

Morbidity Status of Working Women in Informal Sector

By

M.BRINDHA

11PEC02

**A Thesis Submitted To The Avinashilingam
Institute for Home Science and Higher Education for Women
University, Coimbatore-641043**

IN PARTIAL FULFILLMENT FOR THE DEGREE OF

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CERTIFIED AS BONAFIDE RESEARCH WORK

P. Ambica Devi 17.5.13

[Signature]

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CHAPTER-1

INTRODUCTION

The term informal sector and informal economy are used interchangeably to specify that segment of the economy and labour market, which has absorbed significant numbers of job seekers and unemployed workers outside government regulations and formal systems of labour and social protection. In India the informal sector or otherwise called as unorganized sector employs more than 90 percent of workforce, most if not all, are not covered by meaningful social security schemes. The term social security in developing countries is used in much broader sense than that used in developed countries (Ahmad, Dreze and Sen 1991; Guhan 1994; Prabhu 2001; Sarkar and Bhumali 2005). It has been further recognized that the neglect of social opportunities due to lack of adequate progress in social security has been detrimental to the economic and social development in the developing countries including India (Datta 1998:L-2). The informalised workforce is unprotected labor, which implies labor that does not have any socio-economic safety. The protection that a society provides to individuals and households to ensure access to wage and working conditions in a comprehensive sense, in matters of security of employment, health care, maternity benefits, provident fund, retirement benefits, is an essential element of the safety nets that keeps working people and their families from falling into poverty (Sarkar 2004 a).

The informal sector represents an important part of the economy and certainly of labour market in many countries, especially developing countries and poses a challenge to policy makers with regard to issues relating to improvement of the working condition and social protection of the workers engaged in the informal sector (Sarkar 2006a). In the developing economies a substantial share of employment is indeed in informal category and women in all age groups depend on the informal sector more heavily than men. Women are over represented in this sector in the sense that their share in the sector is higher than their share in total labour force. Most women tend to be own account workers and only a few are heads of micro enterprises. Relatively lower level of education among women, compared to men, seems to explain, in part, this gender differential in informal

employment. Discrimination in the labour market also explains in part the disproportionate concentration as it limits women's access to formal and wage employment. Women also face additional constraints because of their homemaking and childcare responsibilities, which limits their participation in formal employment. Even within the informal sector more women than men seem to be in poor quality employment. The causes for participation in the informal sector can be economic and non-economic. Economic reasons are related to unemployment and an inflexible formal labor market, a declining real price of capital and the high cost of formal production. Besides, non-economic causes are concerned with a greater flexibility and satisfaction in work, a complete use of workers professional qualifications and increased leisure time. There are two groups of factors, which determine the decision to become active in the informal sector, more specifically, the structural as well as opportunity factors. The structural factors consist of financial pressure, socio-psychological pressure and institutional constraints. The opportunity factors consist of individual background, skills, education, living condition or non-individual components, environment, values, standards etc. (Sarkar 2004).

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 quantity of consumption and standard of living. Health is an indicator of well being that has direct implications not only for the quality of life but also indirect implication for the production of economic goods and services. Health condition of the persons and economic development of the people go hand in hand, because better health conditions will lead to higher level of capabilities to develop the economy. Health is regarded as an important component for sustained development interventions at the individual, community and national levels. Good health plays a substantial role in economic growth. Economic growth and development affect the health of the people by increasing their level of income, and hence in the consumption of goods and services. It means, there is a positive contribution to economic development which in turns tends to improve the health status of the population in a country. Better health translates into greater and more equitably distributed wealth by building human capital social capital and increasing productivity. In developed countries, the health status is far higher than that of developing countries. Quality of life and health services are also

different among these countries. India being a developing country health facilities are quite inadequate, both in rural and urban areas. (WHO, 2000).

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. Health is an asset and therefore it is important to not only to create incentives and implement policies to invest in health, but also to avoid, or at least minimize, its deterioration in adverse situations. These adverse situations can be systemic (for example, economic crises and natural disasters) or idiosyncratic (for example, illness, death, unemployment, or a bad harvest).

The positive relationship between health and economic growth and development, is evident. 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 also 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 borne 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. In order to explain the relationship between health and economic growth, it is necessary to understand the concept of health in a broad sense.

Women Employment in Informal Sector

Amongst those who are left out of any social protection system in India, and amongst those who are poor, women form a major group. Women dominate those forms of

work that are unregulated and unregistered, found most in the so-called 'informal economy. During the second half of this century, as a result of globalization of economy, there are new trends, which have created new opportunities of employment for women the world over. In many regions, women's participation in remunerated work in the formal and non-formal labour market has increased significantly and has changed during the past decade. While women continue to work in agriculture and fisheries, they have also become increasingly involved in micro, small and medium sized enterprises. Women's share in the labour force continues to rise and almost everywhere women are working more outside the households. In India, the sharing of economic activity by women is nothing new. From time immemorial women have been working both in the home and outside, though not in strict sense of earning wages.

Government of India has been making several efforts in developing health and population policies. However, there are several problems in the implementation of appropriate interventions due to poverty, gender discrimination, illiteracy in the population (Buckshee 1997). According to 2011 census, only 54.3% of Indian women were literate. The literacy level of women can affect reproductive behaviour, use of contraceptives, health and upbringing of children, proper hygienic practices, access to employment and overall status of women in the society. An early marriage and child-birth is a major determinant of women's health and is also responsible for the prevailing wide variation in the socio-economic status. Inadequate and improper utilization of health facilities and wide spread anaemia among all the reproductive age women, leading to high maternal mortality is a common phenomenon (540 maternal deaths per one lakh live births) (NFHS 2).

Poor health has repercussions not only for women but also their families. Women with poor health and nutrition are more likely to give birth to low weight infants. They are also less likely to be able to provide food and adequate care for their children. Finally, a women's health affects the household economic well being, and as a women with poor health will be less productive in the labour force. While malnutrition is prevalent among all segments of the population, poor nutrition among women begins at infancy and continues throughout their lifetime. (Chatterjee 1990; Desai 1994). Because of prevailing culture and

traditional practices in India, the health and nutritional status of women are becoming worse.

Women are generally vulnerable to under nutrition especially during pregnancy and lactation where the food and nutrient requirements are more during that period. The demographic consequences of the lower status in women has formed expression in various forms such as female infanticide, higher death rate for women compared to men, lower sex ratio, lower literacy rate in female, lower level of employment of women in the non-agricultural sector as compared to men etc. (Srinivasan and Tara 1989). Most Indian mothers are malnutrition, anaemic and have short pregnancy interval which could have been easily prevented. Women especially in younger age are at high obstetric risk (using the risk criteria of height less than 145 cm and weight less than 38 kg) (Saramma 1989).

The health of the general population as well as specific groups (infants, women, etc) has for long been an important concern for development studies. When economic development is put in the context of human development, the success of nations to secure good health for their citizens assumes great significance. Morbidity, or physical and mental illness, is increasingly being recognized as a 'measurable indicator of well being' (Shariff 1995). The patterns of reporting of morbidity reveals important facets not merely to the health status of various groups, but also points to inequalities in status and autonomy among various groups of individuals. Morbidity and mortality data have long been used to estimate the level of gender injustice in society. Greater gender justice in the distribution of food, health care and other resources help in ensuring the survival and health of women and female children. Although less clearly understood, women's work autonomy in making reproductive choices and their relative status in the family and community, also have an influence on their health. Morbidity among women is thus an important guide to understand their position in the household and the community. Health defined broadly as a feeling of physical, mental and spiritual 'well being' is often juxtaposed to its definition as absence of disease and infirmity. However, in reality, the relationship between 'well being' and absence of disease is very complex. People's perception of their health, illness and causative factors is based on many factors - social, economic, cultural and environmental.

From a strictly scientific point of view, one may assume that those who live in poverty, degraded living environment, are involved in occupations which are hazardous to health, etc, should necessarily have a lower feeling of well being and thus complain more of ill health and illness. However, studies have shown that this is not necessarily so. The rich and well placed strata complained of illness more often than the poorer strata (Duggal and Amin 1989) or that people in the underdeveloped states in India reported less morbidity than those in the developed states (NSS 1992). There are no straightforward explanations for the process by which an individual's social position is reflected in his/her health status. Even our bodily experiences are colored by our perception of our social role and the definition of that state in our culture. Thus, a state which can clinically be defined as 'illness' may not be experienced so by the woman for whom it may be natural, part of being a woman. Conversely, a clinician may refuse to accept a complaint made by her because it cannot be medically established. However, unless we are prepared to accept and observe both these categories of problems, that part of women's morbidity will not emerge. It is a case of not seeing what we were not prepared to observe in the first place.

Health Status of People

Improvement in the health status of people are linked to number of factors such as household income, public expenditure on healthcare delivery system, availability of private healthcare facilities and general environmental conditions affecting incidence of diseases. Health status was assumed to affect utility directly by the value that individual place on good health and indirectly through increasing healthy time and hence labour income. With rising income levels, the households are able to spend on better health care, education and nutrition leading to an improvement in health status. The income and education are positively co-related with healthcare and health status of people. Health status of a population is now considered as an important indicator of development and health is increasingly being as a development issue rather than just a medical care. Health status was measured through a series of questions relating to the physical and mental attributes of the individuals. Physical health status was measured of the health problems (e.g., diseases or impairments of the eye, ear, or kidney, and so on). Measures related to the mental health of the individual were determined psychological

and emotional feelings (i.e., unhappy, sad, depressed, nervous, worried, hopeless, stressed, happy, cheerful, and content). Thus over the years there has been considerable interest and activity in developing method to measure quantitatively the health status of individuals and population. (**Human Development Report, 1993**).

Health Status is determined by the following basic factors:

- Healthy environment, especially safe drinking water supply, sanitary disposal of excreta and other wastes, and pollution-free housing and work places.
- Adequate nutrition, which in turn depends on production and availability, accessibility, affordability and interfamilial distribution of food.
- Control over communicable diseases.
- Lifestyle changes that influence the occurrence of non-communicable diseases.

Health status is multidimensional in nature and difficult to measure precisely. It is captured through a range of indicators such as mortality, morbidity, life expectancy, disability, nutritional status or calorie intake. Among these Mortality and Life Expectancy at birth are widely used to measure the health status of the population.

Health Problems of Women Workers in Unorganized Sector

Women's occupations are fluid and multi-dimensional. The first problem is to learn what those activities are really involved in different situation and cultures: a simple occupational category is seldom sufficient as a basis for establishing specific health risk. Agriculture workers may dig and hoe and apply fertilizers and pesticides, but not all the workers will perform all of those tasks and where the tasks are segregated by gender the health implications for men and women may be very different. The tasks which men and women undertake vary from culture to culture and at different times in different places. Poor nutrition (for example) may be a more important factor in some types of occupational

health impairment than simply being female. The effects of potential occupational hazards on women's reproductive health have been, probably, the major focus of concern which has increased in recent years as more environmental hazards are identified and as more women enter the paid workforce. Workers in every occupation are faced with a multitude of hazards in the work place. Occupational health and safety addresses the broad range of workplace hazards from accident prevention to the more insidious hazards including toxic fumes, dust, noise, heat, stress, etc. The problem of under nutrition and malnutrition has to be studied in its distributive perspective. By under nutrition we mean calorie deficiency, which signifies a corresponding degree of hunger. In other words, it expresses quantity aspects of nutrition deficiency. On the other hand malnutrition the quality aspects, deals with deficiency of other nutrients. Malnutrition resulting from deficiencies in calories and protein is widespread throughout the developing world. This protein energy malnutrition results in stunting or low height for a given age. Generally, health status includes a set of indicators used to provide important health and health related data regarding incidence and prevalence of disease, health risks and performance of health systems. Health status provides a broad overview of reproductive and child health as well as disability prevailing in the country. With this back ground a study on the "**Morbidity Status of Working Women Workers in Informal Sector**" is undertaken with the following objectives

- To study the socio-economic profile of the respondents.
- To examine the morbidity status and disease pattern of the respondents.
- To assess the availability and accessibility of health care services among the sample respondents.
- To ascertain the views of the respondent about the health and personal hygienic.

CHAPTER –II

REVIEW OF LITERATURE

The literature pertaining to the study “**Morbidity Status of Working Women in Informal Sector**” is present under the following heads:

1. Working Women –Issues Associated with Health
2. Studies on Accessibility of Health Care Services
3. Other Related Studies

1. Working Women –Issues Associated with Health

Health status is hypothesized to be important in developing countries, both as a direct indicator of welfare and because of its possible impact on productivity. Health care utilization also is of interest, both because of its relation to health status and because it is a particular manifestation of demand and supply for a “modern service.” Work on the determinants of health status and health-care utilization in developing economies, however, is flawed because true health status is not directly observable. A latent-variable representation of health is used in a system that determines health and various indicators of health and health-care utilization for Nicaraguan women. Wolfe and Jere (1984) imply that women's schooling increases health-care utilization, literate women report less disease incidence, women's childhood back- grounds affect their adult health and health-care utilization, and general resources favor childbirth-related care, but women's full income favors general care. The most significant result is that several important characteristics usually associated with development-women's schooling, household resources, and women's labor force participation-have inverse or no associations with women's health. The indicators of health status that have been used in empirical studies-anthropometric measures, days ill, self-reported or clinical disease records, inputs such as nutrients, and health-care utilization indices are imperfect indicators of underlying health status and generally do not give a congruent representation of that status. If these results hold in a

dynamic context, they suggest that raising income and women's schooling does not improve female health status significantly and that increasing female labor force participation may worsen it and schooling is not primarily representing productivity, as is widely assumed.

Dogra (1985) analyzed the important source of employment for industrial worker in India, and it has been estimated that nearly 1.5 million workers are employed in the textile mills. These mills have been the scenes of several working class struggles. Working conditions in most of the textile mills are known to be very bad. Dust, heat, noise, contact with dangerous chemicals and high frequency of accidents are the most common occupational hazards.

A study on socio-economic and health conditions of women in Madras by Miranda and Mahadevan (1988) found that more than 50 per cent of the employed women were part time domestic workers and were employed in more than two houses. Stomach ailments, menstrual problems, anaemia and general weakness were the common problems reported by the women domestic servants.

A study on the health status of Kerala by Panicker and Soman(1989) reflects the Kerala scenario which is characterized by a strange combination of low mortality and high morbidity. Another dimension is the comparatively high cost of health care borne by Keralites. Further results of National Sample Survey points out that despite widespread, free and easily accessible public sector medical care institutions, private expenditure on medical care in the state has been the highest among all states or close to the top. If we are to look into the causes of this high cost of medical care, one is the exponential growth of public sector medical institutions. Increased literacy has raised the level of health consciousness among the masses and stimulated prompt response to any morbidity episode. Social reform movements have awakened the right of access to public medical care facilities. Added factor is the increased life expectancy and the proportion of aged in the population.

A rare study based on Kerala society is done by Kannan, et al. (1991). It is significant because of the possible consequences for the removal of inequalities in health

and also because of Kerala's paradoxical situation of economic backwardness with better health status. Here health is viewed as a function of socio-economic and environmental status, nutrition and preventive medicine. It also points out that the low mortality-high morbidity syndrome which was earlier explained by Panicker and Soman. Another peculiar finding is the fast expansion of private medical care in the rural areas and its high rate of utilization by poorer groups.

The problems of women in the unorganized sector cannot be limited to the economic level only, but they also suffer from violence and their health was affected in specific ways, partly due to their role as child bearer and partly due to their social oppression as women. Omvedt had listed their problems relating to remuneration, conditions of work, health, safety, education, sexual exploitation, lack of access to property and caste discrimination. Remuneration was usually given into the hands of the men as head of the family. Women workers have to work for eleven to fifteen hours if domestic tasks are included. The problems relating to health, safety and education in the unorganized sector are the derivatives of poverty and exploitation in this sector (Omvedt et al., 1992).

A study on the perceptions of slum women in Mumbai by Mulgaonkar (1994) and others provides a vivid account of their reasons for refusal to participate in a gynecological health program organized by „Sthreehitkarni“, a women's welfare organization. On the basis of their study interspersed with the voices of women which painfully and poignantly reveal their poverty, insecurity and fears, the authors conclude that the socio-cultural and economic realities that face the women in India, complicate their access to health.

Nair (1997) analyzed the women's health in a coir yarn spinning industry in Kerala. The major objectives of the study were to understand the living and working conditions of coir workers, and to assess the influence of socio-economic factors with focus on perceptions and awareness of their problems, and to find ways for improvement for health and well-being of workers. A total of 150 workers were selected randomly from the village of Shertallai Taluk of Alleppey district. In the work place basic amenities like drinking water, sanitary facilities etc. were found lacking. Majority of the workers suffered from allergic problems affecting skin and respiratory organs followed by body aches and

pains. The general health problems are chest pain, headache, stomach ache, vomiting, gynecological complaints etc. Due to the marginalized life pattern and the insufficient state support in the form of health services, the need of the coir workers for their occupational benefits had gone unrealized. In spite of poor working conditions and still poorer living conditions, the attainment of the benefits for better health and well being is still a distant mirage.

According to the International Labor Organization (ILO), Maximum Weight Recommendation, 1967, (No. 128), stated that an adult man can carry up to 55 kg weight, but a female or weak person should carry less compared to a healthy adult man. The workers have to work in winter, summer, autumn or rainy season. They are exposed to all types of weather conditions. This causes health disorders and they may fall sick. Respiratory, eye and skin disorders, noise-induced hearing loss (NIHL), cancer, and so on are found to be prevalent among workers exposed to hazards like dust, noise, heat and cold, non-ionizing radiation, cement, glass, adhesives, tar, and paint. Psychological ill health is also common with high rates of alcohol and drug abuse. The workers misuse their money on alcohol as they do not have any other recreation. Too much intake of alcohol affects their mental state. This results in them beating their wives and children and scolding them for not being able to fulfill their basic needs (food, clothes, education, etc.).

Saran and Shukla (1994) made a study of physical-health and neuroticism among women engaged in the home-based production of chikan embroidery. The present study examined physical health and neuroticism among women ($n=200$) engaged in the unorganized home-based production of chikan embroidery. Physical health of women chikan workers was examined with the help of an abbreviated version of CMI, and neuroticism, with PGI Health Questionnaire N-2 in easy paced, face to face personal interviews. The results indicated that women chikan workers in general were facing some serious health problems. Significant variations were also obtained across groups of women associated with different centres of chikan production. The study points towards the stressful nature of environment in which these women chikan workers live and work.

Lalitha (2000) exhorted the various aspects of women's employment like types of work, working conditions, and problems faced among women working in Khadi sector and cotton textile mills in Dindigul District. The sample size consisted of 172 labourers engaged in production process out of which 122 were women (70.93%) engaged in blow-room weaving, dyeing, bleaching and printing, mixing, cleaning, cladding, drawing, reeling and packing. Some of the difficulties faced by the workers at workplace were poor ventilation, excessive heat, breathing problem, eyestrain, too much of noise from machine etc. she suggested winding the area for reducing the dust. Health check-up should be made frequently. All the health and safety measures in factories Act should be implemented.

Parikh et.al (2001) explores occupational health hazards among women workers in India. The study indicates that women are exposed to respiratory problems, eye and skin disorders, and noise induced hearing loss caused by dust, noise, heat and cold, etc. Women workers make frequent visits to the doctor.

Health condition of India's population has been improving and females are at advantageous position in terms of certain mortality indicators. Gender gap is narrowing down resulting from mortality decline for females and life expectancy is expected to increase over the rate for males. Therefore India could join with other developed countries so as to achieve gender equity in health status. In India, mortality rates for females are comparatively low and the gender gap seems to be narrowing down, indicating a gain in life expectancy of females. Under this circumstance, Ramachandran et, al (2002) analyze a gender difference in health status of India's population, the changes that are taking place in gender gap and to estimate the future prospects in the context of high prevalence of HIV infection in India. Besides a serious concern about maternal mortality, high prevalence of HIV infection among females and easy transmission of this virus from mothers to children will lead to an incidence of orphanage of children and child mortality.

The incidence of cancer in the large cotton-manufacturing factory in Lithuania was studied by Stukonis et.al (2002). The textile workers are mainly exposed to the textile-related cotton dusts and some other agents throughout the manufacturing process. The study includes the sample size of 10198 workers were employed. Among them only

employees that worked at least one year in the plant were included in the study. There were 1371 men and 4396 women. The cancer incidence of women was very close to expected in Lithuanian population. Among the women in spinning and weaving departments exposed to the cotton dust a total of 163 cancer cases were observed. The overall cancer risk in the cohort of female in the textile-manufacturing factory in Alytus was almost the same as the country general population. Among the women employed in the textile processing form \geq 10 years group the overall cancer risk was 73 per cent higher than in other employment groups, and some separate sites even higher: cervix uteri-166 per cent cancers, ovary-179 per cent and Kidney – 270 per cent.

Loewenson (2002) study entitled Occupational Hazards in the Informal Sector -A Global Perspective. This paper draws on reported global experience and a 1997 survey of 1585 informal sector workers in Zimbabwe (Loewenson 1997b). The growth of the informal sector is largely attributed to the inability of the formal sector to provide adequate incomes or employment, leading to the poor consumer markets and capital starvation of the informal sector. Various informal sector workplaces are described, including home based enterprises, displaying a wide range of poorly controlled work hazards, particularly welfare and hygiene, ergonomic and chemical hazards, worsened by poor work organisation, and poor community environments and social infrastructures. The generally hidden but substantial burden of ill health in informal sector work is described. Improving occupational health in the sector can be done through implementing existing knowledge, but demands efforts to confront the underlying risk environments that undermine the application of such knowledge. Such efforts include building social capital and organisation within the sector, enhancing collective support systems and public infrastructures, supporting multisectoral community based approaches, and ultimately confronting the underlying economic marginalisation of informal sector work.

Physical risks experienced by agricultural workers include extremes temperature, lifting and carrying of heavy loads, standing and walking long distances, exerting physical force, working in awkward positions, and vibration. Several women working in agriculture in developing countries located around the equator are exposed to high humidity and high temperatures. Agricultural workers exposed to extremely high temperatures commonly

present with the effects of heat stress. Agricultural activities and physical risks such as tractor driving, ploughing and pesticide spraying, planting and weeding expose workers to whole body vibration, standing, walking and working in awkward postures for long periods of time. They are also involved in the carrying of heavy loads often in excess of 30 kg (Holmberg et.al, 2003)

Ram Lakhani (2004) made a study on “Occupational Health of Women Construction Workers in the Unorganised Sector”. This study was undertaken to assess the occupational health status of women workers in the construction industry by evaluating incidences of occupational health disorders. One thousand and fifty-two workers were selected by stratified random sampling. Over three-fourths of the women and almost all men reported working for 10 to 12 hours daily. A majority of the women reported headaches and backaches, as well as pain in the limbs. Fifty-six per cent of women and 16 per cent of men reported injuries resulting in work loss. They had no social security or other workers’ benefits. Most women and men said that they would prefer to do some other work. Respiratory, eye and skin disorders and noise-induced hearing loss (NIHL) were found to be prevalent amongst workers exposed to hazards like dust, noise, heat and cold, non-ionising radiation, and exposure to dry cement, glass and adhesives, tar and paint. About 76 per cent women reported gender-specific work stress factors, such as sex discrimination, and balancing work and family demands, above and beyond the impact of general job stressors such as job overload and skill underutilization. Discriminatory barriers to financial and career advancement were found to be linked to recurrent physical and psychological symptoms and more frequent visits to the doctor among women workers.

Singh (2005) analyzed the effect of work on health of workers in unorganized sector. Though there were no scientific and direct evidences to support that women worker in brick kilns contract occupational diseases but there can always be a probability of contracting a diseases due to their continuous exposure to dust, heat and unhygienic housing conditions in rick kilns. It was noticed that some of the women who workers either as the carriers or the unloaders suffered from problems that they said were due to brick kiln work. The women who worked as moulders complained of pain in the back, shoulders,

waist and joints. The carriers had roughening and blistering of hands and fingers. The unloaders complained about cough, chest pain and difficulty in breathing. Where women squat for more than 10 – 12 hours, they suffered from some gynecological problems like the miscarriage. Exhaustion to heat and cold are yet some other problems reported by the women of these kilns. There are episodic occurrences of cholera and typhoid at times, especially in children and women in these kilns. These women complained malnutrition in their children and it was observed that many of the children of brick kiln workers were underweight and suffered from digestive troubles and nutritional deficiencies. The diseases stated by them could be divided under seven broad heads. Women suffer from Bronchial and respiratory diseases like cough, cold, allergies and tuberculosis.

The American Institute of Stress (2005) found that US industry spends \$ 300 million annually on job-related stress which causes absenteeism, diminished productivity, poor labour turnover, high medical cost, legal and insurance fees. The study by Queer and Roy (1989) reveals that same hazardous and dangerous tasks are given to unskilled contract and casual workers in developing countries. Both men and women work for 10 to 12 hours daily. Insecurity of jobs led not only to their economic exploitation but also exposes them to a variety of occupational diseases and accidents. Women as helpers form the lowest strata in the hierarchical construction industry. A majority of women reported headache, back pain and pain in the limbs. About 56 per cent of women and 16 per cent of men reported injuries resulting in work loss.

Kirk Miller, et al. (2007) performed a systematic study on “Health Status, Health Conditions, and Health Behaviors among Amish Women”, Compared with women in the general population, Amish women rated their physical health approximately at the same level, but reported less stress, fewer symptoms of depression, and had higher aggregate scores for mental health. Amish women, as a group, have limited formal education, relatively low incomes, are self-insured, and have many children, yet they also have a lower than expected proportion of low birth weight infants. Amish women may also have better preconceptional health status: lower BMI, less stress, less depression, and much greater social support. Amish women may be more prepared to become pregnant in that they expect it, desire it, lead a lifestyle that supports it, and have the social support

necessary to have a successful outcome. The findings suggest that these outcomes may be due to higher levels of social support and better preconception behavior among Amish women and it help us to understand the Amish women scored only slightly lower than women in the general population on beliefs about internal control of birth outcomes, suggesting that both groups believe their own behavior has approximately the same impact on the outcome of a pregnancy Amish children have a relatively high incidence of certain rare genetic diseases (and a low incidence of others) because the Amish population was founded by relatively few individuals. Amish women have low levels of intimate partner violence, high levels of social support, and they perceived low levels of unfair treatment owing to gender compared with the general population. Amish women also reported higher fertility, fewer low birth weight babies, but the same number of preterm births as the general population.

Ranjwan and Zend (2007), analyzed the Health Status Of Women Employed In Unorganized and Self-Employed Sector mainly focused on Physical fitness of 110 women engaged in unorganized and self employed sector such as construction work. Brick making, domestic work, tailoring and pottery were assessed by step-test method. It was found that physical fitness and Body Mass index of the majority of subjects was below average in all occupational groups. Aerobic capacity of majority of workers was good but it was found to be decreased as per the age. Musculo skeletal complaints were highest among brick makers followed by pottery workers and construction workers. The attitude of women construction workers towards job was negative whereas other workers were in the state of neither liked nor disliked except tailors who had expressed favourableness at moderate level.

Bajaj (2008) in her study on “Women Construction workers in Delhi” finds that among the women surveyed at construction sites, 52 per cent were suffering from chronic energy deficiency. While 24 per cent of these workers has normal body weight index, seven per cent were overweight.

Basu and Sidh (2008) examined the net effect of work status on women's health and whether the effect persists after controlling for the influence of socio-economic factors.

Their hypothesis was that working women face a greater risk of morbidity and mortality, given that most would be expected to shoulder dual responsibilities: market and household. They also examined the risk across regions. In particular, they examined whether the work status-health relationship differs between the southern and northern regions of India, which were known to be distinct in female autonomy. This analysis focuses on only two issues: nutritional status (as measured by body mass index and prevalence of anemia) and reproductive health (as assessed by the presence of reproductive health problems) of women from villages in the study area. Results showed that though both work status and socio-economic factors influence health status, the latter are more important; most of the gross effect of work status is due to socio-economic conditions rather than work participation. This calls for policy intervention in providing better health facilities, female education and supplementary nutrition programs for poor women.

A study made on “Diet and Nutritional Status of Women in India” by Rao et.al (2010) revealed that the health of women is linked to their status in the society. The demographic consequence of the women has formed expression in various forms, such as female infanticide, higher death rate, lower sex ratio, low literacy level and lower level of employment of women in the non-agricultural sector as compared to men. Generally, at household level, cultural norms and practices and socio-economic factors determine the extent of nutritional status among women. National Nutrition Monitoring Bureau (NNMB) has been carrying out regular surveys on diet and nutritional status of different population groups since 1972. They made use of, the data collected during 1998-99 and 2005-06 on diet and nutritional status of tribal and rural population respectively in nine States of India. The intake of all the foods except for other vegetables and roots and tubers was lower than the suggested level among rural as well as tribal women. The study revealed inadequate dietary intake, especially micronutrient deficiency (hidden hunger) during pregnancy and lactation. The prevalence of goiter was relatively higher with 4.9 per cent among tribal women compared to their rural counterparts 0.8 per cent. Tribal women were particularly vulnerable to under nutrition compared to women in rural areas. The prevalence of chronic energy deficiency was higher with 56 per cent among tribal women compared to rural women which were only 36 per cent.

Parveen and Patil (2010) examined Women In Informal Sector: A Case Study Of Construction Industry. Workers working in the unorganized sector even though contributing a major share to the national development are unsecured and backward socio-economically, educationally , politically , and in other aspects. Women are playing a dominant role in certain aspects in the informal sector such as agriculture, construction, etc. The present paper discussed on the nature of work of women in the informal sectors and analyzed national level statistics on the informal sector . Further , on the basis of different studies conducted on the women in informal sector and in construction, the present study analyzed the problems of the women construction workers

Saha et.al (2010) analyzed the Health Status of Workers Engaged in the Small-scale Garment Industry. Though India is now considered a major power and is turning into a developed country from a developing country, a large section of its population still belong to the poorest of the poor. In developing countries, great efforts are directed towards the advancement of small-scale industries as these are considered the engine for their economic growth. According to WHO, over 1000 million people worldwide are employed in small-scale industries. The ‘garment’ industry of India is one such industry. It is an unorganized sector, mostly run by private establishments. It provides employment for both men and women, mainly those from the lower socioeconomic classes. The employees of this industry hardly ever benefit from occupational health-and-safety provisions. As a result their health suffers. Studies show that musculoskeletal problems, diseases of the respiratory system and eye, accidents, injuries, skin diseases, stress, insomnia, etc. are all common among these workers. The ill health is compounded by various socioeconomic factors such as poverty, lack of education, poor working conditions, excess working hours, and poor diet. The study focus on morbidity profile of the workers with special reference to musculoskeletal disorders, socio-demographic and occupational factors with the musculoskeletal disorders and the felt needs of these workers. The study concluded that The variety of morbidities detected among garment workers, especially the high prevalence of musculoskeletal problems, is alarming. It is high time that steps are taken for revising their wages and the other conditions related to their jobs so that they can improve their socioeconomic condition. Counseling for alcohol and tobacco addiction is necessary and they must be educated regarding the prevention of common diseases and the importance of

personal hygiene.Periods of rest in between their long hours of work and seats with adjustable backrests that provide support for the lumbar region would go a long way to reduce postural strain and low back pain. The responsibility for improving the health and safety conditions of garment workers lies with the government and nongovernmental agencies as well as the employers.

Balasubramaiyan (2011) analysed the major trends in Healthcare, occupational safety and medical expenditure in India. The study reveals that as many as 22 occupational diseases generally affects the health of the workers in India. These diseases can cause vomiting, joint pain, loss of appetite, wrist drop, body ache, etc. The ever increasing industrialization, chemicalisation and sophistication have made industrial jobs more and more complex and intricate. This has led to dangers to human life in industries through accidents.

A Study on the Health Problems of Women Working in a Textile Unit in Coimbatore by Thomas (2011) revealed that 50 women (31.65 per cent) used to get head ache frequently and 15 women (9.49 per cent) were affected by fever once a month. Forty two women (26.58 per cent) suffered from backache due to the long hours of work in standing position. Many women had certain ailments, very often. Nineteen women (12.03 per cent) suffered from cough, 20 women (12.66 per cent) had knee pain, nine women (5.91 per cent) had stomach pain and three women (1.9 per cent) suffered from the blood pressure.

Tiwarly et.al (2011) study entiled A review on the occupational health and social security of unorganized workers in the construction industry. Construction is one of the important industries employing a large number of people on its workforce. A wide range of activities are involved in it. Due to the advent of industrialization and recent developments, this industry is taking a pivotal role for construction of buildings, roads, bridges, and so forth. The workers engaged in this industry are victims of different occupational disorders and psychosocial stresses. In India, they belong to the organized and unorganized sectors. However, data in respect to occupational health and psychosocial stress are scanty in our country. It is true that a sizable number of the workforce is from the unorganized sectors –

the working hours are more than the stipulated hours of work - the work place is not proper – the working conditions are non-congenial in most of the cases and involve risk factors. Their wages are also not adequate, making it difficult for them to run their families. The hazards include handling of different materials required for construction, and exposure to harsh environmental conditions like sun, rain, and so on. On account of this, in adverse conditions, it results in accidents and adverse health conditions cause psychosocial strain and the like. They are victims of headache, backache, joint pains, skin diseases, lung disorders like silicosis, other muscular skeletal disorders, and so on. The repetitive nature of the work causes boredom and the disproportionate earning compared to the requirements puts them under psychological stress and strain and other abnormal behavioral disorders. The Government of India has realized the importance of this industry and has promulgated an Act in 1996. The state government are being asked to adhere to this, although only a few states have partially enforced it. In this article, attempts have been made to review some of the important available articles for giving a broad idea of the problem and for furtherance of research in this field.

Govindappa (2012), made a analysis on the occupational health problems and sanitary facilities of “Women Workers in Garment Factories in Karnataka”. From the analysis the author found that 210 respondents complained no bathroom facility, 190 respondents reported no proper urinal facility, 170 respondents claimed no toilet facility, 230 respondents forming majority (92 per cent) claimed no cloakroom facility. Only 30 per cent i.e., 78 respondents reported about satisfactory drinking water facility. Sixty per cent of the respondents carry food and other 40 respondents depended upon canteen facility. Sixty one respondents suffered from breathing difficulties, 43 from allergic squeezing coming out of cotton dust. According to the survey conducted by the Associated Chambers of Commerce and Industry (Ass Ocham), 68 per cent of working women in the age bracket of 21-52 years were found to be afflicted with life style ailments such as obesity, depression, chronic backache, diabetes and hypertension.

Wrigley (2012) examined Unraveling the health-related challenges of women in the informal economy: accounts of women in cross-border trading in Accra, Ghana. The majority of urban informal sector workers lack basic health and social protection services

and work in an unhealthy and unsafe environment. Women in cross-border trading are one such group. Even though they contribute significantly to and are an important component of many economies, they do so at their personal and economic risks. As these women travel, they experience health hazards which add to their existing occupational exposure. Using in-depth interviews and observation, this paper unravels the health-related risks that women in cross-border trading face. The most common physical health complaints were musculoskeletal problems such as body aches, back pains, waist pains and swollen feet as a result of long hours of travelling and poor road networks. In addition to the limited access to information on sexually transmitted diseases, women also go through psychosocial problems arising out of constant thinking and 'worrying too much' about their safety in the vehicles, the cash they carry along, the activities of gendarmes and armed robbers, untrustworthy clients as well as the safety of the children they leave behind. It is recommended that more attention should be paid to women's work in the informal economy and cross-border trade in particular, so as to unravel the ways in which women's work affects their physical and mental health. It is only through this that policies could be put in place to address the health-related challenges of women in the informal economy.

2. Studies on Accessibility of Health Care Services

A study by Navaneetham and Dharmalingam (2000) on "the patterns and determinants of maternal health care use across different social setting in south India: in the states of Andhra Pradesh, Karnataka and Tamilnadu." focused on most recent births to ever married women that took place during the four years prior to the date of the survey. They have used logistic regression models to estimate the effect of covariates on the utilization of maternal health services viz., antenatal care, and tetanus toxic vaccine, place of delivery and assistance during delivery. The study indicates that determinants of maternal health care services are not same across states and for different maternal health care indicators. Although illiterate women were less likely to use maternal health care services; there was no difference among the educated. The level of utilization of maternal health care services was found to be highest in Tamil Nadu, followed by Andhra Pradesh and Karnataka. Part of the interstate differences in utilization is likely to be due to differences in availability and accessibility among the three south Indian states. It is argued that the differential in

access to health care facilities between rural-urban areas is an important factor for lower utilization of maternal health care services, particularly for institutional delivery and delivery assistance by health personnel in the rural areas of the three states. Results from this study indicate that health workers might play a pivotal role in providing antenatal care in the rural areas.

Daniel Buor (2004) examined “the utilization of health services by women in the rural and urban areas in Ghana.” The study reveals the key factors that impact significantly on the Utilisation of health services by women in the Ahafo-Ano South district are, distance, income and family size (number of children) while for Kumasi metropolis they are education, distance and marital status. It is clear that distance is a common problem facing women in both rural and urban areas in Ghana in the Utilisation of health services, marital status and number of children have emerged as contrasting factors influencing Utilisation of health services. Recommendations to improve Utilisation include the location of maternal and child health services within easy reach in the rural areas, intensification of family planning education in the rural areas, the empowerment of women through access to formal education and vocational training for income generation activities and the full implementation of the National Health Insurance Scheme (NHIS). A model of Utilization of health services by women in the rural and urban areas has emerged.

A study by Dayoung Song et al. (2004) examined the mental health service use among publicly insured white and African-American pregnant and postpartum women who live in a metropolitan area. The study examined the extent to which ethnicity, physical health problems, and behavioral health risk factors are associated with the probability of service use during the prenatal- postpartum period. It also analyzes the patterns of service utilization for those women who used mental health services. Medicaid claims and eligibility data, County Reporting System claims and admissions data, and Pennsylvania State Vital Birth Records were integrated using a unique algorithm. Logistic regression was employed to estimate the probability of mental health service use among 3,841 low-income women residing in Philadelphia who were continuously enrolled in Medicaid for 9 months preceding delivery and 6 months

postpartum. Analyses were also conducted on the intensity and location of service use, as well as psychiatric diagnosis, during pregnancy and the postpartum period. About 10% of the women used mental health services during the study period. Women were more likely to use services if they were Caucasian, had a number of chronic diseases, had a number of pregnancy complications, and smoked. Among users, the same proportion (ca. 6%) used services during pregnancy and postpartum, with the average number of outpatient visits slightly higher during pregnancy than during the postpartum period. Most outpatient services (86%) were delivered in the specialty sector. Most women who used mental health services (84%) were diagnosed with minor psychiatric disorders including minor depression and anxiety disorders. Women who used services during the postpartum only were more likely to be diagnosed with major depression, whereas women who used services throughout the perinatal period were more likely to be diagnosed with severe mental disorders. Health providers can use information generated in this study to identify women who are likely to have a need for mental health services.

3. Other Related Studies

Gangrade and Gathia (1983) attempted to study the women and children in unorganised sector. They aim at examining what is work and what is unorganised? Why are certain workers excluded in the census measurement and certain others not. What is the employment structure in this sector? What kind of projects and programmes will help working women in informal sector to move towards a self reliant spirit and increase their confidence? How are working women in the informal sector to be formulated? They classify the working women into three categories on socio-economic basis-(1) Agricultural worker and those engaged in traditional menial services. This group is the largest and very poor. Their counterparts in urban areas are construction labour, migrant workers, domestic servants and self employed women in the informal sector. (2) The second category mostly comprises of women who work in offices or are professionals. They can be called blue-collar women workers. (3) The third group includes those women who are better educated and enjoy economic security but they are small in number. Women from this category work for improving their living standard and for self actualisation. The author concluded that women in the informal sector face many problems- low wages, long hours of work,

insecurity regarding job and sexual harassment etc. but most of these women work for economic reasons. In some cases women take up jobs to support the family income. In few cases, jobs are taken up for leading a life of independence of self actualisation or of escaping boredom. Some unmarried women have to take up jobs to help save money for their dowry.

Manohar (1983) discussed the exploitation of women in unorganised sector with reference to male dominance. He stated that women were dependent and subservient, which forced them to live under miserable social and economic conditions. Poverty and other economic difficulties forced them to take up menial jobs where education is not essential e.g. maximum women workers were employed in bidi industry, cotton textiles, domestic servants and weaving etc.

Banerjee (1991) attempted to analyse the impact of new export oriented industries on women workers in India. She had covered main industries viz. leather, garment, silk spinning etc. The focus was on the relationship between technologies, market conditions and service conditions of women workers. The conclusions drawn are that these women did unskilled works, worked for long erratic hours and under miserable working conditions and terms of work.

Sultania (1994) conducted a study at micro-level in the major parts of Jaipur city on the women workers engaged as contract labourers. The main analyses were based on the causes of inequality of women as contract labourers and its impact. The characteristics, profile and recruitment were also dealt with. The women workers in the unorganised sector generally experience sexual and socio-economic exploitation. They are illiterate, earning fewer wages, experience male dominance, work for 10-12hours daily, have no medical or leave facilities and so are under pitiable state of affairs.

Gabriel Dietrich (1995) is of the view that insecurity and lack of safety are the hallmark of the employment of women in the informal sector. Majority of the women workers are classified as marginal workers because of the irregular nature of their employment. Since they are marginal workers, they are devoid of several social security

benefits such as maternity benefits, pension etc. Work security is nil as even work records are mostly non-existing.

Chandola (1995) studied the nature of garment manufacturing units and women workers in unorganised segment of these units situated in Lucknow, Kanpur, Varanasi and Delhi. The emphasis was that the industry practised wage exploitations, the production process was fragmented and decentralised. The decentralisation of unorganised sector was done with a view to have cheap labour and escape government regulations. The women worked as piece rate workers; there was easy entry into the labour market which forces them to seek employment as unorganized labour leading to exploitation.

Deshpande, Sudha (1996) conducted a study by pointing out that the country points to the awful conditions of women workers in the informal sector. Ignorance, traditional bound attitudes, illiteracy, lack of skills, seasonal nature of employment, heavy physical work of different types, long hours of work with limited payment, sex discrimination in wage structures, lack of guarantee of minimum wages/ comprehensive legislation/ minimum facilities; migration and disintegration of families, bondage and alienation etc are some characteristics of employment of women in this sector. But these unattractive sectors still involve many women because they search these jobs for their livelihood.

Informalisation of labor force in South Asian countries seem to be increasing- Jeemol Unni (2001). The study identified two broad components of the informal economy -non-wage employment and wage employment - and they show an increasing participation of women. Though low quality of employment thus obtained are disturbing, the chances are that the informal employment is what that helps many households reduce the intensity of poverty. Declining opportunities for formal sector work has contributed to increasing number of women seeking informal sector work.

Unni and Rani (2002) studied people's social security concerns at the household level. It was reported that nearly half the workers felt that the nature of their work had an adverse effect on their health. While this finding may be based on the perceptions of the individual workers, their poor working environment and low income status, along with a

high proportion of chronic addiction and illness, leads to insecurity among the households working in the informal sector. The vulnerability of the poor informal workers increases when they have to pay fully on their own for their medical care with no subsidy or support. The study found that about 79 percent of the workers paid for the entire cost of medical care without any support. The precarious existence of these workers is quite evident. The workers not only suffered a loss of income due to sickness or ill health but also had to bear the entire cost burden of healthcare. Further, less than 5 per cent of the workers had some form of medical insurance. Even this was mainly because the sample consisted of some SEWA members, a trade union providing some medical insurance cover to its members.

Sinha (2003) is of the opinion that the chances of maternal mortality would be higher among poor women facing the additional burden of economic activity in the informal sector where the conditions of work are strenuous. Another concern of the poor informal women workers is the loss of income during the advanced period of maternity and immediately after child birth when they are not able to work for some time. Maternity and child birth also result into a lot of risks and expenses. It leads to financial crisis among the poor household due to borrowing and high interest expenditure. This would inevitably result in reduction in income of the poor household.

Significant changes in the world economy such as rapid globalization, fast paced technological progress and growing informalisation of work in a study by ILO (2003) greatly altered womens labour market status. While providing new opportunities for economic growth in global and national economies, these changes have generated major challenges - meeting the greater demand for skilled jobs, maintaining the employability of a large segment of national labour force and containing the potential instability arising from such changes.

Mehrotra (2008) analysed the conditions of work (for example, hours of work, hazardous nature of work, safety conditions and wages rates) in the prevailing labour market conditions, where there is excess supply of labour. The unorganised sector workers themselves are fragmented and almost always not organised into unions, where they suffer from access to imperfect information and are not fully aware of their limited rights. To

make it even more difficult, they are mostly illiterate or barely literate. If the pre-requisites for improving their conditions of work do not exist, he suggested that the state should focus its attention on improving the social protection for such workers, that is, social assistance and social insurance. This implies that the state should focus on doing the 'doable'.

Dhas and Helen(2008) analysed Social Security for Unorganised 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. It is argued that India had a long tradition of informal social security and social assistance system directed particularly towards the more vulnerable sections of the society but underwent steady and inevitable erosion. The social security initiatives of the Centre, State and NGO's implemented during the past indicated that the needs are much more than the supports provided and the efforts must be targeted and vast enough to cover the growing unorganised workers. It is argued that the major security needs of the unorganised workers are food security, nutritional security, health security, housing security, employment security, income security, life and accident security, and old age security. In sum, the study calls for a Comprehensive, Universal and Integrated Social Security System for the unorganised workers in India.

A Study on Job Satisfaction of Women Employees in Unorganised Sector with special reference to Tamilnadu was carried out by Vanitha (2012). Woman is an element of source of income in modern society. The civilized pattern of life system needs the support of viable economic resources and that can be brought by more than one earning in every family. In this aspect unorganized sectors give economic support to women in terms of regular employment, but at the same time the job security and working environment in unorganized sectors do not facilitate the proper job satisfaction among the employees and especially women employees who undergo for work pressure, poor work support, lack of lucrative wages, inconvenience and so on. Due to the reason the job satisfaction among women employees turned to be inconsistent. In order to understand the issues of women employees in unorganized sector, the job satisfaction among them, the reason for job satisfaction and dissatisfaction, the present study was designed and carried out. The study found that under working environment related factors, work status, income, working

conditions were identified factors leads or affect job satisfaction. Under environmental related factors, the support of government, the attitude towards job and work life balance with respect to their jobs were identified as the factors leads to job satisfaction among women employees working in unorganized sector at Tamilnadu. This is the only one way to the workers of the unorganized sector to protect their rights, life and livelihoods. With the help of the study the real problems leads to job satisfaction among women employees in unorganized sectors of Tamilnadu can be brought in to light.

CHAPTER-III

METHODOLOGY

The methodology adopted in the current study is discussed under the following heads:-

3.1 Selection of the Area

3.2 Selection of the Sample

3.3 Database of the Study

3.4 Period of Study

3.5 Techniques of Analysis

3.1 Selection of the Area

Coimbatore also known as Kovai is the second largest city in the [state](#) of [Tamil Nadu](#). It is the administrative headquarters of [Coimbatore District](#). Known as [Manchester](#) of Southern India, it is also a part of [Kongu Nadu](#) region of Tamilnadu. Situated on the banks of the [Noyyal River](#), Coimbatore is known for its textile factories, engineering firms, automobile parts manufacturers, healthcare facilities, educational institutions, pleasant weather, and hospitality and for its Kongu Tamil. Charming Coimbatore, also known as Kovai had its origins, from the Irular tribes of Kovan who settled in Kongunadu during the early times. Then this place was conquered by the Cholas and under the British reign who ruled this place and named it as Coimbatore.

Coimbatore is surrounded by the Fairy Queen; The Nilgiris (the Blue Hills) in the north, the revolutionary Western Ghats side of Kerala in the west, newly formed Tiruppur in the south and south east, and the highly agriculturally commercial turmeric Erode District in the East. This highly progressive, entrepreneurial and commercial district of Tamil Nadu lies between 10, " - 10' and 11," -30' Northern latitude and 76,"-40' and 77,"-30' Eastern longitude. The district has a geographical area of 7469 sq.kms. With the

formation of Tiruppur district in 2008, the geographical area of Coimbatore shrank to 4,849.89 sq.kms. The district is divided into three revenue divisions, nine taluks, 19 blocks and 482 revenue villages.

Located in the rain shadow region of Western Ghats, Coimbatore enjoys pleasant weather throughout the year. The rich red loam soil and red sandy soil in the district are favourable for production of cotton and a wide variety of cereals and food grains, spices, and condiments. The region has a total cultivable area of 330,584 hectares. Forest coverage spans across 158,801 hectares and is primarily suitable for timber, mango, walnut, and silk cotton. The black soil, good rains and water resources had made this place a major agricultural centre. Cotton is grown in bulk and this made Coimbatore a textile city. Today Coimbatore is the Textile Capital of south India. The other major industries are machinery, automobile spares, motors, electronics, and steel and aluminium foundries. Now there are over 5000 small, medium and large textile mills.

Coimbatore City (Kovai) is one of the top 10 fastest growing cities of India. Coimbatore district has a population of about 34.73 lakhs (Census in 2011). The decadal growth rate of population during 1981-91 was 14.65 percent and during 1991-2001, it was 18.46 percent. Nearly 40 percent of the workers are in agriculture as cultivators, and agricultural labourers, 3 percent in household industry and 56 percent come under the census category of 'other workers'. There are 1, 77,211 construction workers, 3, 97,614 agricultural workers, 70,255 workers in household industries and 13, 24,252 other workers (Census, 2001). The work participation rate is 46.62 percent. As per the estimates of Government of Tamil Nadu, the share of Coimbatore in GSDP (Gross State Domestic Product) of Tamil Nadu is estimated to be about 10 percent in 2006-07. Coimbatore District comprises major towns of Mettupalayam, Pollachi, Udumalpet, and Palladam. It is number one revenue district in the state of Tamil Nadu with revenues crossing more than Rs. 6000 Crores.

Coimbatore has been among the front runners in attracting a large amount of domestic and foreign industrial investments. The city is fast evolving into diversified activities such as engineering, textiles, power loom, hosiery, auto components, pumps, and motor sets. Rapid urbanization and improved standard of living is making the region one of

the most preferred destinations for industrialization. Coimbatore is also a commercial base for about 58,072 (as on May, 31, 2008) registered micro, small and medium enterprises. As per the Annual Employment Report of Coimbatore for 2007-08, only 3.4 percent of the population is employed in organized services. The unorganized sector plays a crucial role in absorbing the poor, and a majority of those in the unorganized sector is women.

Coimbatore district is an educational hub of Tamil Nadu, with a large base of educational institutes. In 2007-08, the literacy ratio among males and females was about 55.5 percent and 44.5 percent respectively. The district comprises of a number educational institutions including five universities, more than 1,400 primary schools, 420 middle schools and 165 higher secondary schools. Coimbatore is well connected with other cities and states through a vast road network across 322 kms of National Highways and 4,058 kms of State Highways. The three National Highways, NH-47 (Kanyakumari–Salem), NH-67 (Coimbatore– Nagappattinam), and NH-209 (Bangalore–Dindigul) pass through the city. The district has 20 railway stations with Podanur and Coimbatore North being the two prominent junctions. The rail network comprises both broad gauge and meter gauge with total route length of 211.7 kms and track length of 327.62 kms. Coimbatore also has an international airport at Peelamedu, which handles domestic and international passengers and various types of cargo. The nearest major port is located in Cochin.

The Healthcare Industry in Coimbatore has witnessed a tremendous growth in the last decade. With the increasing demand for best treatment and best facilities, the Coimbatore hospitals have established themselves. Surprisingly, Coimbatore has the sophisticated large hospitals offering the world class quality treatments equivalent to the best hospitals around the world. The number of hospitals delivering healthcare to the masses is increasing every day in the city. Coimbatore charity trusts have ensured that the district has a unique place in healthcare industry. Coimbatore is all set to emerge as one of the important hub for medical tourism. The well developed and multifaceted hospitals of Coimbatore are Kuppusamy Naidu Hospital, PSG Hospitals, the Kovai Medical Centre and Hospital (KMCH), KG Hospital, Ramakrishna Hospital, GEM Hospital and Ganga Hospital. On other hand Ayurvedic, Homeopathy Clinics, Naturopathy hospitals, Siddha

Hospitals, and Acupuncture treatments are also emerging with innovative ideas to treat the people with their ancestral knowledge.

3.2 Selection of the sample

The present study is confined to a selected group of 80 women workers from informal sector who were working in various activities such as construction workers, vendors, house maid and domestic servants from Coimbatore city. For the purpose of present study specified area was selected on the assumption that specific area based studies are expected to give more meaningful and significant information. In the view of fact general public has been considered as unit of investigation, a sample framework consisting of equal number of respondents. We collected the required information from women workers residing in Poomarket and Sivananada Colony by using simple random sampling. Data of three respondents are deleted because after cross-checking they were found irrelevant. Hence, our sample size confined to 77.

3.3 Data base of the study

Data pertaining to the study were collected by personal interview method. The interview schedule consisted of questions relating to the socio-economic profile of the women workers, living conditions, consumption expenditure pattern, accessibility of healthcare services and its utilisation, expenditure for health and opinion about the health and personal hygiene. After the pilot study the questions were modified and their interview schedule was administered. This is given in Appendix I.

3.4 Period of study

Data for the study were collected from the sample units by administering a pre-tested interview schedule during the period December 2012- January 2013.

3.5 Techniques of Analysis

Besides averages, percentages and graphs, the following techniques were applied.

3.5.1 Discriminant Analysis

Discriminant analysis involves deriving a variate. The discriminant variate is the linear combination of the two (or more) independent variables that will discriminate best between the objects (persons, firms, etc) in the groups defined a priori. Discrimination is achieved by calculating the variates weights for each independent variable to maximize the differences between the groups (i.e., the between group variance relative to the within group variance). The variate for a discriminant analysis, also known as the discriminant function, is derived from an equation much like that seen in multiple regressions. It takes the following form:

$$Z_{jk} = a + W_1X_{1k} + W_2X_{2k} + \dots + W_nX_{ik}$$

Z_{jk} = discriminant Z score of discriminant function j for object k

a = intercept

W_i = discriminant coefficient for independent variable i (i = 1,2,...n)

X_{ik} = independent variable i for object k

Discriminant analysis was used to identify the variables that distinguish the morbidity status of the respondents. The classification of the respondents was done on the basis of the usage of healthcare services. The classification of the households was done on the basis of the morbidity status. The first group consisted of those households who were having morbidity status while the second group consisted of all those who have no morbidity status. The morbidity status was hypothesized to be function of the sex of the households(S), age (A), educational status (E), marital status(MS), occupation (OCC) and monthly income (Y).

3.5.2 Garrett's Rating Scale

To find out the strength of factors ranked by the selected sample groups in relation to the opinion about the health and personal hygiene, Garrett's rating scale

technique was used. From the ranks given for each factor, percent positions were calculated by using the formula.

$$\text{Percent position} = 100 * (R - 0.5) / N$$

Where R is the rank assigned and N is the number of items ranked. The percent position was then converted into scores using Garrett's scores table (Garrett H, 2005). Garrett ranking scale technique was used in ranking the various opinions about the health and personal hygiene in their order of priority.

CHAPTER-IV

RESULTS AND DISCUSSION

The results of the study on “**Morbidity Status of Working Women in Informal Sector**” are presented and discussed in the under following heads:-

1. Socio-Economic Profile of the Respondents
2. Living Condition of the Respondents
3. Consumption Expenditure
4. Morbidity Status
5. Availability of Health Facilities
6. Health Expenditure
7. Health and Personal Hygiene

1. Socio-Economic Profile of the Respondents

Poor health status is likely to be more detrimental for labour force in general and women in particular in informal sector as they are experiencing serious problems with working conditions, quality of service provided, availability and accessibility to health care and its delivery, lack of time and income to seek better health care etc.. These will have great impact on the health conditions of women. The general notion is that the social environment is a combination of factors such as religion, caste, family structure, marital status, size of family and age, while economic environment is made up factors such as education, occupation, income and expenditure. A clear insight into the socio-economic factors is of paramount significance to establish the influence of these factors on the life and activities of the respondents. A probe into the socio-economic conditions of the sample will be of immense use for any study. The current study was done taking into amount 77 women employed in various sectors in the informal sector. Hence, to develop a proper

perspective analysis, all the components of social and economic environment must be considered. The table 4.1 depicts the socio-economic profile of the respondents.

Table - 4.1

Socio-Economic Profile of the Respondents

Characteristics		Frequency	Percentage
Religion	Hindu	31	40.3
	Muslim	28	36.4
	Christian	12	15.6
	Others	6	7.8
Caste	SC/ST	26	33.8
	MBC	22	28.6
	BC	17	22.1
	FC	12	15.6
Age	Below 30 years	27	35.1
	31-49 years	39	50.6
	Above 50 years	11	14.3
Marital Status	Married	37	48.0
	Unmarried	13	16.9
	Widow	19	24.7
	Divorced	8	10.4
Education	Illiterate	15	19.5
	Primary	29	37.7
	Secondary	19	24.7
	Higher secondary	14	18.1
Occupation	Self employed/Vendors	30	38.9
	Domestic workers	23	29.9
	Construction workers	17	22.1
	Agriculture activity	7	9.1

Monthly Income (in Rs)	Less than 5000	49	63.6
	5000-100.000	23	29.9
	Above 100.000	5	6.5
Type of Family	Nuclear Family	45	58.4
	Joint Family	32	41.6
Household Size (in numbers)	Less than 3 members	23	29.8
	3-6 members	38	49.4
	More than 6 members	16	20.8
Total		77	100.0

Source: Filed Survey, 2013

Religion and caste has a very predominant place in India a while taking any policy decision, be it at a lower or higher level. The government had embarked upon several programmes for the benefit of those belonging to the lower caste in India. Hence we also categorised women on the basis of religion. In the sample more than one third (40.3 percent) belonged to the Hindu religion and 36 percent belonged to Muslim. Only 15.6 percent were Christians. The SC/ST women were to the tune of 33.8 percent while MBC were 28.6 percent and FC was 15.6 percent. The age wise classification revealed that nearly half of the population was in the age group of 31-49 years followed by 35 percent who were less than 30 years of age. There were women (14.3 percent) working even after the age of 50 years. Though it was difficult for these groups to work thy pull all their might and strength and take up jobs for which they earn pittance. It is really pitiable to see many old women working in various fields, despite their poor health.

Table 4.1 portrays the martial status of the women. Around 37 women were married while 12 (16.9 percent) were unmarried. Nineteen of them were widow while eight were divorced. The latter group had to work to look after themselves and their children. These widows and divorced women, normally do not get any support from their kith and kin and unless they come forward to work and earn, it is difficult to pull on. Therefore these women take up diverse activities to earn their living. The relationship between education and economic status is well understood and documented in many

studies. Education enables a person to move higher and higher and reach greater heights. Realizing this, parents from the poor economic background had started sending their wards to schools and educational institutions. Further women's education is gaining momentum and gone are the days when women had to be within the four walls of the house. It was interesting to notice in the study that there were 14 women who had completed secondary education. Nearly 29 women (37 percent) had their primary education, however it was sad to notice 15 illiterate. We still have a quite a large number of people, especially women folk who are illiterate. These women are engaged in activities which does not require any reading or writing or other skills. It was observed that most of them are in the construction activity or engaged in agricultural activities. However occupation was not completely based on education. We have classified the women into four types of occupation, such as domestic servants, vendors, construction workers and house maid. The maximum women were found in the first group i.e. self employment /vendors. The women whom we surveyed were vendors of fruits, flowers, vegetables and such items. They have taken up their job because the investment to start the business is very limited. Women could start her daily business with Rs 500. She either buys a vegetables or fruit for this amount. She buys it from the whole salers and sells it in different places. Many women finish off their jobs by afternoon, so that they have a time left for taking care of their families, the rest of the day. Somehow these women do make a normal profit. Women prefer this job, compared to other work mainly because they get some time for themselves. While those in construction activity have to spend the whole day in the work spot.

It was observed that 17 women were engaged in construction activity. These women have a tough job carrying bricks, cement, sand, water and such heavy materials. This has bad impact on their health. Not only that they have to be in the sun and rain and are treated very badly by the supervisor. Since many of the women are illiterate, the supervisor or other men do cheat them by paying less. The other group is the one which does domestic work or work as house maids. Twenty three women work as house maids. They work in 3-4 houses on a day an hourly basis. In each house they spend an hour or at the maximum two. These women are comparatively better off than their counter parts as they are paid well. There was one woman who works in one house as a cook, she works

for two hours in the morning and three hours in the evening and she paid is Rs 7000/- she is also served food. There are certain selected women who have such a privilege. There were seven agricultural workers. They also like the construction workers have to be in the shine and rain and are paid poorly. They work in other peoples land and these days the daily wage of agricultural workers is Rs 150/-

The income classification of the selected sample is done as follows less than Rs 5000; Rs 5000-Rs 10000 and more than Rs 10000. It could be seen that while 49 women get a monthly income of less than Rs 10000/-. Twenty three women get an income in the range of Rs 5000-10000/-

With economic advancement one can visualize a sprawling growth of nuclear family, wiping out the system of joint family. In the study too there were 45 women from nuclear families and only 32 living in the joint family. For women who work, it is always better to be in the joint families, because when they leave for work, there will be someone to take care of their children or look after the house. With regard to the size of the family, there were 23 women who had small families while 16 had families with more than six members.

Living Conditions of the Respondents

One major indicator which tells about the health status of the women is the living condition. There are several other indicators like the food consumption, working hours, leisure time , environment in which they work, work contentment, relationship with the family members and other members in the society and quite a lot. In the study the investigator has taken few pointers like ownership of the houses, type of house, and source of drinking water, toilet facilities etc and this is explained in the Table.4.2

Table -4.2

Living Conditions of the Respondents

Particulars		Frequency	Percentage
Ownership	Own house	26	33.8

	Rented house	51	66.2
Type of House	Kachcha	20	25.9
	Semi Pucca	32	41.6
	Pucca	25	32.5
Source Of Drinking Water	Public tap	22	28.6
	Public water tank	26	33.8
	Private tap	17	22.0
	Private hand pump	12	15.6
Separate Toilet	Yes	35	45.5
	No	42	54.5
Type of Toilet	Pit	11	14.3
	Open air	3	3.9
	Private toilet	26	33.8
	Public toilet	37	48.0
Drainage Facilities	Closed Drainage	28	36.4
	Open Drainage	49	63.6
Total		77	100.0

Source: Filed Survey, 2013

It is clear from the table that more than half of the women (66 per cent) in the study are living in rented houses; and only the rest had their own house. Having an own house is a dream which cannot be realized by the ordinary common man. In the case of these poor people it remains as a dream only . Those who live in their own houses, is a parental property. Only 25 women (32 percent) live in pucca houses and 32 live in semi pucca and remaining 20 women living in kacha houses

Some of the facilities like drinking water, toilet facilities and washing area are of utmost priority for women. If these are available within our reach it is easy to

finish our chores. Among the selected women only 17 has private tap connection, 12 women had to pump water, which is a difficult task. Twenty two women had to collect water from public tap while the rest (26 percent) had to avail water from public tank. The situation of collecting water was very difficult task for the people in Tamil Nadu but now there has been some change. Government has laid done many salt water connections almost in every street, making water available to people most of the time in a day. This is a great blessing to many. Those women who had to leave for work can keep water and proceed for work.

Having separate toilets to each households to a very great extent reduce the health risks. Women face the most risk of having no toilet facilities. The women who were interviewed stated that 35 women (45 percent) had a separate toilet while a vast majority (54.5 percent) do not enjoy this benefit. So also have a separate washing area, enhance the capability of women by saving more time.

Monthly Consumption Expenditure

The consumption of a wide variety of nutritious foods is important for women's health. Adequate amounts of protein, fat, carbohydrates, vitamins, and minerals are required for a well-balanced diet. Meat, fish, eggs, and milk, as well as pulses and nuts, are rich in protein. Dark green, leafy vegetables are a rich source of iron, folic acid, vitamin C, carotene, riboflavin, and calcium. Many fruits are also good sources of vitamin C. Bananas are rich in carbohydrates. Papayas, mangoes, and other yellow fruits contain carotene, which is converted to vitamin A. Vitamin A is also present in milk and milk products, as well as egg yolk (**Gopalan et al., 1996**). These are the foods that are needed for a healthy living. But sadly this is not the case for the poor. The poor with their meager income is unable to meet both ends and hence there is no question of choosing foods. This study considered the monthly consumption expenditure on both food and non-food items. Table 4.3 shows the expenditure pattern of the selected respondents for various items.

Table-4.3

Monthly Consumption Expenditure

Particulars		Average Expenditure
Food Item	Rice and Cereals	18.27
	Pulses and Dhal	15.34
	Fuel and light	11.41
	Vegetables and fruits	5.47
	Milk	5.54
	Oil	7.67
	Non –Vegetarian	5.91
Non-Food Item	Education	2.60
	House rent	8.16
	Health	4.27
	Entertainment	3.99
	Clothing	4.72
	Alcoholic & Tobacco	6.65

Source: Filed Survey, 2013

Among the food item that are given in the above table, majority of the respondents (18 percent) spend major portion of their income on Rice and cereals, followed by Pulses and dhal (15 percent); Fuel and light (11 percent); Oil (8 percent); Non-vegetarian (6 percent); and for Vegetable and milk they spend 5 percent from their income. The law of demand which assumes the taste and preference of the individual hold good in determining the demand for a commodity. Of course income and price are the major pointers. Food intake is the major determinant of one's health. Nutrition food helps people to maintain good health and also prevent them from incidence of sickness. But it is the affordability which makes them buy the type of food. In these days of spiralling food prices it is very difficult to get the required food for a family. Many are pushed into the pockets of poverty because of poor income and high price level of food items. Similarly in

the case of non-food items major portion of the respondents spend their income mainly for the house rent (8 percent) and women workers in the informal sector use alcoholic and tobacco which is followed by clothing (5 percent) and for health they spend (4 percent). Because most of them utilize the government hospitals and NGOs for their treatment. They spend only 4 percent for education of their children most of them send their children's to government schools but still they have to spend some amount for them.

Morbidity Status

The crux of the study is to identify the incidence of common ailments, the treatments and other issues related to it. Individuals were asked if they had any sickness over the past three months. The ideas of limiting it to three months is to clearly bring out the exact kind of sickness and the medical expenses they had to face and how they were able to cope with it. If it were for a long period they may not give the correct picture. Table 4.4 depicts the morbidity status of the respondents. Morbidity refers to a diseased state, disability, or poor health due to any cause and finds out the degree as how the health condition affects the patient.

Table -4.4

Morbidity Status of the Respondents

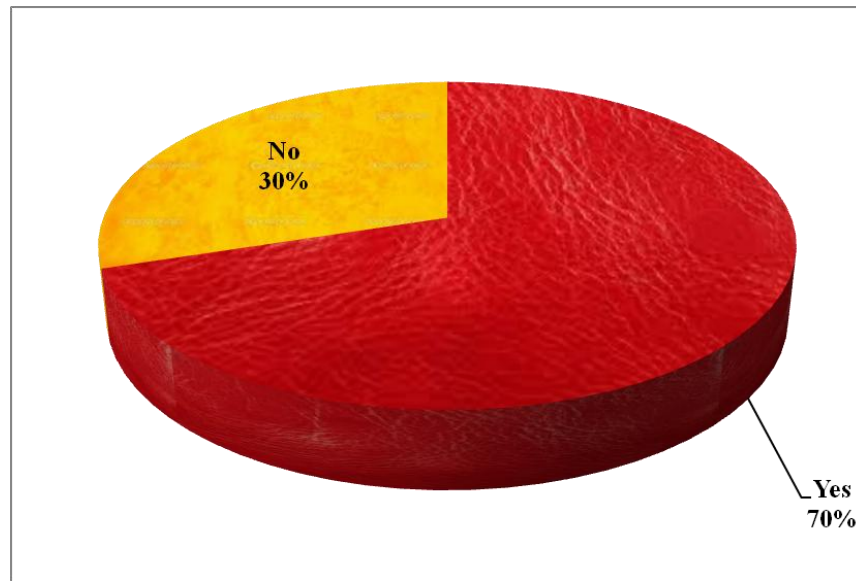
Morbidity Status	Frequency	Percentage
Yes	54	70.1
No	23	29.9
Total	77	100.0

Source: Filed Survey, 2013

Among the sample size of 77 women, 54 of them reported that they had some kind of sickness; it may be the reflection of poverty, unhealthy food and environment. Only 23 women do not have any diseases. Morbidity measures include restricted activity days due to illness, the incidence of rate of certain chronic conditions and a self assessment of health status of a patient.

Figure – 4.4

Morbidity Status of the Respondents



Discriminant Analysis

Discriminant analysis was used to identify the variables that distinguish the morbidity status of the respondents. The classification of the respondents was done on the basis of the morbidity status. The first group consisted of those respondents who were having morbidity status while the second group consisted of all those who have no morbidity status. The morbidity status was hypothesized to be function of the age (A), educational status (E), marital status(S), occupation (OCC) and monthly income (Y). Marital status was considered as dummy variables as follows:

Marital status: MS=1; if married
=0; otherwise

Table- shows the group means, Wilks' Lambda and univariate F ratio for each independent variable. The group means besides profiling the two groups, also identifies the variables with largest differences in the group means. The Wilks' Lambda and univariate ANOVA is used to identify the variables with the largest differences in the group means.

Table-4.5

Group Descriptive Statistics and Test of Equality of Group Means

Variables Groups	Age	Education	Marital Status	Occupation	Income
	Group means for the independent variables				
Yes	44.4000	3.9556	1.4000	2.5333	7.7222 E3
No	41.6562	2.4688	1.4062	1.3125	7.9062E3
All	43.2597	2.7532	1.4805	1.3636	7.7987E3
	Standard deviation for the independent variables				
Yes	11.41450	1.18620	.49543	.84208	5696.44
No	10.07587	1.10671	.79755	.47093	4524.90
All	10.89471	1.17155	.82095	.48420	5210.22
	Test for equality of the group means				
Wilks' Lambda	.984	.958	.934	.994	.992
F – ratio	1.189	3.328	2.023	1.445	0.608
Significance level	.021	.042	.279	.127	.053

Source: Field survey,2013

From the above table 4.5 it is clear that the variables namely, age, education and monthly income showed significant univariate differences between the two groups. The remaining variable monthly income is insignificant.

The group means and standard deviation, the standardized canonical discriminant function which represents a linear composite of the original data variability to within group's variability was estimated as follows:

$$Z = 0.661 \text{ Age} + 0.200 \text{ MS} + 0.751 \text{ Education} - 0.336 \text{ Occupation} + 0.357$$

Monthly Income.

$$\text{Wilk's Lambda} = 0.817^*$$

$$\text{Chi-square value} = 21.648$$

$$\text{Eigen value} = .397$$

$$\text{Canonical correlation} = .473$$

(* significant at 5 percent level)

In the above function the variables age, education and marital status had positive sign indicating that these variables had higher discriminating power between

groups. The variable sex, occupation and monthly income had a negative sign and acted as a suppressor variable. The Wilk's Lambda and Chi-Square value indicated that the function was significant at 5 percent level. The relative importance of each independent variable in discriminating between the groups was assessed in terms of their factor loadings and is shown in table 4.5.1.

Table -4.5.1
Potency Index of the Predictors

Independent variables	Factor loading	Potency Index	Rank
Age	.695	48.3025	1
Marital Status	-.058	0.3364	5
Education	.416	17.3056	2
Occupation	.297	8.8209	3
Monthly Income	.254	6.4516	4

While evaluating the variables on the basis of their factor loadings, any factor is considered to be a substantive discriminator if the factor loading is either equal to or greater than ± 0.30 . Evaluating the factor loadings on the basis of the above criterion, the variables that distinguish the morbidity status from the socio-economic variables are only by age (48 percent) which is followed by education, occupation and income.

The validity of the above discriminating function was evaluated at group centroids (group means) and the results are shown in the table 4.5.2 below.

Table -4.5.2
Classification Results

Morbidity Status	Predicted Group Membership		Total
	Yes	No	
Yes	68.9	31.1	100.0
No	34.4	65.6	100.0

The classification accuracy percentage of the discriminant function for the sample respondents was 67.5 percent. Thus the discriminant function was quite efficient in classifying respondents into groups. The first group consisted of those respondents who were having morbidity status while the second group consisted of all those who have no morbidity status.

Disease Status of the Sample Respondents

A disease status or medical problem is an abnormal condition of an organism that impairs bodily functions, associated with specific symptoms and signs. In human beings, "disease" is often used more broadly to refer to any condition that causes extreme pain, disfunction, distress, social problems, and/or death to the person afflicted, or similar problems for those in contact with the person. In this broader sense, it sometimes includes injuries, disabilities, disorders, syndromes, infections, isolated symptoms, deviant behaviors, and atypical variations of structure and function. An infection that does not produce clinically evident impairment of normal functioning is not considered a disease. Table 4.6 revealed the disease status of the sample respondents.

Table -4.6

Disease Status of the Respondents

Diseases	Frequency	Percentage
Anaemia	8	14.7
Asthma	5	9.3
Vision problems	7	12.9
Abdominal pain	3	5.6
Head ache/joint pain	6	11.1
Fever/common cold	5	9.3

High/low blood pressure	9	16.7
Diabetics	11	20.4
Total	54	100.0

Source: Filed Survey, 2013

Diabetics were the most prevalent health problem among 20 percent of the surveyed population, which is a long standing and non-communicable diseases. This was followed by high and low blood pressure (16.7 percent) and anaemia (14.7 percent). The major reason for these health problems is their working condition and environment. The problem of anaemia is a common sight among the poor. They do not consume adequate food and what they eat is not a healthy diet. Their dietary pattern is quite different. Among the women, who go for work, many skip their breakfast. Their mid-morning breakfast is a cup of tea and a snack. Afternoon they bring some rice and it is mostly devoid of vegetables. The consumption of milk and fruits are very rare. They work the whole day but do not eat adequately. This leads to anaemia and other related problems. The nature of work also makes them feel tired and is prone to back ache, joint pain, fever and cold. However 23 women did not report any kind of sickness over the past three months. These women were less than 30 years of age and they were in the prime of their life. These young women had better knowledge on nutrition and they seem to be having nutritious food.

The most affected group is the construction workers as they were exposed to heat, light, dust and cement day and night. Their working hours are much longer coupled with poor food intake and lack of rest. These women are unable to cope when there is a major deterioration in their health. These women face an inhospitable labour market environment and there is nothing that they can fall back. These women are also prone to accidents and lack of access to adequate health care and exposure top unsafe environmental conditions make their life miserable. There is need to some make improvement made in the enactment of labour laws exclusively for women construction workers, which can take care of them in case of ill health or accidents.

Availability of Health Facilities

In the present day there are lots of health care facilities available to people both in rural and urban areas, but urban areas are enrolled with facilities of all types at all times and people do make use of this tirelessly . People use government hospital (GH), private hospital depending upon their financial ability. The services at government hospitals are poor compared to private clinics, however in terms of cost GH proves to be better. Therefore the poor people avails services from GH. Apart from this there are also clinics run by NGOs , trusts and services minded people.

Table – 4.7
Availability of Health Facility

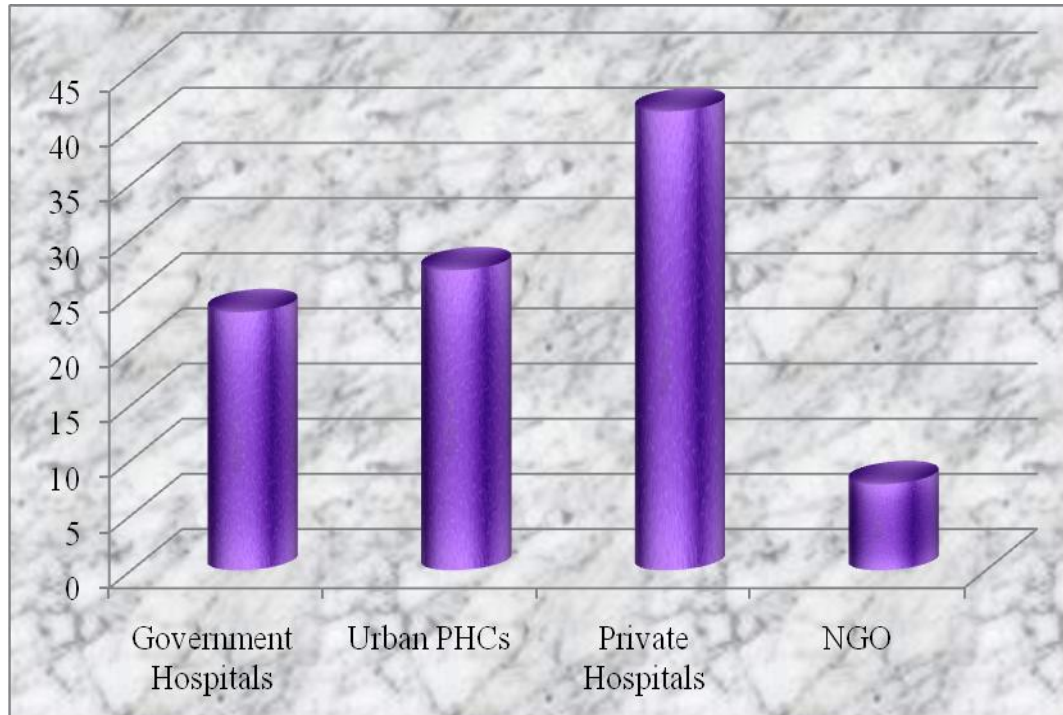
Facility	Frequency	Percentage
Government Hospitals	18	23.4
Dispensary/Urban PHCs	21	27.2
Private Clinics/Hospitals	32	41.6
NGO/Trust Hospitals	6	7.8
Total	77	100.0

Source: Filed Survey,2013

From the survey type of health facility availed by the women workers are given in table 4.9. It was observed that 32 women (41.6 percent) use private clinic or hospital for all kinds of sickness. In spite of the high cost these people prefer this due to better services, cleanliness and good infrastructure, immediate attention and better medical care throughout. This is followed by 21 women taking medical help from urban PHCs. eighteen women prefer government hospitals for medical aid and they pointed out that since it is free of cost they prefer that. Only six women seem to be availing health care services from NGO and trust run hospitals. These type of hospitals are very rare and limited in urban areas and hence the usage is also very less.

Figure– 4.7

Availability of Health Facility



In India the doctor patient ratio is very high compared to developed countries making health centre over crowded most of the time. This is due to lack of doctors and paramedical staff coupled with multiplicity of diseases. So crowding is common site in all medical and health centre. The following table 4.8 gives the scenario about the crowding in health centres in the surveyed area.

Table – 4.8

Crowd in Health Centres

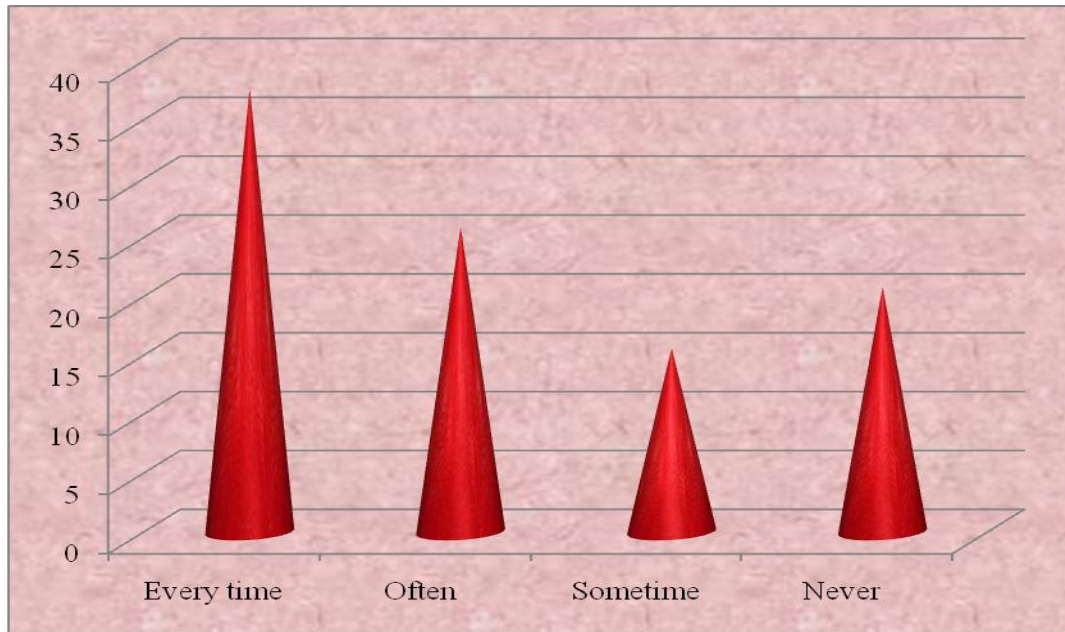
Statement	Frequency	Percentage
Every time	29	37.7
Often	20	25.9
Sometime	12	15.6
Never	16	20.8
Total	77	100.0

Source: Filed Survey,2013

Twenty nine women reported that there is crowding in health centres every time and they found it very difficult to express and talk about their diseases to the doctors comfortably. Twenty women stated that crowding is found quite often while twelve women said only sometime they found it crowded this is because these women go only to PHCs and dispensary run by trust or NGOs which were not over crowded. Same is the case with 16 women who stated that there was no crowd in the health centres.

Figure – 4.8

Crowd in Health Centres



The reasons to visit the health centres are given in table 4.9.

Table -4.9

Reasons to Visit the Health Centers

Reasons	Frequency	Percentage
When I realize I have health problems	34	44.2
When this health problem disturb my daily activities	26	33.8
Only when my health conditions get worse	17	22.0
Total	77	100.0

Source: Filed Survey,2013

Nearly half of the surveyed populations (44.2 percent) have stated that they visited the health centres when they realize that they had severe health problems. Twenty six women admitted that their daily activities were disturbed because of health problems and this made them resolve to health centres. Only 17 women sought medical help from the health centres when the health conditions got worse. This is the case with many women because they try to pull on their life with aches and sickness and continue with work as long as they can. Only in the final stage they will seek medical help, it is very dangerous for such women to prolong their regular activities. Such women need to be given proper counselling to seek medical help right from the beginning in case of any sickness.

Number of Days Away from Work

Individuals and households welfare are closely influenced by an individual's ability to work. Being able to work can be affected by the level of education one obtains, the physical or mental ability required for the job and the willingness of the employer/society to include women in the workforce. Many a time ill-health keeps women away from the forefront of employment and it has great impact on their families. When women fall sick, they try to put on a bold face and work just to earn a living and they would not take any medical help. Only when it becomes worst they approach the doctor. The number of days they abstain from work due to any kind of illness is depicted in table 4.10.

Table -4.10

Number of Days Away from Work

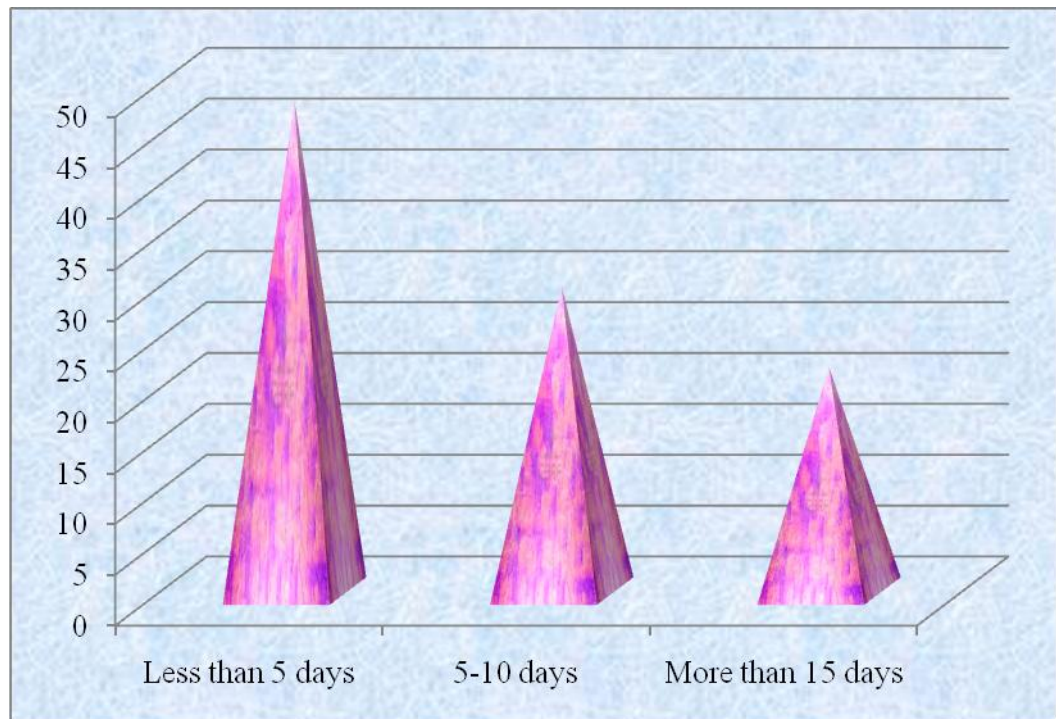
Number of Days	Frequency	Percentage
Less than 5 days	37	48.1
5-10 days	23	29.9
More than 15 days	17	22.0
Total	77	100.0

Source: Field survey, 2013

It is clear from the table 4.12 that 37 women had to abstain from work for less than five days in a month due to illness and 23 women did not go for work for 5-10 days and 17 of them could not attend work for more than 15 days. The last group was very vulnerable and were mostly affected by some sickness.

Figure -4.10

Number of Days Away from Work



Loss of Income

Ill health, thus leads to loss of earnings on account of days absent from work and this together with large expenditures, incurred on medical treatment, can lead to marginal households sliding into poverty. The loss of income of the selected samples, due to hospitalization is listed in the table below.

Table -4.11

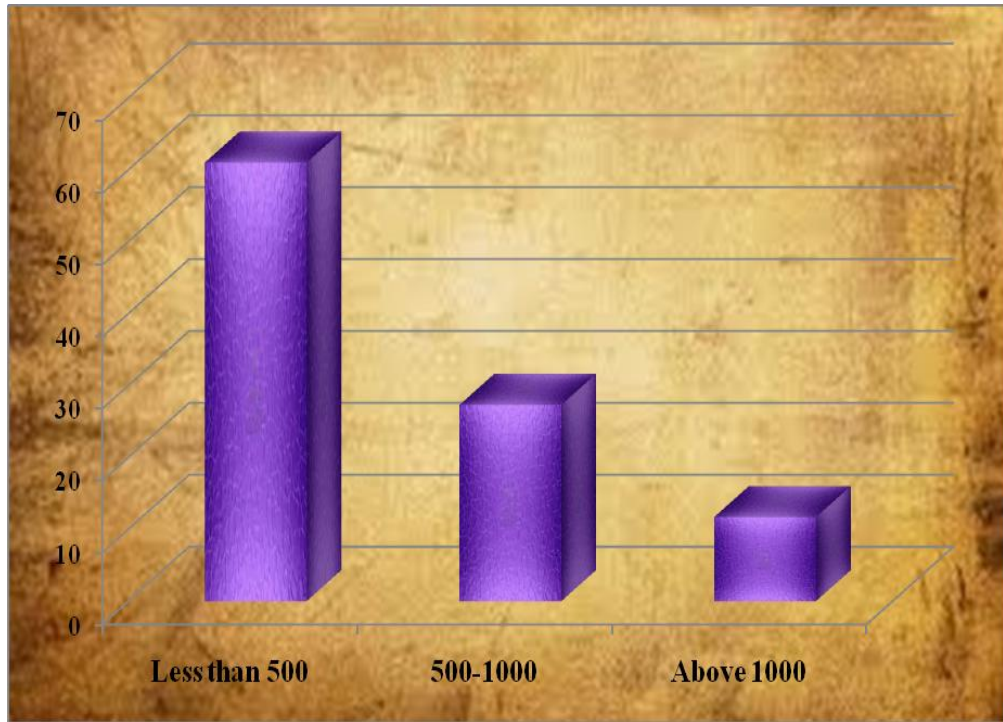
Loss of Income

Amount (in Rs)	Frequency	Percentage
Less than 500	47	61.0
500-1000	21	27.3
Above 1000	9	11.7
Total	77	100.0

Source: field survey,2013

Since the women had to be away from work due to ill health there is a loss of income which is depicted in table 4.13. It is clear from the table that 47 women had to forgo less than Rs. 500 while 21 women make a loss of Rs 500-1000 and nine women incur loss of income above 1000. If the women are good health this amount would be saved and added to the family income. It is therefore very important to keep the health of women intact to ensure regular work and also earn for the livelihood. Due to illness and hospitalization the respondents cannot go for the work regularly. This may incur loss for the working population.

Figure -4.11
Loss of Income



Average Monthly Health Expenditure

People coming from each income group may have comparable income but their sources of income and usage pattern may be quite different. Thus, the income levels of the people are influenced by the sources of income and these together will affect the utilization of health care services. There is direct relationship between higher income and demand for quality products and services and a capital intensive health care service is not an exception. The important fact is that with rising personal and household income the ability of the people to pay for quality health care services also increases considerably.

Table – 4.12

Average Monthly Health Expenditure

Items	Expenditure (in Rs)
Consultation charges	34.75
Medicine charges	17.38
Diagnostics charges	15.82
Operation charges	12.19
Food	6.12
Accommodation	5.91

Transport	7.83
Total	100.0

Source: Field survey,2013

Among the health expenditure item that are given in the above table, majority of the respondents spend their income for consultation charges (35 percent), followed by medicine charges (17 percent); diagnostic charges (16 percent); Operation charges (12 percent). These are the direct expenditure meet by the respondents in day to day life similarly there is indirect cost like food and accommodation (6 percent) and for transport (9 percent). Majority of the respondents spent a large amount for transport from their income.

Increases in expenses burden for and for informal hurts their very badly. the burden

Statement	Frequency	Percentage
Your self	41	53.2
Your spouse	27	35.1

The medical are a big everyone people in sector it budget However, of

expenditure on health care is unduly heavy on households engaged in the informal sector, indicating the potential for voluntary comprehensive health insurance schemes for such sections of the society

Table-4.13

Decisions to Seek Treatment

Your family members	9	11.7
Total	77	100.0

Source: field survey,2013

It was reported that 41 women decided to seek medical help from their own self or self medication. Twenty seven stated that their spouse made decision to seek medical help and nine women were supported by their family members in getting medical treatment.

Overall Health Status of the Respondents

Health Status refers to current state of our own health. It includes the status of wellness, fitness, and any underlying diseases or injuries or refers to the living status of the people without disease or infirmities. Health status will improve the standard of living of people or individual in society.

Table-4.14

Overall Health Status of the Respondents

Overall Health Status	Frequency	Percentage
Excellent	15	19.5
Good	18	23.4
Average	24	31.2

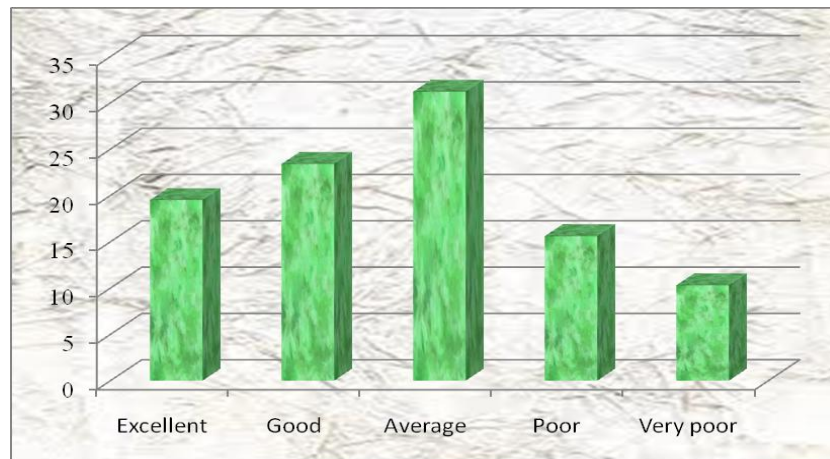
Poor	12	15.6
Very poor	8	10.3
Total	77	1000.0

Source: Filed Survey,2013

It is evident from the surveyed population; overall health status of sample women workers is grouped into five segments very poor, poor, average, good and excellent. Out of 77 sample household members overall health status of 24 women is average and for 18 women overall health status is good. After that overall health status of 15 women is excellent and for 12 women overall health status is poor.

Figure -4.14

Overall Health Status of the Respondents



The overall health status of 8 women is very poor. All this depends upon multitude of factors namely working conditions, food intake health care, and support from family in shouldering family responsibilities and the mental coverage to take up challenges.

The following table 4.15 depicts the various activities undertaken by the women during the health problems.

Table-4.15

Activities Undertaken When You Have Health Problems

Activities	Frequency	Percentage
Take rest	9	11.7
Do exercise every day	6	7.7
Take medicine and herbs	14	18.2
Consult doctor	37	48.5
Buy medicine from pharmacy	11	14.3
Total	77	100

Source: Field Survey,2013

Among the surveyed population (48.5 percent) have stated that they will consult doctor when they have any health problem which is followed by taking medicine and herbs (18 percent); Buy medicine from pharmacy (14 percent); Take rest (12 percent). Only 8 percent of the women do exercise every day. These are the activities undertaken by the women when they have some health problems.

Opinion about Health and Personal Hygiene

Health and hygiene are well correlated several studies have pointed out that a hygienic environment is always vital in providing good health. People and their living condition are determined to a great extent by the environment in which they live. When sanitation is poor and hygiene is not present, people are liable to many ills specially dysentery vomiting and diahorrea. If the women are educated to keep themselves and their household clean much of these ailments will not attack them. The opinion about health and personal hygiene by the women workers in the unorganized sector were listed and the women were asked to rank them in their order of preferences. The ranks were converted into percent position first and from the percent positions the individual scores were determined on a scale of 100 points by using Garrett's rating scale. The average scales and the ranks corresponding to each health and personal hygiene are shown in table 4.16.

Table -4.16

Opinion about Health and Personal Hygiene

Statement	Scores	Rank
Keep oneself clean and healthy	35.51	4
Bath twice a day	18.71	10
Comb hair and tied	43.82	1
Wear washed clothes	30.90	7
Preserve the vegetables and food items	20.25	8
Keep the environment clean	39.14	3
Washing face early in the morning	33.25	5
Take breakfast and dinner properly	19.46	9
Maintain good health condition	41.19	2
Intake hygienic and healthy food	32.87	6

Source: Field Survey,2013

The major health and personal hygiene followed by the women in day to day life has been ‘Comb hair and tied’ (1st rank), followed by ‘Maintain good health condition’ (2nd rank), ‘Keep the environment clean’ (3rd rank), and ‘’ (4th rank), ‘Washing face early in the morning’ (5th rank) ‘Intake hygienic and healthy food’ (6th rank), ‘Wear washed clothes’ (7th rank), ‘Preserve the vegetables and food items’ (8th rank), ‘Take breakfast and dinner properly’ (9th rank) and ‘Bath twice a day’ (10th rank), were significant personal hygiene followed by the women workers before going to take up the job.

CHAPTER-V

SUMMARY AND CONCLUSION

A Major part of the workforce in India and other developing countries work in informal sector. In view of the importance of the unorganised sector in the Indian economy, it is not only desirable but essential that the workers in this sector, whose employment is of a contractual character beset with uncertainty, should be given due protection by the state. It is, however, unfortunate that this large segment of the workforce has continued to be neglected and the vested interest groups have continued to plead that enactment of legislation and other regulatory measures of social protection will adversely affect the existing mechanism prevailing in the informal sector as any intervention is likely to lead to market imperfections creating hurdles in the smooth functioning of the market and economy. Besides, it would also necessitate huge infrastructure and institutional arrangements involving substantial finance. It needs no emphasis that the government has to play the role of a facilitator and promoter to protect the workers in the informal sector so that they not only have a sense of security but at the same time have a decent work environment enabling them to participate in the mainstream of development.

From a human poverty or capabilities perspective, it is possible to see that women are indeed poorer in most societies in many dimensions of capabilities such as education and health, but not necessarily in terms of life expectancy, although there are also societies in which women's life expectancy is shorter than men's due to maternal mortality or child mortality that may result from biases against girls' health and nutrition needs. Resource allocation within households is often biased against girls and women. In addition, it is harder for women to transform their capabilities into incomes or well being. Gender inequalities in the distribution of income, access to productive inputs such as credit, command over property or control over earned income, as well as gender biases in labor markets and social exclusion that women experience in a variety of economic and political institutions form the basis for the greater vulnerability of women to chronic poverty. Although it is often stated that labor is the poor most abundant asset, women are relatively time poor and much of their work is socially unrecognized since it is unpaid. Furthermore, when women are in paid work, the return to their labor is lower than the return to men's

labor. Thus, women on average work more, but have less command over income as well as assets. Nor do they always have control or command over their own labor. This population is growing up by two to three times faster than the overall urban population. The adverse effects of ill health are greater for labourers engaged in the unorganised sector due to their poor living conditions. Their income depends exclusively on physical/manual labour and they do not have enough savings for treatment. These households are considered high-risk for a wide range of morbidity, including various types of communicable, respiratory and other contagious diseases. Against this background a study on the “**Morbidity Status of Working Women Workers in Informal Sector**” is undertaken with the following objectives

- To study the socio-economic profile of the respondents.
- To examine the morbidity status and disease pattern of the respondents.
- To assess the availability and accessibility of health care services among the sample respondents.
- To ascertain the views of the respondent about the health and personal hygienic.

This study was carried out in two areas poomarket and sivananada colony in Coimbatore city. The womenfolk of these areas were engaged in construction work, domestic servants, vendors, Brick-klin work and also self employed women. There were 77 women workers which constituted the sample size.

Main Findings of the Study

Socio Economic Profile of the Respondents

- One third (40.3 percent) belonged to the Hindu religion and 36 percent belonged to Muslim. Only 15.6 percent were Christians.
- The SC/ST women were to the tune of 33.8 percent while MBC were 28.6 percent and FC was 15.6 percent.

- The age wise classification revealed that nearly half of the population was in the age group of 31-49 years followed by 35 percent who were less than 30 years of age.
- Around 37 women were married while 12 (16.9 percent) were unmarried. Nineteen of them were widow while eight were divorced.
- Fourteen women who had completed secondary education. Nearly 29 women (37 percent) had their primary education, however it was sad to notice 15 illiterate.
- The maximum women were found in the first group i.e. self employed/vendors. The women whom we surveyed were vendors of fruits, flowers, vegetables and such items. They have taken up their job because the investment to start the business is very limited.
- Majority of the women (49 women) get a monthly income of less than Rs 10000/-. Twenty three women get an income in the range of Rs 5000-10000/-
- There were 45 women from nuclear families and only 32 live in the joint family.
- With regard to the size of the family, there were 23 women who had small families while 16 had families with more than six members.

Living Conditions of the Respondents

- More than half of the women (66 per cent) in the study are living in rented houses; and only the rest had their own house.
- Only 25 women (32 percent) live in pucca houses and 32 live in semi pucca and remaining 20 women living in kacha houses
- Among the selected women only 17 has private tap connection, 12 women had to pump water, which is a difficult task. Twenty two women had to

collect water from public tap while the rest (26 percent) had to avail water from public tank.

- The women who were interviewed stated that 35 women (45 percent) had a separate toilet while vast majorities (54.5 percent) do not enjoy this benefit.

Monthly Consumption Expenditure

- Among the food item majority of the respondents spend major portion of their income on Rice and cereals, followed by Pulses and dhal (15 percent); Fuel and light (11 percent); Oil (8 percent); Non-vegetarian (6 percent); and for Vegetable and milk they spend 5 percent from their income.
- Similarly in the case of non-food items major portion of the respondents spend their income mainly for the house rent (8 percent) and women workers in the informal sector use alcoholic and tobacco which is followed by clothing (5 percent) and for health they spend (4 percent).

Morbidity Status

- Among the sample size of 77 women, 54 of them reported that they had some kind of sickness; it may be the reflection of poverty, unhealthy food and environment. Only 23 women do not have any diseases.
- Discriminant analysis was used to identify the variables that distinguish the morbidity status of the respondents. The classification of the respondents was done on the basis of the morbidity status. The first group consisted of those respondents who were having morbidity status while the second group consisted of all those who have no morbidity status. The variables that distinguish the morbidity status from the socio-economic variables are only by age (48 percent) which is followed by education, occupation and income. The classification accuracy percentage of the discriminant function for the sample respondents was

67.5 percent. Thus the discriminant function was quite efficient in classifying respondents into groups.

- Diabetics were the most prevalent health problem among 20 percent of the surveyed population, which is a long standing and non-communicable diseases. This was followed by high and low blood pressure (16.7 percent) and anaemia (14.7 percent).

Accessibility and Availability of Health Care Services

- Thirty two women (41.6 percent) use private clinic or hospital for all kinds of sickness followed by 21 women taking medical help from urban PHCs. eighteen women prefer government hospitals for medical aid and they pointed out that since it is free of cost they prefer that. Only six women seem to be availing health care services from NGO and trust run hospitals.
- Twenty nine women reported that there is crowding in health centres every time and they found it very difficult to express and talk about their diseases to the doctors comfortably.
- Nearly half of the surveyed populations (44.2 percent) have stated that they visited the health centres when they realize that they had severe health problems. Twenty six women admitted that their daily activities were disturbed because of health problems and this made them resolve to health centres. Only 17 women sought medical help from the health centres when the health conditions got worse.
- The 37 women had to abstain from work for less than five days in a month due to illness and 23 women did not go for work for 5-10 days and 17 of them could not attend work for more than 15 days.
- The 47 women had to forgo less than Rs. 500 while 21 women make a loss of Rs 500-1000 and nine women incur loss of income above 1000.

- It was reported that 41 women decided to seek medical help from their own self or self medication. Twenty seven stated that their spouse made decision to seek medical help and nine women were supported by their family members in getting medical treatment.
- Majority of the respondents spend their income for consultation charges (35 percent), followed by medicine charges (17 percent); diagnostic charges (16 percent); Operation charges (12 percent). These are the direct expenditure meet by the respondents in day to day life similarly there is indirect cost like food and accommodation (6 percent) and for transport (9 percent).
- Out of 77 sample household members overall health status of 24 women is average and for 18 women overall health status is good. After that overall health status of 15 women is excellent and for 12 women overall health status is poor.
- Among the surveyed population (48.5 percent) have stated that they will consult doctor when they have any health problem which is followed by taking medicine and herbs (18 percent); Buy medicine from pharmacy (14 percent); Take rest (12 percent).

Opinion about Health and Personal Hygiene

- Health and hygiene are well correlated several studies have pointed out that a hygienic environment is always vital in providing good health. People and their living condition are determined to a great extent by the environment in which they live. The major health and personal hygiene followed by the women in day to day life has been ‘Comb hair and tied’ (1st rank), followed by ‘Maintain good health condition’ (2nd rank), ‘Keep the environment clean’ (3rd rank), and ‘ ’ (4th rank), ‘Washing face early in the morning’ (5th rank) ‘

Suggestion

- The government must improve the economic and fiscal policies which will have an effect on the informal economic sector which will in turn affect the health risks of women working in this sector.
- The de-regulation of the informal sector has had a profound effect on its growth. It is important that the policy of de-regulation is accompanied by surveillance such that health risks can be detected early and its consequences minimised.
- The Government must concentrate on the issues relating to unorganized sector not merely from a welfare point of view but from the angle of regulation of employment and to guarantee a minimum earning capacity for the workers.

Conclusion

The health of Indian women is intrinsically linked as one of the indicators to their status in society. Women workers in informal sector, on account of their poor and unhygienic living and working environment breathe inordinate share of health burden. There is no exaggeration in accepting the fact that women workers in informal sector are vulnerable. The study concluded that working women is belonging to poor labour class having no access to proper nutritional food, having lack of health services, burden of children and other family issues. The real financial burden of labour households engaged in the unorganised sector for their health care is quite high. Working women may have better mental and physical health than women who are homemakers. The study suggests that many of the health problems of Indian women are related to or exacerbated by high levels of fertility. While women in formal employment often have access to health services in the workplace, those in the informal sector do not enjoy such access and special efforts should be made to address their needs. The main outcome of work related stress includes occupational health problems, absence during illness, increased medical spending. The income levels of the people are influenced by the sources of income and these together will affect the utilization of health care services.

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APPENDIX

Questionnaire to Elicit Information on the Morbidity Status of the Working Women in Informal Sector

I. General Information

1. Name of the respondent :
2. Sex: Male Female
3. Religion: Hindu Muslim Christian Others
4. Caste: SC/ST MBC BC Others
5. Type of Family: Nuclear Joint
6. Marital Status :
7. Education :
8. Occupation:
9. Household size (in numbers):
10. Monthly expenditure (in Rs):
11. Monthly Income (in Rs) :

II. Housing and Living Condition

1. Ownership of house : Own house Rented house
2. Type of house : Kachcha house Semi pucca Pucca house
3. Source of drinking water : Private tap Private hand pump
 Public tap Public hand tap Public water tank

4. Do you have separate toilet : Yes No

5. Type of toilet : Pit Open air Flush system Public toilet

6. Drainage facilities : Closed drainage Open drainage

III. Household Expenditure (in Rs)

Items	Monthly Expenditure
Food	
Rent	
Education	
Health care	
Recreation	
Transportation	
Clothes	
Pan masala/ tobacco	
Smoking	
Alcohol	

IV. Morbidity status and Health seeking behaviour

1. Do you have any health problems over the past 3 months

Yes No

2. If yes specify the diseases

Diseases	
Respiratory Tract infection	
Asthma	
Fever/ Common cold	
Throat pain	
Anaemia	
Diarrhoea	

Malnutrition	
Vision problems	
Hypertension	
Abdominal pain	
Headache	
Body ache/joint pain	
Skin diseases	
High/low blood pressure	
Malaria	

3. Type of Health facility

Type of Health facility	
Private practitioner	
Private Hospital	
Corporate Hospitals	
NGO/Trust Hospitals	
Government Hospitals	
Ayurvedic Doctor	
Government health centres	

4. Is health centres usually crowded?

Every time Often Sometime Never

5. When would you visit the health centers in case you have health symptoms?

- When I realize I have health problems
- When this health problem disturb my daily activities

- Only when my health conditions get worse

6. What did you do and how often do you do these activities when you have a health problem?

Behaviours	Every Time	Often	Sometime	Never
Take rest				
Exercise				
Take herbs				
Consult doctor				
Consult traditional healer				
Buy a drug from drug store				
Go to government health services				
Go to private/NGO health services				

IV Opinion about the Health and Personal Hygiene

Health and Personal Hygiene	Rank
Bath twice in a day	
Comb hair	
Keep oneself clean and healthy	
Wear washed clothes	
Keep the environment clean	
Washing face early in the morning	