

RESULTS AND DISCUSSION

CHAPTER – IV

RESULTS AND DISCUSSION

The results for the current study on “**Health Status of Working Women in Informal Sector**” are described under the following heads.

4.1 Socio Economic Background of the Respondents

4.2 Food Consumption Pattern of the Respondents

4.3 Health Status of the Respondents

4.4 Occupational Health Hazards of the Respondents

4.5 Chronic Ailments of the Respondents

4.6 Awareness and benefits of Health Insurance

4.1. Socio Economic Background of the Respondents

Socio economic background of the sample respondents is presented in the following section.

Age

Age is an important demographic variable which not only determines an individual’s physical and mental maturity but also depicts his/her marital and economic status, where one is economically active dependent upon others. Further it determines his/her relative attitude to the various methods of production. Other members may be reluctant to adopt new methods of production and hence, are likely to continue with the traditional mode of production. In contrast, the younger generation is likely to accept new challenges and may be more willing to try new methods of production if they are likely to yield more production. We also expect the difference in the educational attainments of the younger and older generations to affect their value orientations. The distributions of the members according to different age categories are indicated in table.

The table 4.1 clearly indicates that a majority of the sample respondents selected were in the active age group from 20-40 years (44.89 per cent). It was noticed that with regard to the elder population there were only 11.02 per cent. The distribution of the members in the

age group of 0-19 years indicates that they were only 4.72 per cent. The last group belongs to the school going children and all the women were sending their children to the school.

Table 4.1
General Background of the Respondents

(N = 127, Percent = 100)

Particulars		Number	Percent
Age	Less than 19	6	4.72
	20 – 40	57	44.89
	41 – 60	50	39.37
	More than 60	14	11.02
Community	BC	50	39.37
	SC	77	60.63
Marital Status	Married	84	66.14
	Unmarried	24	18.90
	Separate & Divorce	19	14.96
Education	Primary	44	34.65
	Secondary	42	33.07
	H.Sc	10	7.87
	Illiterate	31	24.41
Occupation	Agriculture	52	40.94
	Mill Worker	17	13.39
	Brick Work	26	20.47
	Construction	12	9.45
	SHG	20	15.75

Source: Field Survey

Community

Community is a group of interacting people living in a common location and is often referred to a group that is organized around common values and social cohesion within a shared geographical location, generally in social units larger than a household. In India, community is spilt on different group like backward, Most Backward, Forward, Scheduled Caste and Scheduled Tribe. It is a sign of social status.

The information on caste of the respondents revealed that of the 127 women selected 39.47 per cent belonged to the Backward Caste and there were 60.63 per cent who came from the Scheduled Caste. There is no discrimination of Caste while they are at work or outside. All of them co-exist in a well harmonious manner.

Marital Status

Marital status describes a person's relationship with other. Marital status of an individual relates to whether they are married, unmarried, separated and widowed. Marital status is often a question on censuses, credit card applications, and many different polls and premeditated in combination with other aspect which divulge a marriage gap. The present study examined the marital status of the respondent and this is given in the following table.

The table shows the distribution of the respondents in the selected area based on their marital status. It was revealed that majority of the women respondents were married and 18.90 per cent of them were unmarried and only few 14.96 per cent of them were separated/divorce.

Education

Education is considered as an important variable not only for widening mental horizon of the individual but also it helps a person to make use of rational and scientific approach to different problems. Education to a great of extent helps to determine the status of individuals. Apart from working to earn, and helping parents in piece-rate work, daughters of the working mothers, especially in nuclear or splintered labour families, have to spend more time in domestic work than sons, which is responsible for depriving them of schooling. It is a known fact that literacy rate in India, with the exception of Kerala, is very low, and this is

more true in rural areas. Similarly, there are marked differences in the literacy rate among the sexes.

From the above table 4.1 it is clear that 24.41 per cent were illiterate and 33.07 per cent had secondary level of education. Only 7.87 per cent sample respondents completed Higher Secondary. The data reveals that majority of them (92.13 per cent) had education which is very low and hence not qualified for further higher income jobs. The illiterate rate of 24.41 per cent in the study is in conformation with the NSS study 1999-2000, where in 75 per cent of female labour force in rural area are illiterate. Dropout due to family background was heavy and many respondents could not even complete higher secondary. Such dropouts were preferred only in unorganized, low paid wage group.

Occupation

Occupation may refer to a person's job or work in service as an employer solely for income, or professional who has a specialized knowledge. Employers are employed in organized and unorganized sector for activity occupation may be known as job, activity, profession and career of an individual. The women folk who formed the sample were involved in various activities as sho

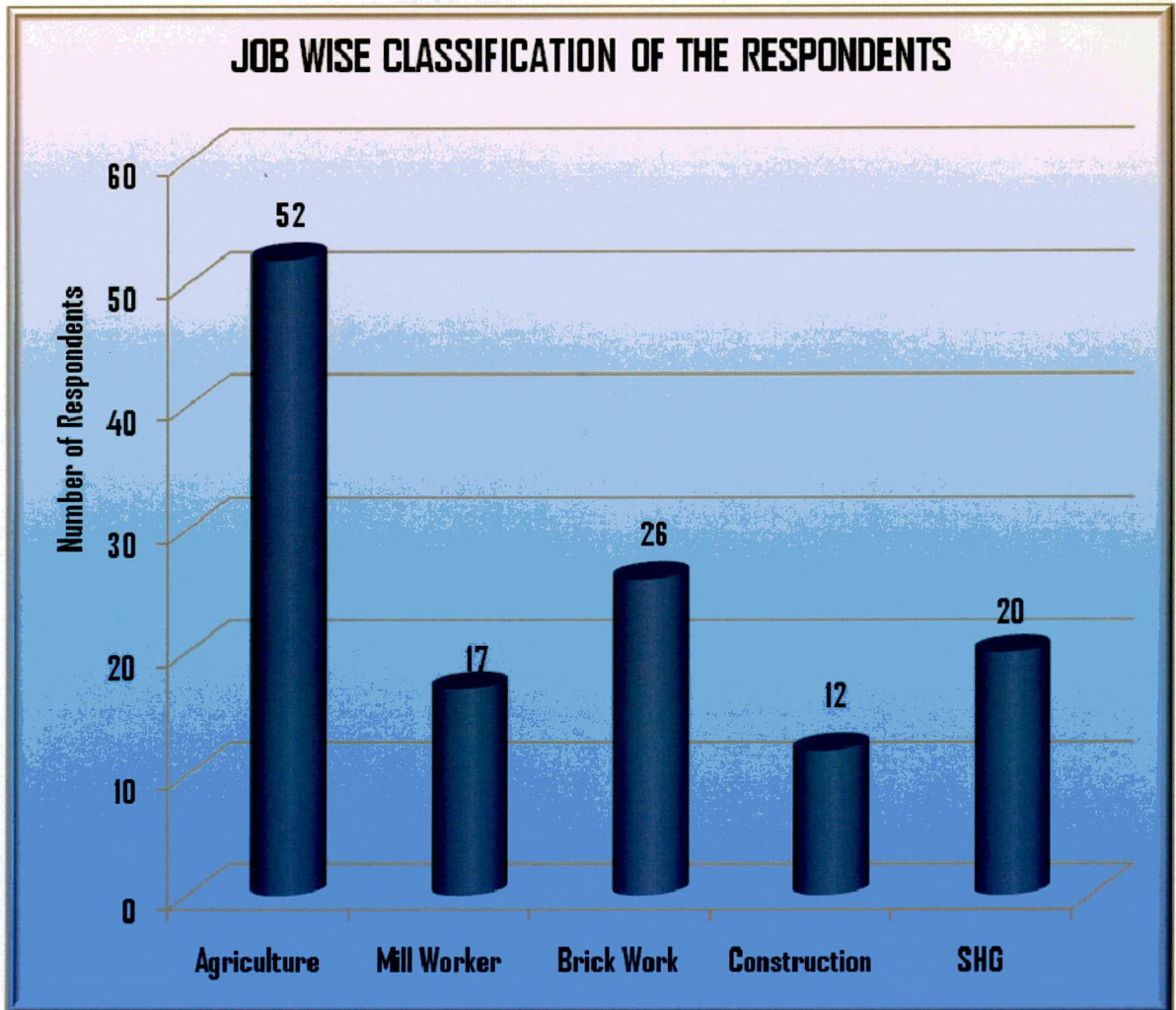
wn in table 4.1.

Majority of the Sample population were doing agricultural activity 40.94 per cent, 20.47 per cent sample respondents were involved in Brick work and next to Brick Work 15.75 per cent were engaged Self Help Group. Only 13.39 and 9.45 per cent involved in Mill Workers and Construction work. Most of them were engaged in the agricultural activities in comparison to other occupation. This is due to low level of education and mostly in rural areas women were engaged in Agricultural activities.

Monthly Income

Monthly income is the amount of money a person or an individual earns from all sources, including employment and self-employment received as wage or salary from organized (or) unorganized sector. Income decides the economic status of an individual in a family and society. Income dictates the mode of life of an individual and family and society. It helps to procure articles of life, which in turn makes one's life comfortable.

Figure 4.1



Income was divided into four groups; around 39.38 per cent got monthly salary between ₹ 3001-4000 and 27.56 per cent stated to earn an income of above ₹ 4001 and only 22.04 Per cent earned an income was between ₹ 2001-3000. An insignificant number of women respondents (11.02 per cent) got monthly wages below ₹ 2000. The persons getting monthly wages below ₹ 2000 depended upon the age and the education level of the sample respondents.

Table 4.2
Income and Saving Wise Classification

(N = 127, Percent = 100)

Particulars		Number	Percentage
Monthly Income (in ₹)	Below 2000	14	11.02
	2001-3000	28	22.04
	3001-4000	50	39.38
	Above 4001	35	27.56
Monthly Savings (in ₹)	Less than 500	22	17.32
	500 – 1000	56	44.10
	1001 – 1500	41	32.28
	More than 1500	8	6.30

Source: Field Survey

Monthly Savings

Almost all the workers spent their earnings to meet the daily needs of their family. Some revealed that the cost of living is increasing but their earnings are more or less constant and therefore their savings are negative. Whatever minimal earnings are saved, they are forced to spend on health-related matters. Based on several studies at macro and micro level, there is sufficient evidence to suggest that rural indebtedness due to expenditure on medical care is high, especially for poorer households. The increase in rural indebtedness is due to

rising costs of medical care and this is borne disproportionately by the lower socio-economic group (Baru, 2006).

Table 4.2 reveals that 22 respondents (17.32 percent) have monthly saving less than ₹ 500 per month, majority of the sample respondents (44.10 percent) maintain monthly saving of ₹ 500 – 1000 per month. Around 41 sample respondents (32.38 percent) had monthly saving of ₹ 1001 – 1500 and only 6.30 per cent saved more than ₹ 1500. Only few of them saved more than ₹ 1500, because the entire women respondent had only low income and this did not allow them to have any savings.

Income is the major factor which determines the savings of the person. To find the significant difference between income and savings the Chi-square test is used.

Table 4.3
Relationship between Income and Savings

Particulars		Savings / Month (in ₹)				Total
		Less than 500	500 - 1000	1001 - 1500	More than 1500	
Income / Month (in ₹)	1001-2000	13	1	0	0	14
	2001-3000	4	17	7	0	28
	3001-4000	2	24	23	1	50
	Above 4000	3	14	11	7	35
Total		22	56	41	8	127
Calculated χ^2 value = 81.77; Table χ^2 Value = 16.91; df = 9						

Source: Estimation Based on Field Survey

The above table reveals that the calculated χ^2 value (81.77) is greater than the table value and hence we reject the null hypothesis which states that there is no significant relationship between the income and the savings. Therefore, we accept the alternate

hypothesis stating that there is a significant relationship between the income and savings of the sample respondents.

Number of Working Hours

Women are working mostly in unorganized sector where they are invariably paid lower wages despite the hard work for long hours in addition to the usual family work such as caring for the kids and elderly persons, cooking, cleaning, washing, maintenance of kitchen gardens and poultry, grinding food grains, collecting water and firewood, etc throughout the day. Our sample respondents also did many works apart from the regular work and it took much of their time. The hours of work, done by the women is given below.

Table 4.4
Working Hours

Working Hours	Number	Percentage
4 – 5 hours	20	15.75
6 – 7 hours	64	50.40
8 – 9 hours	43	33.85
Total	127	100.00

Source: Field Survey

Nearly half of the sample size worked for 6-7 hours per day, while 33.85 per cent had to work for 8-9 hours. In fact this timing are only the specific work time which they have mentioned, but apart from this they use to do many other types of works which are not recognized or rewarded.

Family Type

Family refers to a group of people associated by a consanguinity, kinship or co-residence and to share love, care and affection with each other which shows the value of human being. The functions of the family are to produce and reproduce persons, biologically and socially. In general, family structure is divided into nuclear family and joint family. A nuclear family includes husband, wife, and children who are not of age of marriage and is

referred to as a conjugal family. A joint family includes husband, wife, children, and their parents living under a single roof and is referred to as complex family.

Table 4.5

Family Background of the Respondents

(N = 127, Percent = 100)

Particulars		Number	Percentage
Family Type	Joint Family	17	13.39
	Nuclear Family	110	86.61
Family Size	Upto 3 members	54	42.52
	4-6 members	65	51.18
	Above 7 members	8	6.30

Source: Field Survey, 2011

There were 86.61 per cent living in nuclear family and only 13.39 per cent lived in joint family. The preponderance of nuclear households does not mean that joint living has died out. Many recent studies have highlighted the facilities of living as a nuclear unit for freedom, convenience, self-esteem and lack of space. They boast the importance of nuclear families forgetting the benefits of joint families. In the current study the old traditional system of joint family system seems to be dying out and majority of the women would like to live in nuclear family.

Family Size

Household is the basic residential unit in which economic production, consumption; inheritance, child rearing, and shelter are organized and carried out. Household size refers to all individuals or group of peoples who live in the same dwelling or roof.

In case of composition of family, most of the respondents had 4 – 6 members in the family and the rest of the respondents were from the small and large families, which had less than 3 members and above 7 members. There were 42.52 per cent in the former group and 6.30 per cent in the latter groups.

Housing

A house is a building or structure that has the ability to be occupied for habitation by humans or other creatures. The term house includes many kinds of dwellings ranging from rudimentary huts of nomadic tribes to complex structures composed of many systems. Houses can be built in a large variety of configurations. A basic division is between free-standing or detached dwellings and various types of attached or multi-user dwellings. Both sorts may vary greatly in scale and amount of accommodation provided. Houses made from mud, thatch, or other low-quality materials are called kachha houses, houses that use partly low-quality and partly high-quality materials are called semi-pucca houses, and houses made with high quality materials throughout, including the floor, roof, and exterior walls, are called pucca houses. In the selected area too, there were all types of houses as is depicted in the table below.

The table clearly indicates that the majority (70.06 per cent) of the respondents were living in Semipacca houses whereas 18.90 per cent respondents lived in Katcha house and only few 11.04 per cent respondents lived in Pacca house. The Pacca house type is very low in number due to their low level of income.

Table 4.6

Housing Details of the Respondents

(N = 127, Percent = 100)

Particulars		Number	Percentage
Type of House	Pacca	14	11.04
	Semipacca	89	70.06
	Katcha	24	18.90
Type of Flooring	Mud	24	18.90
	Cement	94	74.02
	Tile	9	7.08

Source: Field Survey

Type of flooring

Type of flooring in respondent's houses is be broadly classified into three main categories such as Mud, Cement and Tile. This again is based on the income level. Now a day almost everyone has cement flooring and very few has other type of flooring.

The above table 4.6 shows that the majority of the respondents i.e. 74.02 per cent were having cement flooring, followed by 18.90 per cent with mud flooring and only few i.e. 7.08 per cent having tile flooring. The samples with cement flooring were quite high in sample houses because majority of the sample respondents live in semipacca house. Further five households had five rooms and nearly 80 per cent had only houses with two rooms. Only 62.20 per cent of the respondents had separate kitchen. Only 87 per cent of the households had electricity connection while the rest of them had no electricity connection. We have progressed in several sphere, there are still areas which are not connected by electricity. These people make use of kerosene lamps or candle during night. It is very difficult for children to study in the evening and also for women to carry on their activities. It is paucity of funds making them still to be in darkness.

Source of Drinking Water

About 101 billion people lack access to an improved drinking water supply globally and many more drink contaminated water. Lack of safe water perpetuates a cycle whereby poor pollutions become further disadvantaged, and poverty becomes entrenched. Globally, about 4 billion cases of diarrhea occur and about 1.8 million people die per year; the vast majority being children under 5 years of age, of which 88 per cent is attributable to unsafe water. WHO estimates that 94 per cent of diarrhea cases are preventable through interventions by the increased the availability of clean water, sanitation and hygiene. Progress towards these interventions is indicated by the proportion of households reporting the use of improved water supplies, such as piped household connections or protected wells stated by (Mithra, 2010).

Most households in India have access to an improved source of drinking water, with access in urban areas being higher than in rural areas (95 percent and 85 percent, respectively). An improved source of drinking water includes, in addition to water piped into the dwelling, yard or plot, water available from a public tap or standpipe, a tube well or

borehole, a protected dug well, a protected spring, and rainwater. The most common improved source of drinking water for urban dwellers is piped water and most people in rural areas obtain their drinking water from a tube well or borehole; however, one in eight rural households gets their drinking water from unprotected wells or springs.

With regard to the availability of drinking water, the study found out that 70.07 per cent of households had piped water in the living area. On the other hand, only 9.46 per cent of households had access to ground water. Out of 127 sample respondents 89 have drinking water from a tube well or bore well (20.47 per cent).

Table 4.7
Drinking Water Facility in Houses

(N = 127, Percent = 100)

Particulars		Number	Percentage
Source of Drinking Water	Piped Water	89	70.07
	Ground Water	12	9.46
	Well	26	20.47
Purifying Method	Strain by Cloth	19	14.96
	Water Filter	14	11.02
	Boiling	5	3.95
	Nothing	89	70.07

Source: Field Survey

Treatment of Water

A study on Ecology of drinking water, point out that contamination of drinking water is a major health hazard, as sixty per cent of diseases are water-borne in a country like India. Lack of awareness, about water quality parameters, purification methods, health impacts and measures to overcome, is a hurdle in achieving safe water practices. **(Ravichandran et.al, 2002)**. The data collected on water treatment pointed out that majority of households (70.07

percent) do not treat drinking water. Straining water through a cloth (14.96 percent) and water filter (11.02 percent) are the most commonly used methods. Only few of respondents (3.95 percent) used boiling method to treat drinking water. In India 88 per cent of the population of the country have access to an improved water source, 53 per cent lives in households with water on the premises, and 67 per cent do not treat their drinking water to improve its portability (NFHS, 2006).

Toilet Facility

The proportion of households without any toilet facility is much greater in rural areas (74 percent) than in urban areas (17 percent). Overall, 29 percent of households have toilet facilities that are improved and not shared with any other household. Improved toilet facilities include toilet facilities with a flush or a pour flush that is connected to a sewer system, septic tank or pit latrine, a ventilated improved pit (VIP) latrine, a biogas latrine, a pit latrine with slab, and a twin pit, composting toilet. If a household has any of these types of toilet facilities but shares them with other households, the household is considered not to have an improved toilet facility (NFHS, 2006).

Table 4.8

Toilet and Waste Disposal Facility in Houses

(N = 127, Percent = 100)

Particulars		Number	Percentage
Separate Toilet Facility	Yes	52	40.85
	No	75	59.15
Waste Disposal	On Road	46	36.22
	Backside of the house	49	38.58
	Corporation collects	32	25.20

Source: Field Survey

The above table gives the distribution of households based on latrine facilities. A majority of households (59.15 per cent) do not have latrine facility in their houses and only

40.85 per cent have latrine facility that are improved and not shared with any other households.

Waste Disposal Facility in House

The collection of disposal waste is not made regularly. Some dispose their refuse indiscriminately, some in open space, some through burning which causes air pollution, some are roadsides and drainages which hampers the free flow of run-off and constitutes comfortable breeding grounds for flies, mosquitoes and other health infected animals that could contribute to the spreading of diseases (**Mahananda, et al, 2012**).

In our study the facility of waste disposal is broadly classified in three such as in throwing on the road, backside of the house and collection by cooperation. From the study it was observed that 38.58 per cent and 36.22 per cent sample respondents dispose their waste items at the backside of the house and in the road. Only 25.20 per cent households have awareness of disposing waste in dustbins kept by corporation.

Discriminant Analysis

Discriminant analysis was used to identify the variables that distinguish the ownership of houses of the households. The classification of the households was done on the basis of the ownership of houses. The first group consisted of those households who were having own houses while the second group consisted of all those who have rented houses. To find out whether two groups can be discriminated and if so, the contribution of the selected factors which discriminate the two groups. The factors included are separate kitchen, flooring in houses, electricity supply, source of drinking water, treatment of water, separate toilet and waste disposal.

The mean of Separate kitchen, Flooring in houses, Source of drinking water, treatment of water, and Waste disposal are higher for group I compared with group II. The standard deviation of Separate kitchen, Flooring in houses, Source of drinking water, treatment of water, and Waste disposal are high for group I compared with group II.

Table – 4.9**Group Statistics of Mean and Standard Deviation**

Variables	Group I		Group II	
	Mean	Standard Deviation	Mean	Standard Deviation
Separate kitchen	1.40	0.495	1.36	0.484
Flooring	1.96	0.638	1.83	0.377
Electricity supply	1.08	0.274	1.16	0.365
Source of drinking water	1.78	0.864	1.32	0.733
Purifying drinking water	4.04	1.470	3.96	1.681
Separate toilet	1.26	0.443	1.81	0.399
Waste disposal	1.90	0.789	1.88	0.778

Source: Estimation Based on Field Survey

Univariate analysis was applied to test the null hypothesis that the means of the each variable in the selected two groups are not significantly different. The calculated wilk,s lambda (u-statistics) is given in table 4.10. wilk,s lambda is the ratio of within the group sum of squares to the total value is equal to one, it means that the means of the variables for the two groups are same. If the value of wilk’s lambda is 0, it indicates that the means of two groups completely varies and that the total variability between the two groups is attributable to the differences between the means of the two groups.

It can be seen from the table – 4.10 that wilk’s lambda is one in the variable ‘waste disposal’. For the other variables, it is less than one. Hence, the means of the variables viz., separate kitchen, Flooring in houses, Electricity supply, Source of drinking water, treatment of water and Separate toilet are found to be significantly different in the two groups.

Table – 4.10
Wilks' Lambda

Variables	Wilks' Lambda	Significant
Separate kitchen	0.999	0.683
Flooring	0.984	0.155
Electricity supply	0.988	0.211
Source of drinking water	0.925	0.002
Purifying drinking water	0.999	0.787
Separate toilet	0.707	0.000
Waste disposal	1.000	0.906

Source: Estimation Based on Field Survey

The estimated discriminant function of own house with the chosen variables and the constant is given below.

$$Z_1 = -43.12 + 6.16X_1 + 13.79X_2 + 11.98X_3 + 4.89X_4 + 2.48X_5 + 8.89X_6 + 3.34X_7$$

The estimated discriminant function of rented house with the chosen variables and the constant is given below.

$$Z_2 = -45.41 + 5.90X_1 + 13.63X_2 + 11.91X_3 + 4.24X_4 + 2.37X_5 + 11.98X_6 + 3.22X_7$$

The discriminant function shows how the two groups are distinguishable from each other in terms of the selected variables. The first group is found to be significantly different from second group in terms of separate kitchen, flooring in house, electricity supply, and source of drinking water, treatment of water, separate toilet and waste disposal.

4.2. Food Consumption Pattern of the Respondents

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.

There are substantial differences in the food consumption patterns of the households. Women with no education have poorer and less varied diets than those with an education, and their diet is particularly deficient in the consumption of fruits. So expenses for fruits is less than any other products. As expected, poverty has a strong negative effect on the consumption of nutritious types of food. Women in households with low standard of living are less likely than others to eat each type of food listed, and their diet is particularly deficient in fruits and milk and milk products. Food intake is the major determinant of ones 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 spiraling of 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. The investigators probed into the monthly consumption expenditure of the selected households and this is presented in the table 4.11.

Table – 4.11 indicates the percentage of households who consumed different food items during the one year period preceding the survey and the average value or expenditure incurred on the food items per household. It is to be noted that the value of food items consumed out of farm/household production, the price of PDS supply and the price of items purchased from market are as reported by the households and not adjusted for any standard. Accordingly, the value/expenditure on rice consumed per household during the one month period before the survey is ₹ 567 on an average.

Table 4.11**Monthly Consumption Expenditure on Food Items (in ₹)**

Products	Monthly Expenses of the Respondent (Average Value in ₹)
Cereals & cereal substitutes	192
Pulses & their products	165
Rice	567
Milk & milk products	156
Edible oil	197
Egg, fish & meat	313
Vegetables	396
Fruits	86
Sugar, salt and spices	108
Beverages, refreshments & processed food	200

Source: Field Survey

Apart from the staple food items, on average the households have reportedly spent per month about ₹ 192 each on cereal and cereal substitute and ₹ 165 on pulses/pulse products. On an average the households spent ₹ 156 towards the consumption of milk and milk products, ₹ 396 for vegetables and ₹ 86 for fruits. For sugar, salt and spices on an average the households spent ₹ 108 and around ₹ 197 edible oil/vanaspati, ₹ 200 each on beverages related items, refreshment and processed food and the average value/expenditure on egg, fish and meat ₹ 313.

Eating Habit of the Respondents

The study collected information on women's consumption of various food items, including meat, chicken or fish. The information can be used to estimate the proportion of population who are vegetarians or non-vegetarians. From the survey it was clear that a majority (91.34 per cent) are non-vegetarian and only 8.66 per cent of women are vegetarian. The habitual consumption of non-vegetarian food is presented in the table below. Though the prices of these items are quite high, compared to vegetables, people still consume this.

Table 4.12

Habitual Consumption of Non-Vegetarian Food

Consumption Level	Number	Percentage
Weekly once	15	12.93
Monthly twice	39	33.63
Monthly once	51	43.96
Rarely	11	9.48
Total	116	100.00

Source: Field Survey

From the above table it is clear 43.96 per cent were consuming non-vegetarian food monthly once and 33.63 per cent were consuming twice a month. But weekly once and rarely consumption is low in number. Only 12.93 per cent and 9.48 per cent were consuming non-vegetarian food weekly once and rarely, respectively. Taste and preference is a major determinant of demand theory. It may be that which makes these women also consume non-vegetarian regularly inspite of the high price.

Eating outside has become the order of the day. When people go out, even for a small purchase, they do eat outside. When we asked the women, the reason for this most of them said, it is very convenient and after a heavy load of work, coming back in the evening and again cooking for the night for the entire family is very difficult. So they eat out and many a time gets a packet for the people at home. This helps them to get a leisure time or for many it is the time they put their house in order, or keep something ready for the next day. The number of times the respondents had food outside is reported in the following section.

Table 4.13
Eating Outside

Number	Number	Percentage
Weekly once	8	6.30
Monthly twice	15	11.81
Monthly once	92	72.44
Rarely	12	9.45
Total	127	100.00

Source: Field Survey

Ninety two of the respondents (72.44 percent) reported that monthly once they had outside food, 15 women (11.81 percent) reported that monthly twice they had outside food and 12 women (9.45 percent) reported to have outside food rarely. While having food outside 42.52 per cent had idly and dosai followed by 32.28 per cent eating porata and 25.20 per cent had different types of food available at the time of eating according to their preference.

Habit of Eating Raw Vegetables

Vegetable are a great source of vigor and energy. It contains vitamins, minerals, protein and other related nutrients. Vegetables should definitely form a major portion in our daily diet. A vegetable when cooked loses much of its nutrient contents. So dietician insist to eat raw vegetables. We do normally take cucumber, onion, tomato, carrot, etc. regularly. But other vegetables like cabbage, capsicum, beetroot, radish, garlic, etc. also can be taken. This knowledge of eating raw vegetables has not percolated to the rural set up. So to find out if these sample women are in the habit of eating raw vegetables the investigator made an attempt and the responses are presented in the following table.

Table 4.14
Eating Raw Vegetables

Raw Vegetables Eating Habit	Number	Percentage
Weekly once	8	6.30
Monthly twice	19	14.96
Monthly once	42	33.07
Rarely	58	45.67
Total	127	100.00

Source: Field Survey, 2011

From the above table it is clear that nearly half of the populations are not in the habit of eating raw vegetables regularly. They consume it rarely. However 14.96 per cent of the women take it twice a month and 33.07 per cent is reported to be having it once a month. It is therefore of utmost importance to educate the women folk to include this item on a regular basis.

Usage of Salt

Iodine is an important micronutrient. A lack of iodine in the diet can lead to Iodine Deficiency Disorders (IDD), which can cause miscarriages, stillbirths, brain disorders, and retarded psychomotor development, speech and hearing impairments, and depleted levels of energy in children. Iodine deficiency is the single most important and preventable cause of mental retardation worldwide. It has been estimated that 200 million people in India are exposed to the risk of iodine deficiency and more than 71 million suffer from goiter and other iodine deficiency disorders (MOHFW, 2005). Iodine deficiency can be avoided by using salt that has been fortified with iodine. In 1983-84, the Government of India adopted a policy to achieve universal iodization of edible salt by 1992. All states and union territories were advised to issue notifications banning the sale of edible salt that is not iodized. The ban on non-iodized salt was lifted in September, 2000, but it was reimposed in November, 2005.

However, the reimposed ban did not take effect until May, 2006. With regard to the wade of salt respondents revealed different types of salt used by them as is shown them in table 4.15.

Table 4.15

Salt used by the Respondents

Types	No .of. Respondents	Percentage
Powder	6	4.72
Crystal	44	34.65
Both Powder & Crystal	77	60.63
Total	127	100.00

Source: Field Survey

The table reveals the type of salt used for cooking. Most of the respondents 60.63 per cent used both crystal and powder salt for cooking, 34.65 per cent used only crystal salt and 4.72 per cent used only powder salt for cooking. In powdered salt presence of iodine is high. Households in the higher wealth quintile use adequately iodized salt, compared with households in the lower wealth quintile. Knowledge with regard to powder salt is less and women need to be oriented towards the usage of powder.

Fuel used for Cooking by the Respondents

Smoke from solid cooking fuels is a serious health hazard. Solid cooking fuels include coal/lignite, charcoal, wood, straw, shrubs, grass, agricultural crop waste and dung cakes. To study the potential for exposure to cooking smoke from solid fuels, the study collected information on the type of fuel used for cooking.

Table 4.16

Fuel used for Cooking

Fuel	No .of. Respondents	Percentage
Wood	15	11.81
LPG	27	21.26
Wood and Kerosene	38	29.92
Kerosene and LPG	47	37.01
Total	127	100.00

Source: Field Survey

From the data collected it was clear that 11.81 per cent respondents used wood for cooking. Twenty seven women (21.26 percent) were using only LPG for cooking and 29.92 per cent were using wood and kerosene. Kerosene and LPG both are used by only 37.01 per cent. From this it is clear that many of them started using modern method as it was easy and convenient. It also saved lot of time.

4.3 Health Status of the Respondents

Health is the basic factor that affects the physical and mental efficiency of human beings and acts as a reinforcing force for life. Every woman is a working woman in India. Whether she works at home or outside, the mental and physical health hazards are innumerable and varied. This is because women in the developing countries spend most of their time in survival tasks. Maintain households and generating income is essential to keep the family and the economy alive. Women's health is basic to women's advancement in all fields of endeavours and as mother's health is the bulwark of her family, it is the foundation of community and social progress.

Height

The height of an individual is principally a measure of skeletal body tissue, pelvis, spin and skull. The height of the sample respondents was measured in cm (cent meter). Out of 127 samples 43.31 per cent had a height ranging between "146-155" cm. Next to that, for

29.92 per cent height ranged between “156-165” cm. Only few women 18.11 per cent had their height below 145 cm and 8.66 per cent showed their height as above 165 cm.

Table 4.17

Height, Weight and BMI of the Respondents

(N = 127, Percent = 100)

Particulars		Number	Percentage
Height (in cm)	Less than 135	4	3.15
	136-145	19	14.96
	146-155	55	43.31
	156-165	38	29.92
	More than 165	11	8.66
Weight (in kg)	Less than 30	5	3.94
	31-40	29	22.83
	41-50	57	44.88
	51-60	25	19.69
	More than 60	11	8.66
BMI	Below 18.5 (Underweight)	47	37.00
	18.5-24.9 (Normal)	67	52.76
	Above 25 (Overweight)	13	10.24

Source: Field Survey

Weight

Body weight is the sum of bone, muscle, organs, body fluids and adipose tissue. Some or all these components are a reflection of growth, reproduction status, variation in exercise level and the effect of ageing. Out of total sample 3.94 per cent women were below

30 kg, 29 women (22.83 percent) had weight between 31-40 kg. Nearly 44.88 per cent had weight between 41-50 kg. Twenty five women (19.69 percent) had weight between 51-60 kg. Only few 8.66 per cent women had weight more than 60 kg. It proved that only few of the working women are in good health.

BMI

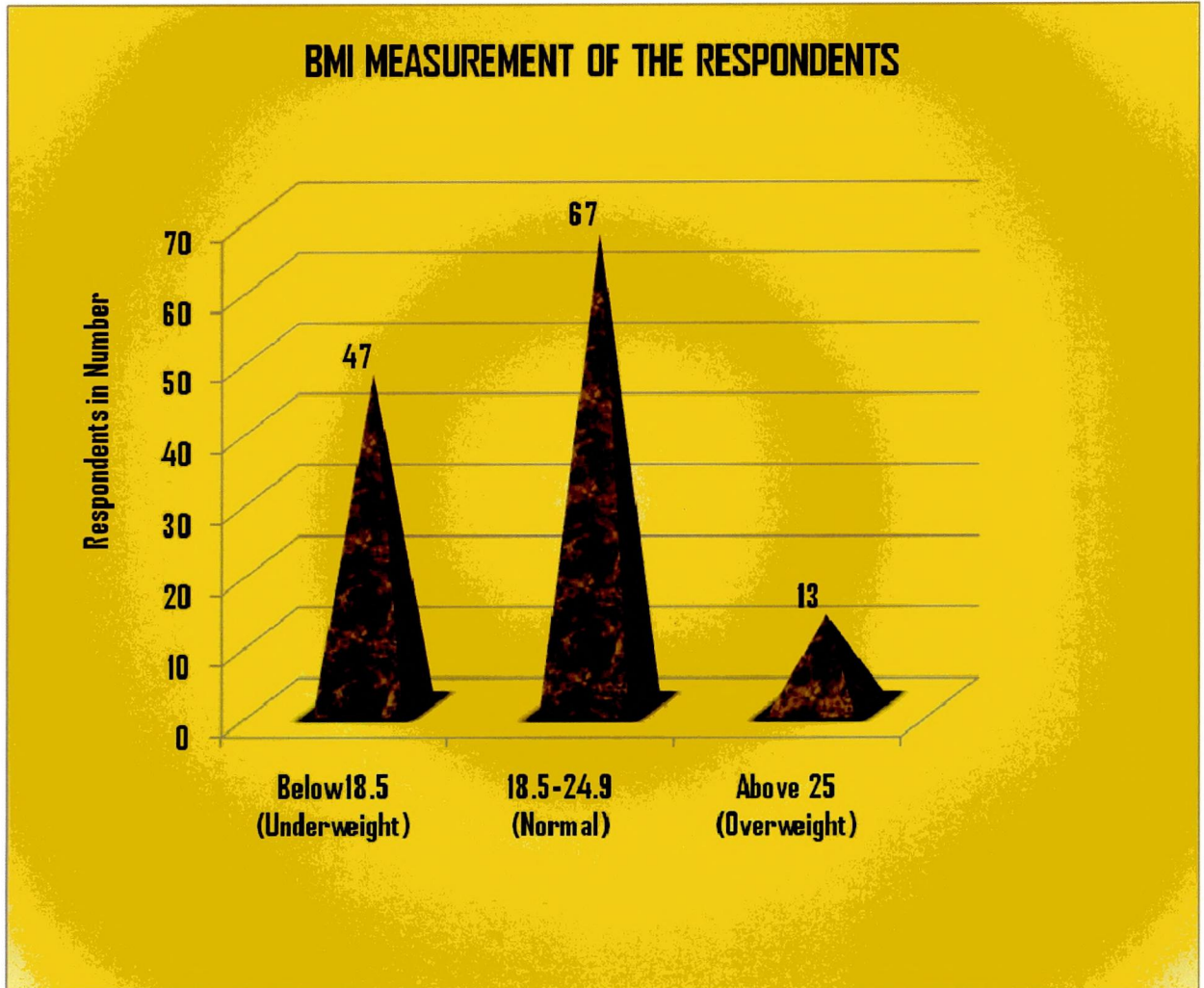
The indicator used to access the nutritional status of women is Body Mass Index (BMI). BMI is an effective and widely used indicator of nutritional status. The height and weight measurements in the study are used to calculate the BMI. The BMI is defined as weight in kilograms divided by height in meters squared.

$$\text{BMI} = (\text{kg}/\text{m}^2)$$

A BMI below 18.5 indicates chronic energy deficiency or undernutrition. A Person with a BMI below 18.5 is considered to be too thin for their height. A person with a BMI of 25 or higher is considered to be overweight or obese. A normal weight for height is indicated by a BMI of 18.5-24.9.

The above table clearly explains the BMI level of the women sample respondents. Around 37 per cent of the respondents were below 18.5 which are considered as underweight and half of the respondents (52.76 per cent) are between “18.5-24.9” which is normal. About 10.24 per cent of the respondents above 25 which indicate that they are overweight. The people who were below 18.5 BMI indicate that they are not having proper dietary food. When women are underweighted they are prone to all kinds of sickness. Long hours of hazardous jobs coupled with poor intake of food and lack of rest makes them vulnerable and liable to any kind of diseases. Women should eat nutritious food. but in India, women are the last and least to eat in the family. Most of the time they don't get adequate food. This is more so in the case of poor families. Hence women in the unorganized sector have poor health.

Figure 4.2



Relationship between BMI and Weight

Weight is the major factor which determines the BMI of the person. To find the significant difference between BMI and Weight the Chi-square test is used.

Table 4.18

Relationship between BMI and Weight

Particulars		Weight (in Kg)					Total
		Less than 30	31-40	41-50	51-60	More than 60	
BMI	Less than 18.4	5	23	15	1	0	44
	18.5 - 24.9	0	6	42	13	0	61
	More than 25	0	0	0	11	11	22
Total		5	29	57	25	11	127
Calculated χ^2 value =124.12; Table χ^2 Value = 15.50; df = 8							

Source: Estimation Based on Field Survey

The above table reveals that the calculated χ^2 value (124.12) is greater than the table value and hence we reject the null hypothesis which states that there is no significant relationship between the BMI and the Weight of the respondents. Therefore, we accept the alternate hypothesis stating that there is a significant relationship between the BMI and Weight of the sample respondents.

Relationship between BMI and Height

Height is the major factor which determines the BMI of the person. To find the significant difference between BMI and Height the Chi-square test is used.

Table 4.19

Relationship between BMI and Height

Particulars		Height (in cm)					Total
		Less than 135	136-145	146-155	156-165	More than 165	
BMI	Less than 18.4	0	11	14	13	6	44
	18.5 - 24.9	4	7	29	17	4	61
	More than 25	0	1	12	8	1	22
Total		4	19	55	38	11	127
Calculated χ^2 value =14.01; Table χ^2 Value =15.50; df = 8							

Source: Estimation Based on Field Survey

The above table reveals that the calculated χ^2 value (14.01) is greater than the table value and hence we reject the null hypothesis which states that there is no significant relationship between the BMI and the Height of the respondents. Therefore, we accept the alternate hypothesis stating that there is a significant relationship between the BMI and Height of the sample respondents.

General Appearance

To analyze the health status a general observation was done, in terms of their physical appearances such as good and moderate. Out of 127 samples, 21.26 per cent had good appearance and the remaining 78.74 per cent were only in moderate condition.

Eye Sight

Eye sight of the sample was studied making two classifications as clear and dull. Out of total 127 sample respondents 81.10 per cent had clear eye sight and the remaining rest of 18.90 per cent had dull eye sight.

Table 4.20**Health Indicators of the Respondents****(N = 127, Percent = 100)**

Particulars		Number	Percentage
General Appurtenance	Good	27	21.26
	Moderate	100	78.74
Eye Sight	Clear	103	81.10
	Dull	24	18.90
Hair Type	Rough	32	25.20
	Tangle	76	59.84
	Normal	19	14.96
Skin Type	Rough	44	34.65
	Wrinkle	61	48.03
	Smooth	22	17.32
Hygiene	Good	16	12.60
	Moderate	86	67.72
	Poor	25	19.68
Angular Stomatitus	Prevalent	23	18.11
	Non Prevalent	104	81.89

Source: Field Survey

Hair

With regard to hair we considered three types of hair such as rough hair, tangled hair and normal hair to study the neatness and health condition of women respondents. Nearly 25.20 per cent had rough hair, 59.84 per cent had tangle hair and the remaining 14.96 per

cent had normal hair. Majority of them are had either no time or lacked interest to keep themselves clean and tidy.

Skin Type

The types of skin of the women also indicate their health condition. Among the respondents 34.65 per cent had rough skin, a maximum of 48.03 per cent had wrinkle skin and 17.32 per cent had smooth skin.

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. These are real diseases which takes away the lives of many. And it is children who are scum bed to such ailment. If the women are educated to keep themselves and their household clean much of these ailments will not attack them.

The present study explored the neatness of the house and the environment and it revealed that a whopping proportion 68 per cent had only moderate level of cleanliness. Around 20 per cent had very poor environment and only 13 per cent showed a betterment in this regard.

Angular Stomatitus

Angular Stomatitus is one indication of poor health. When there is lack of vitamin B in the human body there is every likelihood that the person would be affected by Angular Stomatitus. To overcome this one should consume lot of green leafy vegetables especially greens and fruits. This awareness need to be created among the women and the investigator did impart such information during the study period, because nearly 23 of the women had this problem. Out of total sample, 81.89 per cent women had Angular Stomatitus and 18.11 per cent women tried to protect themselves from this.

Common Aliments

Some of the ailments that affect the individuals like fever, cold, back pain, leg & hand pain, head ache and stomach problem are common to all. There is every likelihood that these

tend to be more or the incidence of such sickness will be greater for the poor, weak and over worked people. When people work hard they need to eat good nutritious food. But hard work, devoid of nutritious food will definitely lead them to malnourished state and in course of time the human capability to do the normal work gets reduced. The common ailments that befall on the respondents is disclosed in table.

Table 4.21

Common Ailments

Common Ailments	Number	Percentage
Fever	47	11.38
Cold	53	12.83
Back pain	78	18.89
Leg & Hand pain	96	23.24
Head ache	104	25.18
Stomach problem	35	8.47

Source: Field Survey

From the study it was revealed that 25.18 per cent use to get head ache frequently and 23.24 per cent suffer from leg and hand pain. Forty seven women (11.38 percent) and 12.83 per cent were affected by fever and cold once in a month. Seventy eight women (18.89 percent) suffer from back pain due to long hours of working. Thirty five women (8.47 percent) suffered from stomach problem at the time of menstrual cycle.

4.4 Occupational Health Hazards of the Respondents

Generally the health conditions of women workers in India are dismal. Due to unfavorable working conditions and workplace environment they suffer from various illnesses. The National Commission (1988) on self-employed women and the women in the informal sector had stated that in order to understand the occupational aspects of health, it is necessary to have a detailed examination of women's work and its effects in terms of physical and mental health. It is necessary to analyze them in terms of physical stresses, the

postural positions and their effects and occupation related health problems (**Ranjwan and Zend, 2007**).

Anticipate Sickness Due to Work

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. Therefore a nation ought to give adequate attention to the health care of its people. While at the time of work many of the women suffer from health problems and their health reduces the income level and creates vicious circle of the women workers. The major objective of the current study was to examine the health status of women workers. In this regards the study estimated the relationship between work and health.

The response of the women under study revealed that 67.72 per cent realized occupational wise health hazards and 32.28 per cent did not face any occupational health hazards. Occupational health hazards depend upon the type of work, age and place of work.

Type of Health Problem in Work Place

An attempt has been made to find the most important health problem in work place. Most of the common health problems in their work place are categorized such as Injuries and Dills, Back Pain, Weakness, hypertension, Headache, Leg and hand Pain and Eye problem. These are cited in the following table 4.22.

Among the total sample, most of them experienced the job hazards. Only 1.04 per cent felt the hypertension. According to occupation of women in the study region 26.39 per cent suffered from leg and hand pain and next to that 25.35 per cent suffered from back pain. Nearly 20.49 per cent had head ache and most of the women suffered from weakness because they were not taking proper diet.

Table 4.22

Health Problem in Work Place

Health Problems	Number	Percentage
Injuries and Dills	22	7.64
Back Pain	73	25.35
Weakness	41	14.24
Hypertension	3	1.04
Headache	59	20.49
Leg and hand Pain	76	26.39
Eye problem	14	4.85

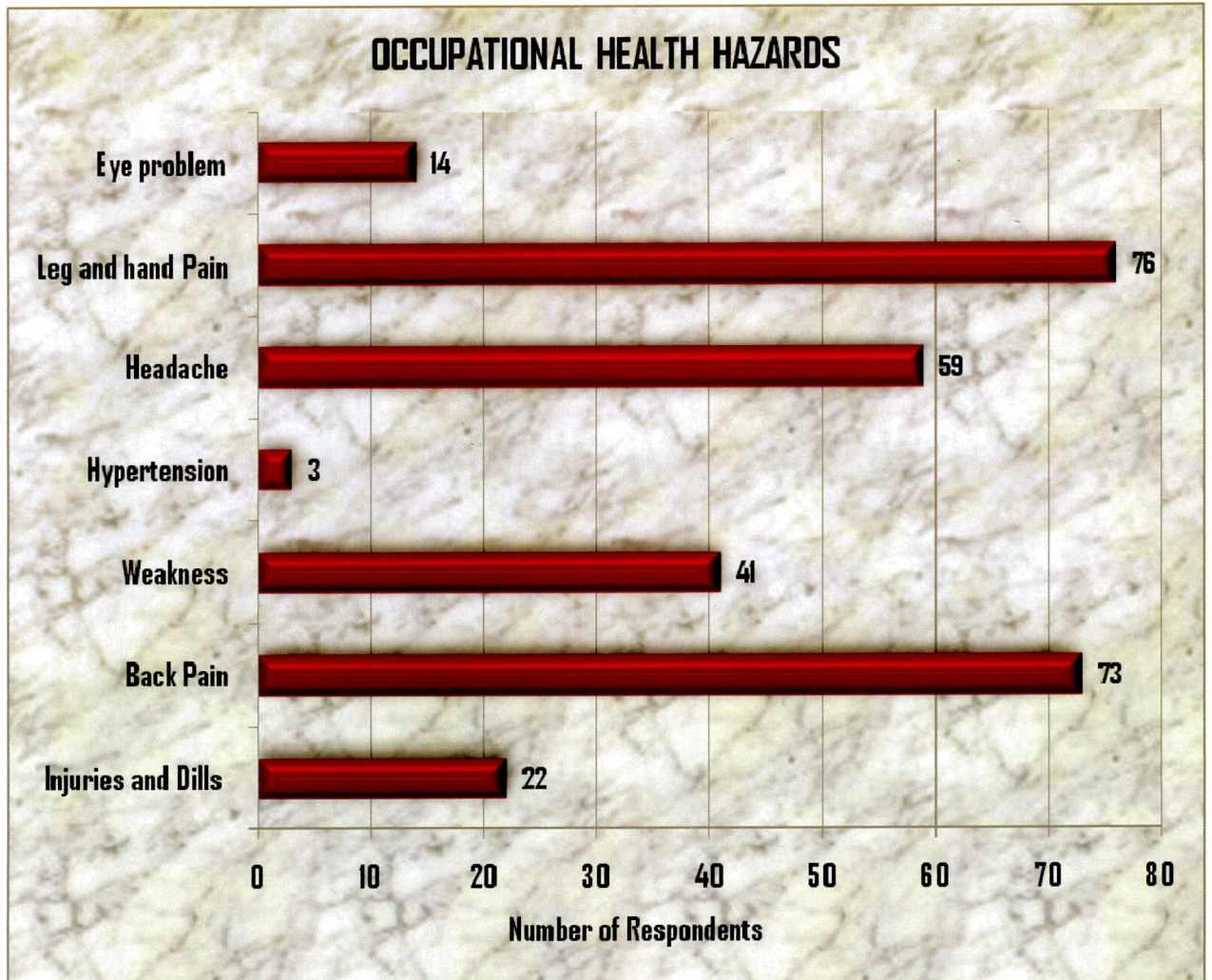
Source: Field Survey

Most of the women in construction work and mill work, faced lot of mishap like injuries and dills. Only few 7.64 per cent suffered from injuries and dills and 4.85 per cent working in brick-klin work faced eye problem due to lot of heat while at the time of work.

4.5 Chronic Ailments of the Respondents

A chronic illness isn't the name of just one illness. It's a word used to describe a group of health conditions that last a long time. In fact, the root word of chronic is "chromos", which refers to time. But chronic illnesses can be tendency to get them on to their children before they are born through genes. If a person has a chronic illness, he needs to take care of his condition for months or years. Because there are so many chronic illnesses, it is difficult to say exactly what to expect. Although chronic illness are managed in different ways, all of them have one requirement in common: a doctor, frequent doctor visit and doing tests to help guide treatment are often part of what it takes to manage a chronic illness, chronic diseases, mainly cardiovascular disease, cancer, chronic respiratory diseases and diabetes were estimated to cause more than 60 per cent (35 million) of all death. In 2005; more than 80 per cent of these death occurred in low-income countries and middle income countries (WHO, 2005).

Figure 4.3



Chronic Illness of the Women Workers

In medicine, a chronic disease is a disease that is long-lasting or recurrent. The term chronic describes the course of the disease, or its rate of onset and development. A chronic course is distinguished from a recurrent course, recurrent diseases replace repeatedly, with periods of remission in between. As an adjective, chronic can refer to a persistent and lasting medical condition. The study found that almost half of the sample size had some kind of chronic illness, as is given in the table 4.23.

Table 4.23

Chronic Illness

Illness	Number	Percentage
Disorder of Joints and bones	32	46.37
Heart Diseases	4	5.80
Diabetes	16	23.19
Bronchial Asthma	14	20.29
Cancer	3	4.35
Total	69	100.00

Source: Field Survey

The table indicates the chronic illness of the sample respondents. It is clear that 46.37 per cent had suffered from disorder of joints and bones next to that 23.19 per cent had suffered from Diabetes. Both the diseases mainly occur because they are not taking proper food. Fourteen women (20.29 percent) had suffered from Bronchial Asthma. Heart Diseases and Cancer were found among a handful of respondents.

Primary Healthcare Center (PHC) near Residence

Any disease has to be treated. There are various centers where people can go for treatment. Since health is a merit good, there are both public and private centers which cater to the needs of the people. While the private centers are known for the better services it is unaffordable for the poor and down trodden. So this group approaches government hospitals.

In this study area it was found that most of the women go to PHC for taking any medical help. Primary Health Care is essential health care; based on practical, scientifically sound, and socially acceptable method and technology; universally accessible to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination (WHO & UNICEF, 1978).

From the survey it was revealed 47.24 per cent women had to travel 2.5 Km and for 28.35 per cent women it was 2.6 Km to 4.0 Km distance from home. Only few of women i.e. 24.41 per cent have to go more than 4.0 Km from their residence.

Hospitalized during last one year

An assessment of hospitalization (admissions and total nights hospitalized) for a nationally representative sample workers during their last year of life in order to identify indicators associated with increased risk of using hospital services were normally taken in any health study. Determination of indicators associated with higher levels of hospitalization in the last year of life should lead to a greater understanding of the characteristics of individuals likely to have relatively higher expenditures when they are in their last year of life. This understanding, in turn, may contribute to the development of policies to ensure appropriate care and efficient use of health care resources.

For most of the chronic illness the person had to visit the hospital once in a month, sometimes there is a chance for hospitalization. Out of 127 sample respondents 69 women suffered from chronic illness out of which 19 women (27.54 per cent) were hospitalized during last one year.

Number of Days Hospitalized

Hospitalization and number of hospitalized depend upon the illness and the doctor consultant. In our study the number of days the respondents were hospitalized are classified into three categories, such as less than 5 days, 6 – 10 days and more than 10 days in a month.

Table 4.24
Number of Days Hospitalized

No. of. Days Hospitalized	Number	Percentage
Less than 5 days	14	73.68
6 – 10 days	3	15.79
More than 10 days	2	10.53
Total	19	100.00

Source: Field Survey

It is significant to note that maximum of 73.68 per cent were hospitalized less than 5 days, 15.79 per cent were hospitalized six to ten days. Only two women (10.53 per cent) were hospitalized more than ten days. This means these women cannot go for work on these days and also few days before and after hospitalization.

Loss of Income Due to Sickness

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. In the case of death of working members, the household suffers a permanent loss of income. Such a loss is likely to be greater (as a proportion of income) for people engaged in daily labour as they do not enjoy any form of sick leave or other compensatory allowance. It is also likely to be greater for households unable to count on support from extended family members. The loss of income of the selected samples, due to hospitalization is listed in the table below.

Due to illness and hospitalization the respondents cannot go for the work regularly. This may incur loss for the working population. Maximum of 81.16 per cent lost up to ₹ 1000 and 11.59 per cent lost ₹ 1001 to 3000, all due to sickness.

Table 4.25**Loss Due to Sickness**

Income Loss (in ₹)	Number	Percentage
Less than 1000	56	81.16
1001-3000	8	11.59
3001-5000	2	2.90
5001-7000	1	1.45
More than 7000	2	2.90
Total	69	100.00

Source: Field Survey

There were two who met a loss of ₹ 3001 – 5000, only 1.45 per cent women lost ₹ 5001 – 7000 and 2.90 per cent who were hospitalized during last one year, had to face a loss of ₹ 7000.

Total Expenditure

A country like India whose people experience adverse health problems in addition to high levels of illiteracy and poverty needs to have consistent and much pronged strategy and plans to ensure and to implement a satisfactory health care system in most countries. India and Tamil Nadu is no exception to this. The WHO has pronounced that the equitable policies and political will are the two important factors for achieving success in improving the health of a nation's population (Nayar, 2000). The table below 4.26 explains the total health care expenditure of the sample respondents.

The empirical finding reveals that approximately 75.36 per cent spend money ₹ 1000 at the time of hospitalization and 15.94 per cent incurred an expense between ₹ 1001 to 2000. Only 1.45 per cent had medical expenses above ₹ 2001.

Table 4.26

Total Expenditure for a Year

Total Expenditure (in ₹)/year	Number	Percentage
Less than 1000	52	75.36
1001-2000	11	15.94
2001-3000	1	1.45
More than 3000	5	7.25
Total	69	100.00

Source: Field Survey

Increases in medical expenses is a big burden for everyone and for people in informal sector it hurts their budget very badly. It is have we recommended some insurance to be catered to this section of population.

Source of Treatment

The delivery of modern healthcare depends on groups of trained professionals and paraprofessionals coming together as interdisciplinary teams. This includes professionals in medicine, nursing, dentistry and allied health, plus many others such as public health practitioners, community health workers and assistive personnel, who systematically provide personal and population based preventive, curative and rehabilitative care services. While the definitions of the various types of healthcare vary depending on the different cultural, political, organizational and disciplinary perspectives, there appears to be some consensus that primary care constitutes the first element of a continuing health care process, that may also include the provision of secondary and tertiary levels of care. As far as the treatment for the sample are concerned they resorted to different sources as is indicated in table 4.27.

Figure 4.4

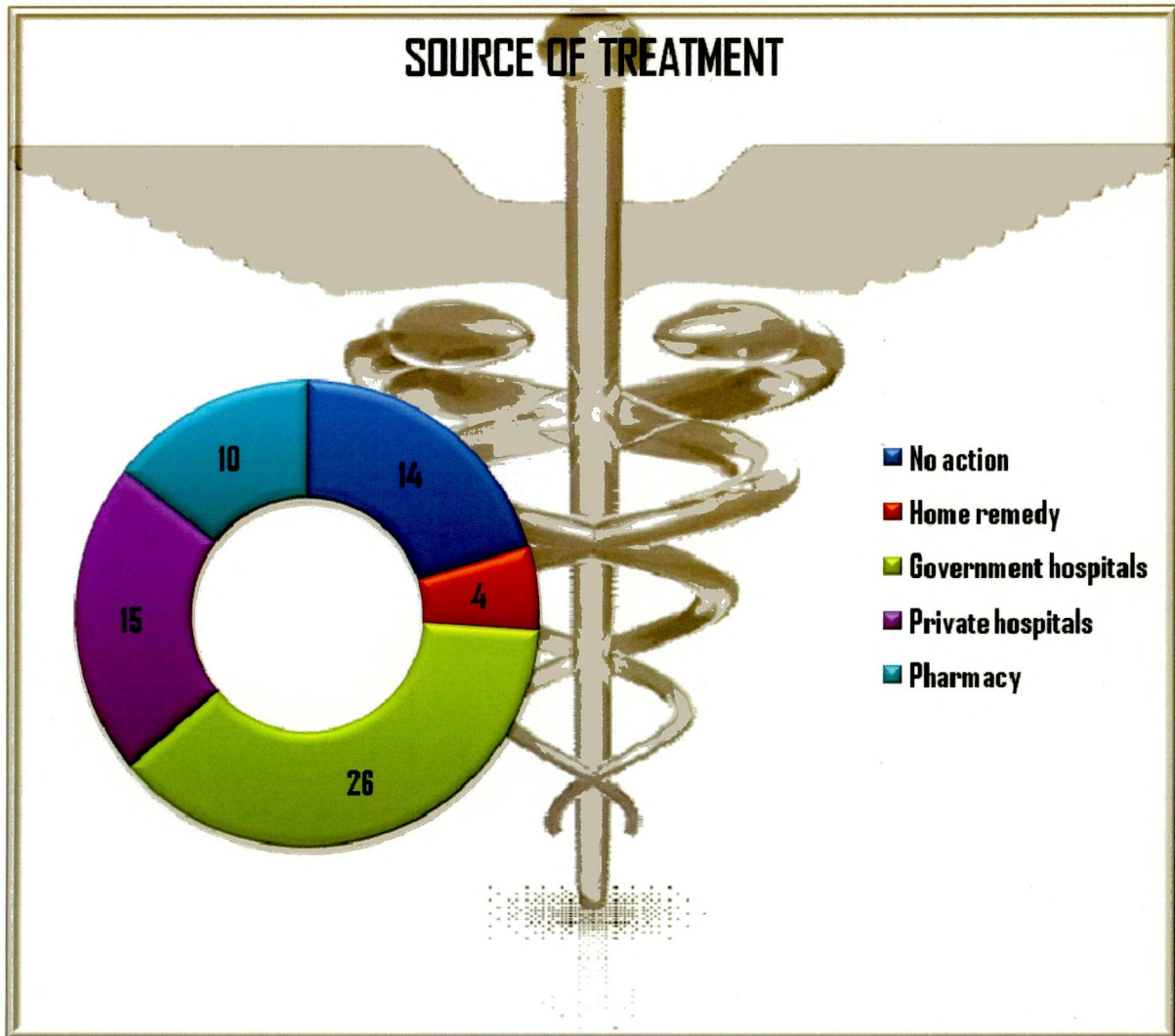


Table 4.27
Source of Treatment

Source of Treatment	Number	Percentage
No action	14	20.29
Home remedy	4	5.80
Government hospitals	26	37.68
Private hospitals	15	21.74
Pharmacy	10	14.49
Total	69	100.00

Source: Field Survey

It is clear that 37.68 per cent were taking treatment mainly in Government Hospitals and 21.74 per cent preferred treatment in private hospitals. Other than that 20.29 per cent were not taking any treatment for their illness. This is a peculiar situation in India. Women try to pull on with their sickness for quite some time. They have a phobia that if they are ill, all the households work would be pending, children would starve and everything would be stand still. So they just continue. However 20.29 per cent were found taking home remedy and 14.49 per cent were consulting pharmacy members for the treatment.

Expenses for the Caring Person

Home care is said to be the most comfortable care for patients as all the facilities at home are utilized by the patients, the main reason being the patients do not feel lonely. They are always accompanying with the members of family and relatives or friends at home care provide lot of advantage to the patient because special care will be given in the presence of the family members. Food and medicines will be given in time. The care taken is always monitored by the elder person of the house. In the study it was noticed that the person who took care of the sick, had to forego a day's job and therefore the pay also. In this there are many who had to face some loss as is given in table 4.28.

Table 4.28**Expenses for the Caring Person**

Caring Person Expenses (in ₹)	Number	Percentage
Less than 100	16	23.19
101-200	25	36.23
201-300	19	27.54
More than 300	9	13.04
Total	69	100.00

Source: Field Survey

An expense for the caring person is also main expenses at the time of visiting hospital or at time of hospitalization. Sixteen women (23.19 per cent) stated that upto ₹ 100 spends for the caring person. Majority of 25 women (36.23 per cent) spend ₹ 101-200 and 19 women (27.54 percent) spend ₹ 201-300 for one time visiting hospital. Only nine women (13.04 percent) spend more than ₹ 300 for the caring persons.

Managing the Medical Expenses

Income level or purchasing power has a direct effect on the potential demand for the product or service. 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.

Expenditure statistics many not adequately reveal the full implications of ill health on long-term standards of margins of subsistence end up selling their major income-earning assets, or borrowing at usurious rates of interests. The respondents managing the medical expenses to meet their hospitalization expenditure are classified as follows.

Table 4.29

Managing the Medical Expenses

Managing the Medical Expenses	Number	Percentage
Savings	44	63.77
Money Lender	14	20.29
Health Insurance & Other Sources	11	15.94
Total	69	100.00

Source: Field Survey

The respondents are managing the medical expenses through savings, borrowing from money lenders and through health insurance. From the study it is clear that 63.77 per cent women manage their expenses through savings and 20.29 per cent manage their expenses by borrowing money from money lenders and only 15.94 per cent manage their expenses through health insurance and other sources.

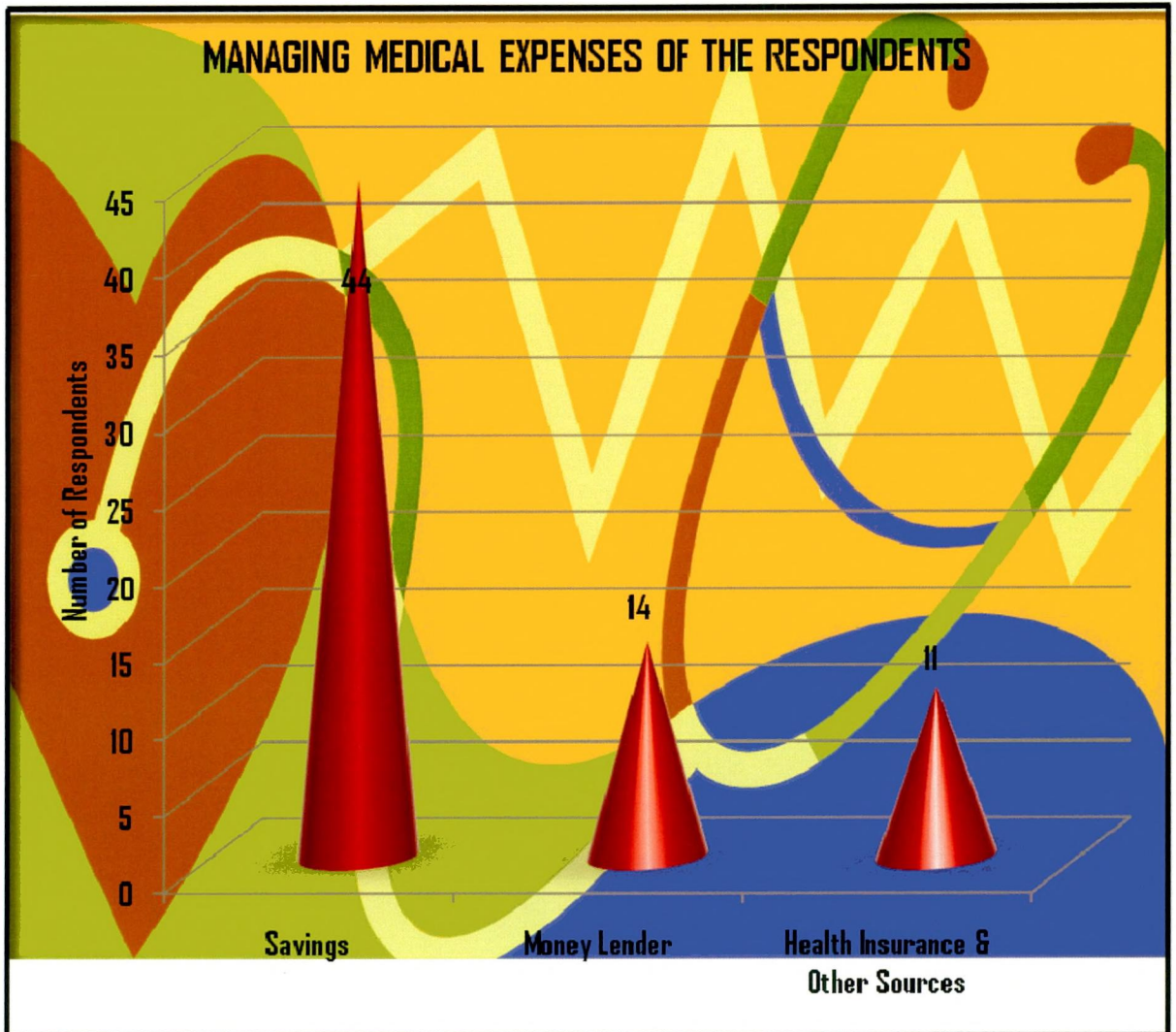
Benefits Receiving from the Employee

The women respondents are receiving some benefits from the employee. Such benefits are sickness allowance and leave facility. From the survey it was clearly noted that only 5.80 per cent are getting sickness allowances from the employee and the remaining 94.20 per cent are getting only leave in work place. Mostly in informal sector the benefits received from the employee are very low.

4.6 Awareness and benefits of Health Insurance

Health insurance in rapidly developing countries such as India and China needs to be segmented. One challenge is that the main advantage of health insurance for a family is the financial protection the insurance provides, which may trade off against public policy goals of increasing access, since greater access means higher premiums relative to the value of health benefits. As India continues on the path to development, it may increasingly face the problem of providing drug benefits, whose cost is difficult to control or constrain, especially in a setting where the country is producing for the world market (Pauly, 2008).

Figure 4.5



Awareness of the Health Insurance Scheme

The health insurance is a vital method of financing the spiraling costs of medical care. The high cost of hospitals services coupled with unpredictability of health needs and the inadequacy of personal savings is the primary reason for the growing importance of insurance as a means of financing health services.

Table 4.30

Awareness of the Health Insurance Scheme

Awareness Health Insurance	Number	Percentage
Yes	76	59.84
No	51	40.16
Total	127	100.00

Source: Field Survey

In spite of the growing importance of health insurance schemes the number of people covered by health insurance is very less in India. In this background an attempt has been made to know whether the women workers are in this study are aware of health insurance or not.

The sample revealed that 59.84 per cent have awareness of the health insurance scheme and 40.16 per cent does not have proper awareness of the health insurance scheme. The reason for not having proper health insurance scheme is, due to low level of education among the respondents.

Enrolment of the Health Insurance Scheme

The Health Insurance Scheme could either be a personal scheme or a group scheme sponsored by an employer. Some of the existing Health Insurance Scheme currently available are individual, family, group, Indian Senior, Senior Citizens in Scheme, long term health care and insurance cover for specific diseases.

In our study out of total 127 respondents only 48 women (37.80 percent) have enrolled in health insurance scheme and 79 women (62.20 percent) have not enrolled in

health insurance scheme. While collecting the data an attempt is made to collect information from the sample respondents like, since how long they are associated with health insurance policies.

Table 4.31

Period of having Health Insurance

Since When	Number	Percentage
Less than 2.0	12	25.00
2.1 - 4.0	28	58.33
More than 4.0	8	16.67
Total	48	100.00

Source: Field Survey

Around 58.33 per cent informed that they were having the health insurance policies since last two to four years. Only 16.67 per cent of the respondents informed that their policies are in tune since more than four years. Nearly 25.00 per cent of the respondents informed that they have taken the policy recently as per the advice of agents and their friends.

Classification of Health Insurance

Unpredictability of human needs and inadequate of personal savings together create the need for health insurance. The insurance company in India, mainly GIC and LIC provides various health insurance schemes to the people. GIC provides the most popular health insurance schemes namely, mediclaim and also the Jan Arogya Bhima Policy. The central government provides a contributory health scheme to its employees called the central government health schemes (CGHS) from 1954 and insurance scheme called Employment State Insurance Scheme (ESIS) from 1948, both schemes meant for the employees working in the public sector enterprises in the country. Thus, the government role in organization and financing health insurance is limited to those two major schemes. In this context an attempt was made to know from the workers about the type of insurance coverage they are having.

Table 4.32

Classification Health Insurance

Classification of Health Insurance	Number	Percentage
Government Scheme	22	45.83
ESIS	17	35.42
Private	9	18.75
Total	48	100.00

Source: Field Survey

All the women (35.42 percent) working in mills has Employment State Insurance Scheme (ESIS) and 22 women have Government Health Insurance Scheme. Only nine women (18.75 percent) have Private Health Insurance Scheme.

Types of the Health Insurance Policy

The name of the Health Insurance policy is broadly classified in our study into accident policy, Government policy, LIC policy, Star Health Insurance. Some of the policy held by the women respondent is given in table 4.33.

Table 4.33

Health Insurance Policy

Types	Number	Percentage
Accident Policy	17	35.42
Government Policy	22	45.83
LIC	5	10.42
Star Health	4	8.33
Total	48	100.00

Source: Field Survey, 2011

The study revealed 35.42 per cent employed in mill are having accident policy and 45.83 per cent have Government Policy. Only 18.75 per cent have LIC and Star Health Insurance Policy which is under private sector.

Motivation for Joining the Health Insurance Scheme

An attempt is made to collect the information about the persons who motivated the respondents to take a health insurance policy. The motivating factor is classified into Beneficiary & Employee, Self, Insurance agents and Newspaper & Media.

Out of 127 respondents, 35.42 per cent respondents in the sample informed that they are motivated by the beneficiary and employees. Nearly 31.25 per cent of respondents were self-motivated. Around 18.75 per cent informed that they were motivated by agents of insurance companies.

Table 4.34

Motivation to Joining the Health Insurance Scheme

Motivation Factor	Number	Percentage
Beneficiary & Employee	17	35.42
Self	15	31.25
Insurance agents	9	18.75
Newspaper & media	7	14.58
Total	48	100.00

Source: Field Survey

By informing the advantages of the health insurance policies they motivated the respondents to take the policies. Only 14.58 per cent got information from newspapers and media and this led them to avail health insurance.

Source of Finance for paying the Premium

The following table 4.35 clearly indicates the source of finance for paying the premium of the sample respondents. The main sources of finance are Organization, current Income and State Government.

Table 4.35

Source of Finance for Paying the Premium

Source of Finance	Number	Percentage
Organization	17	35.42
Current Income	9	18.75
State Government	22	45.83
Total	48	100.00

Source: Field Survey

Twenty two women (45.83 percent) were not paying the premium which is approved by the state Government and 17 women (35.42 percent) were paying the premium through Organization and only nine women paid the Premium from their own income.

Annual Premium

Insurance premium per capita in India was 19.7 and overall penetration in India was 3.07 per cent of GDP in 2004. In a country of one billion people it is estimated that only about 40 million are insured. In the study the payment of annual premium is classified into broad three categories as shown in table 4.36.

Table 4.36

Annual Premium for Health Insurance

Annual Premium (in ₹)	Number	Percentage
Less than 6000	16	61.54
6001-9000	7	26.92
More than 9000	3	11.54
Total	26	100.00

Source: Field Survey, 2011

Most of the respondents 61.54 per cent were paying the annual premium of only less than ₹ 6000 and 26.93 per cent women respondents were paying the annual premium of ₹ 6000 - 9000. Only 11.54 per cent respondents were paying annual premium of more than ₹ 9000. The annual premium, paid by the respondents is yearly once and once in six month. The mode of payment is based on the annual income of the respondents.

The payment of premium is made by 68.75 per cent yearly once and the only 31.25 per cent paid once in six month. The mode of payment is based upon the convenience of the respondents.

Reasons for Not Subscribing the Health Insurance Scheme

There are many reasons for not subscribing health insurance scheme. In our study the main reasons for not subscribing health insurance scheme is classified into three main categories, such as unawareness, lack of money and not all illness covered.

Table 4.37

Reasons for Not Subscribing the Health Insurance Scheme

Reasons for Not Subscribing	Number	Percentage
Unawareness	19	24.05
Lack of Money	40	50.63
Not all illness Covered	20	25.32
Total	79	100.00

Source: Field Survey, 2011

Among the total sample respondents, 79 women did not subscribe for health insurance scheme in that 40 women (50.63 percent) reported that it was due to lack of money. Remaining 49.37 per cent women did not subscribe for health insurance scheme due to unawareness and most of the health insurance does not cover all illness.

Problems Faced in Subscribing to the Health Insurance Scheme

There are many problems in subscribing to health insurance scheme. Some problems such as high premium, poor quality of services, not covering all illness and only hospital coverage, etc., were the major problems cited by the respondents.

Nearly half of the respondents voiced their opinions towards non-covering of all illness as the major problem faced in subscribing premium. Some of them were of the view that only hospital charges were covered.

Table 4.38

Problems Faced in Subscribing to the Health Insurance Scheme

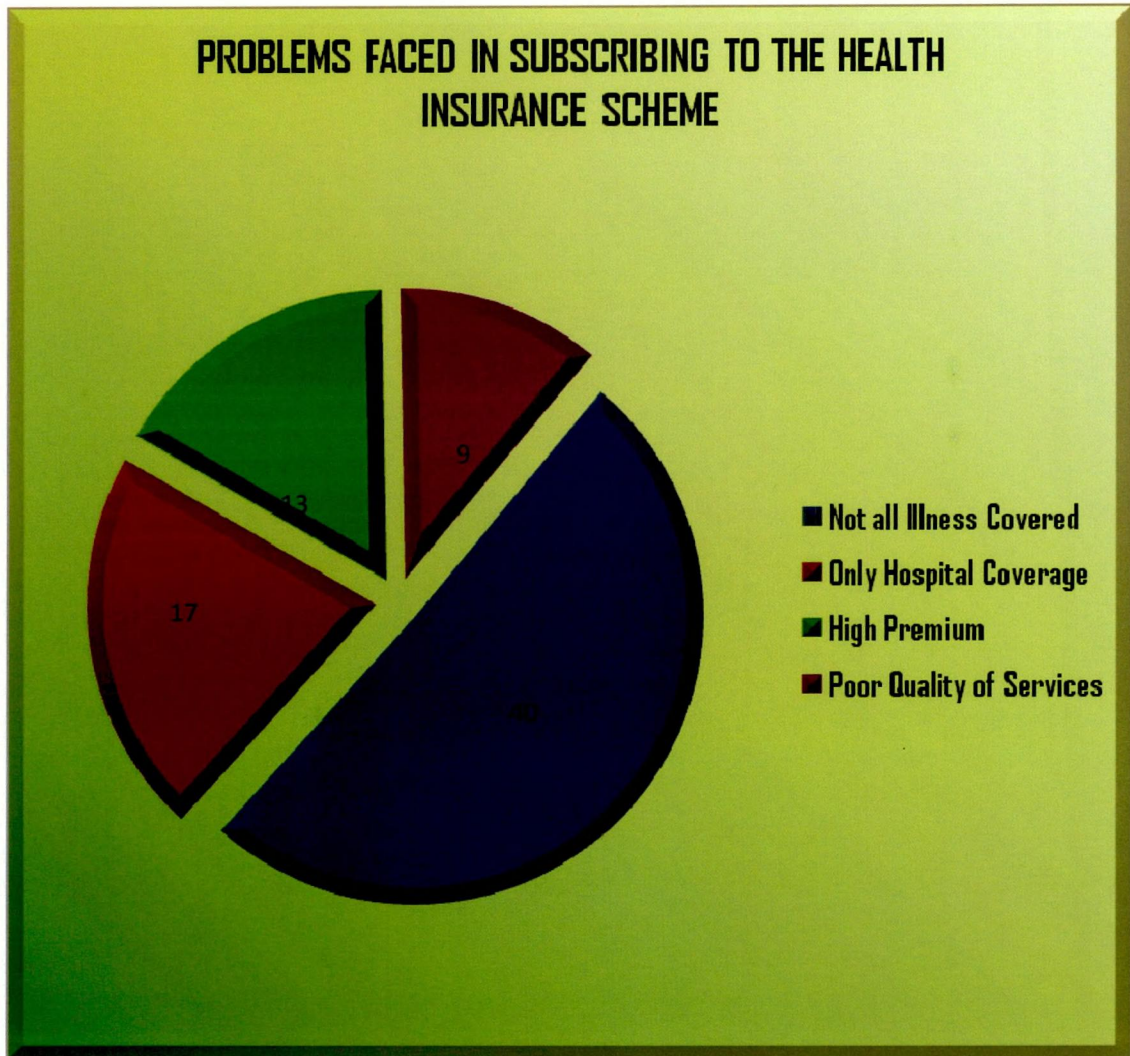
Problems Faced	Number	Percentage
Not all Illness Covered	40	50.63
Only Hospital Coverage	17	21.52
High Premium	13	16.46
Poor Quality of Services	9	11.39
Total	79	100.00

Source: Field Survey

Only 16.46 per cent respondents said that premium. Out of total 127 sample respondents' only 48 women had taken health insurance and the remaining 79 women not have health insurance. An attempt has been made to estimate the respondent's interest to join health insurance policy.

The survey revealed that 35.44 per cent have the interest to join health insurance policy and the remaining 64.56 per cent did not have any idea to join health insurance policy. Further nearly 67.86 per cent women like to join in government health insurance scheme and 32.14 per cent women like to join in private health insurance scheme. Most of these depend upon the motivating factors, and claims. And with regard to that they would like to pay, only 28 women were of the opinion that they would like to pay.

Figure 4.6



Desired Premium per month

The classification of the respondents is based upon the premium desired to pay per month. The amount the desired to pay is broadly classified into three groups such as less than ₹ 5000, ₹ 5001-7500 and more than ₹ 7500. Only 39.29 per cent women respondents were willing to pay ₹ 5001-7500 and 35.71 per cent women respondents were willing to pay more than ₹ 7500. Twenty five per cent of respondents were willing to pay less than ₹ 5000.

Factor Influencing for the subscription of New Health Insurance Scheme

The respondents who like to join health insurance policy have stated the factors influencing for subscribing new health insurance scheme. The main three factors suggested are cheaper, coverage of all illness and coverage of all services.

Table 4.39

Factors Influencing for the subscription of New Health Insurance Scheme

Factors	Number	Percentage
Cheaper	13	46.43
Coverage of all illness	9	32.14
Coverage of all services	6	21.43
Total	28	100.00

Source: Field Survey

Majority 46.43 per cent of the sample respondents reported that being cheaper is the main reason for joining new health insurance scheme. Less than 15 people stated that coverage of all illness and all services is the main motivating factor to join new health insurance scheme.

Factors Determining the Demand for Health Insurance

The table shows the multiple linear regression model using stepwise regression. The data were collected from 48 sample respondents who have health insurance were validated and processed. As explained in the empirical models, the dependent variable sum of insurance was regressed with the explanatory variables, viz. Income of the Insurer, Premium

amount, Age of the insurer, occupation of the insurer and education of the insurer were used to estimate among the sample respondents.

Table 4.40
Factor Determining the Sum of Amount Insured by the Respondents
(N=48)

S. No	Independent variables	β- Coefficients
1.	Constant	4301.94
2.	Income	11.18**
3.	Premium amount	0.003**
4.	Age	-0.045**
5.	Occupation	-0.025**
6.	Education	0.013**
	R ²	0.958

Source: Estimation Based on Field Survey, Significant at *1% and **5% levels

$$Y = 4301.94 + 0.18(X_1) + 0.003(X_2) + (-0.045)(X_3) + (-0.025)(X_4) + 0.013(X_5) + \mu$$

The β- coefficients presented in the table stated that the entire independent factor influences the sum of Insurance of the sample respondents. Monthly Income, Premium amount, Age, Occupation and Education influence the dependent variable the most. One unit increases in income would result in 11.18 per cent increases in the sum of insured. If premium amount increases by one unit it would result in 0.003 per cent increases in the sum of insured. One year increases in age would result in -0.045 per cent of the sum insured. One unit increase in occupation would result in -0.025 per cent of the sum insured. When the education level increased by one level it would result in 0.958 per cent of the sum insured. The model was fit by the explanation of R² value 0.958 per cent. It is therefore worthy to note that the role of income plays an important role in the determination of demand for health insurance.