority of the unorganised workers does not have stable and durable avenues of employment. Even those who appear to be visibly employed are not gainfully and substantially employed, indicating the existence of disguised unemployment.

• The workplace is scattered and fragmented. The workers do the same kind of job(s) in different habitations and may not work and live together in compact geographical areas.

• There is no formal employer-employee relationship between small and marginal farmers, share croppers and agricultural labourers as they work together in situations which may be marginally favourable to one category but may be broadly described as identical.

• In rural areas, the unorganised labour force is highly stratified on caste and community considerations. In urban areas while such considerations are much less, it cannot be said that it is altogether absent as the bulk of the unorganised workers in urban areas are basically migrant workers from rural areas.
• Workers in the unorganised sector are usually subject to lot of fads, taboos, and outmoded social customs like child marriage, excessive spending on ceremonial festivities etc. which lead to indebtedness and bondage.

• The unorganised workers are subject to exploitation significantly by the rest of the society. The unorganised workers receive poor working conditions; especially wages much below that in the formal sector, even for closely comparable jobs i.e., where labours productivity are no different. The work status is of inferior quality of work and inferior terms of employment, both remuneration and employment.

• Primitive production technologies and feudal production relations are rampant in the unorganised sector, and they do not permit or encourage the workmen to imbibe and assimilate higher technologies and better production relations. Large scale ignorance and illiteracy and limited exposure are also responsible for such poor absorption.

• The unorganised workers do not receive sufficient attention from the trade unions.

In general, unorganised workers are observed to be large in numbers, suffering from cycles of excessive seasonality of employment, scattered and fragmented work place, poor in working conditions, and lack of attention from the trade unions (Dhas and Helen 2008).

1.10 Unorganized Workers in India

The unorganised workers account for about 93 per cent of the total workforce and there is a steady growth in it over years in India. India is the most populous country in the world, next to China. If one looks at the characteristics of Indian population it reveals the interesting dimension about the existence of unorganised sector, which is the dominant sector and could not be properly attend to under the social security measures initiated so far: As per the 2001 census, the total work force in our country is 402 million, of which 313 million are main workers and 89 million are marginal workers. Out of the 313 million main workers, about 285 million is in the unorganised sector, accounting 91 per cent (Economic Survey: 2005-06). The estimates provided by the National Sample Survey Organisation also reveal the similar pattern. As per the NSSO estimates for the year 2004-2005, India had a population of 1093 million, with a workforce of about
385 million. Of these, about 7 per cent belongs to organised and the rest 93 per cent of the workforce include those self employed and employed in unorganised sector (Ratnam CSV : 2006, Economic Survey 2007-2008).

Construction workers constitute the second largest category of workers in the unorganised sector. According to the NSSO estimates, about 5.57 percentages of workers are engaged in building and other construction works in 2004-2005 (Economic Survey: 2007-2008). The construction industry covers a vast field of activity in the civil, mechanical, electrical and public health area processes. A large number of multinational, national and local companies employ lakhs of such workers. More over, a large number of self employed individuals are engaged in actual construction works and allied activities like white washing, painting, plumbing and fixing of mechanical or electrical fixtures etc. (Economic Survey, 2007-2008)

1.11 The Construction Industry

Construction sector is the world’s largest industrial employer with seven per cent of total world employment and 28 per cent of industrial employment. Construction activity is an integral part of a country’s infrastructure and industrial development. In India, the construction sector is the largest employer of unorganised labour next to agricultural sector (Laskar and Murty, 2004). The contribution of construction sector in India the GDP (Gross Domestic Product) at factor cost in 2006-2007 was Rs.1,965,550 million, registering an increase of 10.7 per cent from the previous year and the share of construction industry in GDP has increased from 6.1 per cent in 2002-2003 to 6.9 per cent in 2006-2007 (Government of India, 2008b). Around 16 per cent of India’s working population depends on building construction for its livelihood and the Indian construction industry today employs about 31 million people and creates assets worth over Rs.200,000 million. (Government of India, 2008).

The strength of skilled workforce in construction has dwindled substantially from 15.34 per cent in 1995 to 10.57 per cent in 2005, whereas relative proportions of unskilled workers have gone up from 73.08 per cent in 1995 to 82.45 per cent in 2005.
(Government of India, 2008b) and it is a clear indicator that there is a great demand for skilled workers in the construction sector. To make up this shortage, it becomes imperative to convert semi-skilled or unskilled women workers into skilled workers.

It is a recorded fact that outside the agricultural sector, a significant and gradually increasing proportion of women workers are engaged in the construction sector (Shah, 2002). It is estimated that more than half of the 31 million construction workers in India are women (Government of India, 2008a). Women are employed in semi-skilled and sometimes in skilled jobs in other industries but in the construction industry women are employed mostly as unskilled laborers (Jhabvala and Kanbur, 2002, Baruah, 2008).

1.12 Status of Construction Industry

The construction industry has major linkages with building material industry, since the construction material accounts for sizeable share of the construction industry. These include sand, cement, steel, bricks, tiles, fixtures, fitting, paints, aluminium, glass, plastics, petro products, timber etc., The construction industry is the largest employers in the country. In 1999-2000, it employed 17.62 million workers, a rise of 6 million from the year 1993-1994. The sector has also recorded highest growth rate in generation of jobs in the last two decades (National Commission for Women, New Delhi 2004).

The following are the features on the construction industry.

- Construction industry occupies a prominent status in the National economy of the country.
- Almost all development projects and programmes depend on this industry.
- Around 40 per cent of planned allocation of funds is invested in this industry.
- Highly labour intensive and employs vast number of workers.
- Number of ancillary industries such as brick kilns, tile factories, stone quarrying, and sand dredging etc/lime kilns, are inter-linked to this industry.
- Contracting, sub-contracting and piece rated systems are very common in this industry (Census 2001).
1.13 General Features of Construction Sector

The construction sector has remained labour intensive production with low level of mechanization. Most of the features of the organization of the construction sector as well as the work relations are inherited for centuries from a pre-industrial society. The modern construction sector in public as well as in private enterprises has been the ramification of colonial era. However, some of the basic ingredients have remained more or less same. For instance:

1. The mason’s status as artisans has remained intact even today;
2. The head “mason” or the “maistry” is a sub-contractor as well as heads a team of construction workers involved in a particular task;
3. The maistry usually works with a team of workers of his choice and moves from site to site with more or less the same team;
4. The maistry is often, especially in small construction sites, free to choose the way he works, the order in which the work is to be completed etc;
5. All the jobs are undertaken on a piece-rate basis. A maistry is contracted to complete a piece of work for a certain fixed payment;
6. The caste system is still the institution within which apprentices are trained to become skilled workers, carpenters, masons etc. especially in villages and small towns;
7. Even in the formal industrial sector, the contractors in major construction sites, both private and public, are mere financiers with no understanding of the production process and labour management. They are considered as implementers of a plan by the main employer. The production in construction sector has been carried out based on subcontract (Tripathy, 1996).

1.14 Women Workers in the Construction Industry

More than half of the 31 million construction workers in India are women and their potential is not used to the maximum (Government of India, 2008a). They clean the building sites and the serve the skilled men workers by carrying materials as head load and doing tasks directed by them. *The differentiation in work allotted to men and
women on building sites occurs on the grounds of what is considered appropriate for men and women, and not on the basis of the skill and the capacity of the women to do the work.

Construction is one of the few industries where people can work their way to the top from the bottom level (Fisher, 2007). But women in India are denied promotional opportunities in the construction sector. In the absence of mechanization of work, many backbreaking and energy sapping jobs are assigned to women workers who are treated no better than draught animals, so to say. It is no exaggeration that the job of a woman worker is more strenuous in the construction sector that in other manufacturing industries. In recent times, heavy machinery is replacing women workers in large construction sites (Vankar, 2005), yet the continued availability of cheap labor forces, builders and contractors to seek women laborers. Their work is naturally regarded as unskilled, and they are given no opportunity to acquire skills. Men, on the other hand, learn and up-grade construction skills while working. Men start as unskilled workers and move up to work as masons and then become supervisors and some even become contractors (employers). The male dominated construction sector does not encourage women to become masons (Baruah, 2008). Women workers in India are not at all considered to do skilled work like bricklaying and basic masonry. Even when they master such skills, they do not find work because they are simply not considered. All the women construction workers in Tamil Nadu have the same job title “chithal” (means small worker in Tamil – a South Indian language) whereas men have many job titles and promotional opportunities (Kalpana Sharma, 1988).

1.15 Need for the Study

The construction industry is the second largest employer of informal workers, with about 31 million workers and contributing to 5.3 per cent of the country’s Gross Domestic Product. The industry engages 80-85 percentages of skilled and unskilled workers with female workers of about 50 per cent of the total work force. According to the NSS 61st round (2004-2005), 38.9 per cent of unorganised non-agricultural women workers were casual labour in the construction industry.
The construction industry is also one of the largest industries absorbing the maximum number of migrant labour force. The migrant labour force comprises mostly of marginal farmers or landless labourers belonging to the lower strata of society. Women come into the industry as migrant work force and live on the construction site itself. They are drastically deprived of good living as well as working conditions. The facilities at their dwellings are very poor in terms of quality as well as quantity. The availability of space in them is extremely inadequate and this space is used for all purposes like stores, bedroom and even kitchen. The provisions of ventilation, drainage, and sanitation, lighting and potable water are totally absent. There are no facilities relating to a canteen or a crèche.

Women are forced to adapt to an unnatural life style with no privacy or safety at the sites. Even the toilet timings have to be in the middle of the night. There is no enclosure even for bathing or changing clothes. Thus, they crave for seemingly simple needs like a latch on the inside of the door of their hut, so that they can bolt it and sleep peacefully. Their continuous exposure to heat, dust and unhygienic working conditions increases the possibility of contracting diseases of the eyes, skin, joints and bronchial and respiratory problems like asthma and cough, menstrual disorders and spontaneous miscarriage due to heavy labour (Singh, 2005).

The worst burden comes in the form of total negligence to their physical health mostly reproductive health. They marry early and survive without any government health coverage. They have to deliver babies at home in absolutely unhygienic conditions with the help of neighbours. Their children remain out of the purview of the immunisation campaigns. They are exploited by the employer, contractors and also many times bear sexual harassment and exploitation at work place. Many times they also face violence at the hands of the spouses.

There is no fixed working hours and unauthorized deductions and untimely payments are a common feature. Almost all the women workers are indebted to either their intermediary or the owner. Although advance in cash or kind is rendered illegally under the Bonded Labour System (Abolition) Act, 1976, even then majority of the workers in this industry were found having taken huge amounts of money as advance.
The gain from a number of laws purporting to provide basic social security benefits relating to old age, marriage, maternity, sickness, injury and death have only been marginal. The life of women workers in construction industry is very tough, as they have to perform a dual role relating to production and reproduction. While bearing and rearing children remain their primary responsibility, they are invariably involved in the economic activities also. They are unprotected and suffer from economic exploitation. Their ignorance, illiteracy and poverty have added to their woes all the more. A majority of them have not been benefited by the protective legislation in the critical areas of wages, maternity benefits, child care and social security.

Hence, there is an urgent need to give top priority to the issues and problems of the workers in the construction sector. A very little attention has been paid to the health of the women construction workers. There is a need for comprehensive study to address the health problems of this largest, poorly unorganised women construction labour force. This study makes an attempt to fill the research gap and focus light on the various dimensions of construction workers. Thus the findings of the study can be generalised in the context of Indian Economy and appropriate policy paradigms can be formulated in order to ameliorate the condition of women workers.

1.16 Scope of the Study

The scope of the study helps to understand the social and economic background of the women construction workers, nature of migration, reasons for migration, reasons for joining the present job, living and working condition of the workers, problems faced by the women construction workers, health status and health seeking behaviour of the women construction workers. Findings of the study may also help the governments to formulating policies and programmes for the welfare of the women labourers. It can be useful to the voluntary organization who is involved in implementing welfare programmes for women and women labour, especially the poor migrant women labourers. This can help other researchers to take up further research work on empowerment of migrated women and women labourers.
1.17 Objectives of the Study

1. To examine the social and economic background of the women construction workers.
2. To study the migratory aspects of the women construction workers.
3. To examine the living and working condition of the women construction workers.
4. To study the health status and health seeking behaviour of the women construction workers.

1.18 Methodology and Data Source

Coimbatore has been selected for the study because it is one among the state’s biggest cities in terms of business development, industrial and population growth. It is otherwise known as the Manchester of South India. With regard to construction industry, the real estate boom experienced in Coimbatore as a result of large scale land conversion and change in land use pattern, which has made a lot of land available for real estate development. The growth in the construction sector generated a great demand for unskilled as well as skilled labour. Since the domestic supply of labour falls short of the demand for labour, excess demand is met by migrant labour force. The study uses both primary and secondary data.

To understand the health status and health seeking behaviour of women construction workers, primary data was collected using a pre-tested interview schedule. The study covered a sample of 525 migrated women construction workers from urban Coimbatore. Coimbatore city was selected purposively. Within the zones, the researcher intended to collect data from 600 women construction workers in Coimbatore city. As the entire Coimbatore city is divided into 4 zones namely, East, West, South, North and in order to give due representation to all these zones, the researcher fixed a sample of 150 per zone. However, while collecting data from these zones, 49 women workers did not respond and 26 women workers were not available. Hence, the researcher finally able to collect a total sample of 525 (East zone = 132, West zone = 125, South zone = 128, North zone = 140, Total = 525). The data from these sample women was collected during the period March 2009 to May 2009. The interview schedule contained items like social
and economic background, migratory aspects, living and working conditions, problems faced by the women construction workers, health status and health seeking behaviour of the women construction workers.

1.19 Data Analysis

Appropriate statistical tools have been used to draw inferences from the data collected. To study the reasons for migration from native place to the present destination and reasons for joining in the construction work “Garret Ranking Technique” is used. Health status was assessed using self assessed health status of the respondent with the help of 5 point Likert scale. In order to study the relationship between living condition and health status, working condition and health status, hours of work and health status, income and choice of health care services, healthcare expenditure and socio economic factors, “chi-square test” was used. To identify the determinants of demand for health services “Logit Model” has been used.

1.20 Limitations of the Study

The present study is based on the primary data collected through interview method which generally suffers from recall bias. Even though adequate care has been taken at every stage to eliminate this error through cross checks, the presence of it cannot be totally rule out. Since, the study is confined to Coimbatore city, the results and final implications of this study have to be generalized with caution.

1.21 Organisation of the Thesis

The research work is divided into eight chapters.

Chapter - I  presents a detailed picture of Health Status, Investment on Health and Economic Development, Importance of Women – As a Human Resources, Women and Health during Five Year Plans in India, The Role of Women in Health Care, Women and Health, Women work force in the labour market, Unorganised Labour and their Characteristic in India, Unroganised Workers in India, The Construction Industry, Status of Construction Industry, General Features of Construction Sector, Special
Features of Construction Sector, Women Workers in the Construction Industry, Need, Scope, Objectives, Methodology and Data Source, Data Analysis, Limitations and Chapter Scheme.

**Chapter - II** has been divided into three sections:

Section – I deals with theoretical background of migration and related empirical studies.

Section - II deals with theoretical background of labour market and related empirical studies.

Section - III deals with concepts related to health, theoretical background, and review of empirical studies.


**Chapter - IV** presents the Social and Economic background of the Women Construction Workers.

**Chapter - V** Migratory aspects of the Women Construction Workers

**Chapter - VI** provides the living and working conditions of the Women construction workers.

**Chapter - VII** deals with Health Status and Health Seeking Behaviour of the women construction workers.

**Chapter - VIII** explains the Summary of Findings, Conclusion and Suggestion based on the study.