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ORIGINAL ARTICLE

HEALTH PROBLEMS OF WORKING WOMEN

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Abstract:

Many of the studies were made on the general health problems of women from birth till death. But, none of these studies were focused the health problems of working women. The present paper looked into the statistics of health problems faced by working women in India. It is noted that due to the lack of time, working women are not giving much attention to their health. As such, they are suffering from health problems such as psychological distress, mental tension, anxiety, role conflict, anemia, negligence in reproductive health, etc. This may prove dangerous for the working women. Hence, there is need for working women to give much attention to their health care and it is also suggested to the policy makers to look into the health problems of the working women.

INTRODUCTION

Women's health in India has assumed importance only of late, particularly after the International Conference on Population and Development held at Cairo, Egypt in September 1994 and the Fourth World Conference on Women, held in Beijing in September 1995. Both these conferences placed immense importance on women's health, empowerment and reproductive rights. Not discounting the importance of health needs and health status of men, the fact remains that over a lifetime the health of women is usually worse than that of men. Moreover, certain health problems are more prevalent among women than among men and certain health problems are unique to women/affect women differently than men. Furthermore, some environmental problems have a disproportionate impact on women compared to their male counterparts.

The health needs of men and women are different where women with their biologically and culturally assigned roles have more health care needs than men. To elaborate, biologically they bear the burden of reproduction. Women alone have to go through all the problems and discomforts related to pregnancy and delivery. Culturally, in India, women are expected to be subservient to the male members of the household and work for the latter's happiness and satisfaction. Further, society expects them to play a very important role in providing informal health care to all the members of the family. It is their responsibility to rear children on healthy lines, teach them health habits, prepare and select the family's food, and care for the young, the sick, the aged and the disabled. Due to emphasis on gender equality, the Government of India formulated many schemes and policies to encourage higher education and employment for the women. Hence, modern women are gaining their status in terms of employment.

The globalization and especially technological transformation opened the door for the women new opportunities towards their work life. Now, women occupied in all the occupations and professions, which were occupied by men earlier. Hence, the women engaged as successful professionals as Medical Practitioners, Nurses, Teachers, Lawyers, Bankers, Lecturers, Librarians, Information Technologists, Engineers, etc. But, the women are not like men. Earlier there were the responsibility that the men have to lead the family and work outside for earning and women have to look after the household work and women

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are biologically proved as weaker sex. But now, the women also working outside like men and looking after the household work. In this way, now-a-days, women are playing a dual role in her office work and house work. Further, a great majority of employed women are playing significant role in unorganized sector and only few women are playing significant role in organized sector of employment.

It is emphasized that the employment of women, generally living in rural areas, most of the work that women do, such as collecting fuel, fodder and water, or growing vegetables, or keeping poultry for domestic consumption, goes unrecorded in the Census counts. It is well known that women and children work in huge numbers in beedi-rolling, agarbatti-rolling, bangle making, weaving, brassware, leather, crafts and other industries. Yet, only 3 percent of these women are recorded as labourers. They are forced to work for pitiable wages and are denied all social security benefits. A study by SEWA of 14 trades found that 85 per cent of women earned only 50 per cent of the official poverty level income.

The Distribution of Main Workers by Sex according to Education Level in India in 2001 is shown in the following table.

Table No. 1. Distribution of Main Workers by Sex according to Education Level in India (2001)

Education Level	Population (In Million)			% Main Workers		
	Persons	Males	Females	Persons	Males	Females
Total	1028.6	532.2	496.5	30.4	45.1	14.7
Illiterate	467.9	195.6	272.3	24.3	35.3	16.5
Literate	560.7	336.5	224.2	35.5	50.9	12.5
Literate but below Matric/Secondary	381.8	220.6	161.2	29.8	43.8	10.7
Matric/Secondary but below Graduate	117.4	76.1	41.4	43.4	61.0	11.3
Technical Diploma or Certificate not Equal to Degree	3.7	2.9	0.8	60.9	64.6	46.8
Graduate and above other than technical Degree	32.6	21.9	10.7	57.0	73.4	23.5
Technical Degree or Diploma Equal to Degree or Post-Graduate Degree	5.1	3.6	1.4	65.6	72.2	48.6

Source : Ministry of Statistics and Programme Implementation, Govt. of India.

It is noted that now women are increasingly participating in all the sectors and industries along with the agriculture. The industry category-wise distribution of main workers by sex in 2001 is presented as under.

Table No. 2. Industry Category-wise Distribution of Main Workers by Sex in India (2001)

Industrial Category	Percentage Share		Percentage Share of Different Industries in Female Employment
	Female	Male	
Agriculture, Hunting and Forestry; Fishing	36.7	63.3	14.5
Mining and Quarrying	13.8	86.2	1.1
Manufacturing and Repairs	21.6	78.4	36.1
Electricity, Gas and Water Supply	4.4	95.6	0.3
Construction	9.2	90.8	4.3
Wholesale and Retail Trade	6.9	93.1	7.4
Hotels and Restaurants	9.1	90.9	0.9
Transport, Storage and Communications	2.9	97.1	1.5
Financial Intermediation; Real Estate, Renting and Business Activities	12.4	87.6	3.0
Public Administration and Defence; Education; Health; Community and Social Services; Pvt. Households; etc	24.9	75.1	31.1
Total	17.1	82.9	100

Note : Figures for 2001 exclude those of three sub-divisions of Senapati district of Manipur.
Source: Compiled from the statistics released by : Ministry of Statistics and Programme Implementation, Govt. of India.

The statistics also revealed that the women of all the age groups are participating in employment now. Following table disclosed the age group-wise work force participation rate by sex and sector in India in different years.

Table No. 3. Age Group-wise Workforce Participation Rate by Sex and Sector in India in Selected Years

Age Group Year	Rural						Urban					
	Male			Female			Male			Female		
	1993-94	1999-00	2004-05	1993-94	1999-00	2004-05	1993-94	1999-00	2004-05	1993-94	1999-00	2004-05
5-9	11	7	9	14	7	3	4	3	3	4	2	3
10-14	139	93	70	142	96	75	71	52	53	47	37	35
15-19	598	532	529	371	314	331	404	366	381	142	121	144
20-24	902	889	981	470	425	435	772	755	769	230	191	250
25-29	980	975	982	528	498	530	958	951	957	248	214	261
30-34	988	987	988	587	557	593	983	980	987	283	245	308
35-39	992	986	991	610	578	642	990	986	984	304	289	340
40-44	989	984	985	607	586	627	984	980	983	320	285	317
45-49	984	980	982	594	566	616	976	974	976	317	269	269
50-54	970	953	963	543	515	562	945	939	939	287	264	259
55-59	941	930	931	468	450	509	856	811	832	225	208	218
60 & Above	699	640	645	241	218	254	443	402	366	114	94	100
All (0+)	561	540	555	331	302	333	542	542	570	164	147	178

Source : Ministry of Statistics and Programme Implementation, Govt. of India.

The Work Force Participation Rate (WFPR), also called Labour Force Participation Rate (LFPR) is the percentage of the working population to the total population of a country. It is an important factor which affects production, saving and capital formation. It helps in analyzing the occupational structure of a country and thus its level of employment. The WFPR depends upon the age and sex structure of the population, age of marriage, average size of the family, education, health, attitude to work, availability of work, etc. The work force participation rates in India for the Census years 1901 to 2001 are shown in Table No. 4. The WFPR in the pre-independence period from 1901-31 was higher than in the post-independence period from 1951-91, except for the Census year 1961, the reason being the use of different definition of the 'work force' in these censuses. In the pre-independence census, the main workers were lumped with unpaid family workers. But in the 1951 census, the unpaid family workers were excluded from the main workers. That is why the WFPR in 1951 was 39.1 percent and more than 43 percent in the pre-independence years (1901-1931). Again in 1961, the WFPR increased to 43 percent because persons whose main activity was not economic were included in the main workers. The WFPR declined to 34.2 percent in 1971 because the persons engaged in part-time activities were excluded from the category of the main workers. But since the Census of 1981, the WFPR has raised to 36.7 percent in 1981 to 37.7 percent in 1991 and to 39.3 percent in 2001. This is because of the adoption of a rigorous meaning of “worker” in terms of main workers and marginal workers (Pulla Rao, 2007).

Table No. 4. Gender-Wise Work Force Participation Rate in India: 1901-2001
(In Percentage)

Year	Females	Males	Total Persons
1901	31.1	61.1	46.6
1911	33.7	61.9	48.1
1921	32.7	60.5	46.9
1931	27.6	58.3	43.3
1951	23.3	54.0	39.1
1961	28.0	57.1	43.0
1971	14.2	52.7	34.2
1981	19.7	52.6	36.7
1991	22.7	51.6	37.7
2001	25.7	51.9	39.3

Source: Census Reports for various years.

According to Muthuraj (2001), the type of work done by women in India can be classified into the following categories:

1.Wage and salaried employment;
2.Self-employment outside the household for profit;
3.Self-employment in cultivation and household industry for profit;
4.Self-employment in cultivation for own consumption;
5.Other subsistence activities in all allied sectors like dairy, other livestock rearing, such as, poultry, goats, pigs, etc., and fishing, hunting and cultivation of fruit and vegetable gardens;
6.Activities related to domestic work, such as, fetching fuel, fodder, water, forest;
7.Producing, repairing of dwellings, making cow-dung cakes, food preservation, etc;
8.Domestic work, such as, cooking, cleaning, care of children, the aged, and sick.

Of course, the working women have already improved the status in the society. But along with the outside work, women have also play social role and family role. Hence, there is role conflict of the working women in the family and at the work place. Women playing only the role of housewife do not have such role conflict, but they have lesser or no economic freedom as their work in the family is considered as unproductive. It is emphasized that even though the services of housewives considered as economically unproductive, their contribution in the care of the family members especially husband and children is precious and valuable. Of course, the working women are also looking after their family members, but they have lack of much attention, due to the outside work. Hence, working women are facing many problems such as career problems, role conflict, health problems, etc. The present paper analyzed the health problems of working women.

HEALTH PROBLEMS OF WORKING WOMEN:

The Working women are constantly facing the problems of role conflict or dual role. Work–family conflict has been associated with a number of dysfunctional outcomes, including burnout (Bacharach, et al, 1991), decreased family and occupational well-being (Kinnunen and Mauno, 1998), psychological costs and physical complaints (Frone, et al, 1992), and job and life dissatisfaction (Netemeyer, et al, 1996). These findings underscore the importance of understanding the conflict and its sources. Marriage and home-making require self negative where as wage necessitates self enhancement for going ahead. The former implies cooperation while the later leads to competition. Due to role conflict, there are reports of psychological distress, mental tension, anxiety, etc, which affect the psychological well being of working women. Further, there is also lack of care to the husband, elders and children and as such, it may also affect the mental state of working women.

Of the major problems, which are faced by the working women, the statistics revealed that Anemia is a major health risk. Anemia is yet another important index of diet related problems. It is a condition where the number of red blood cells in the blood is below 'normal' for age and sex of the individual. Iron deficiency is the root cause of anemia with kids and teenage girls. Usually women after conceiving a child suffer from iron deficiency which will eventually lead to anemia. When a person turns anemic, her/his body tissues get lesser amount of oxygen, the result of which is fatigue, lethargy and many other medical complications in due course of time (Ajith Kumar and Radha Devi, 2010).

Of the health problems of women, reproductive health problems are playing dominant role, which adversely affects much the health of working mothers. Indian women have high mortality rates, particularly during childhood and in their reproductive years. India's maternal mortality rates in rural areas are among the world's highest. From a global perspective, India accounts for 19% of all live births and 27% of all maternal deaths. The health of Indian women is intrinsically linked to their status in society, especially for those living in a rural area. The health care during pregnancy shows the health problems of women and it is revealed from the statistics of visits to the Ante-Natal Care Centres (ANCs). Following table shows the Ante-natal care of mothers in India.

Table No. 5. Details of Ante-Natal Care 2005-06 (Percentage)

Items	Percentage
At least one ANC visit	76.4
Three or more ANC visit	52.0
Received all recommended types of ante-natal care	15.0
Mothers who were given/ purchased iron and folic acid tablets	65.1
Mothers who had Blood Pressure check up during pregnancy	63.8
Mothers who had at least two TT injections	76.3
Mothers who had abdominal check up during pregnancy	72.0
Mothers who had their weight taken during pregnancy	63.2

Source: National Family Health Survey-3

Above table revealed that nearly half of the mothers do not visit any Ante-Natal Care Centres and do not follow the prescriptions of the doctors. In this way, it can be stated that women are neglected in terms of health. Even though, Government is providing free health check-up facilities, working mothers do not find time to visit the health centres and hence, their health is needed concern.

Pregnancy and child birth requires specialized care, generally agreed to be a preventive activity. Where visits do occur, they appear to occur infrequently, late in the pregnancy and their content is unclear. Moreover, it appears that antenatal services are likely to be sought by women who experience difficulty or signals of a complicated delivery than other women. Poor availability of health services reflects cultural and socio-economic constraints as well as perceptions regarding accessibility of facilities and quality of care. Nearly 64.00% of women who did not utilize antenatal services consider it unnecessary; reflecting both the traditional notion that child bearing is not an event worthy of medical attention (Jejeebhoy, 1997). Even though, working mothers are literates, still they do not find time to visit the health centres during the pregnancy. Consequently, due to poor health care, there may be maternal mortality or infant mortality. The statistics revealed by Indiastat (www.indiastat.com) of the total sample 5348441 of female population selected, there were 436648 live births and 1110 maternal deaths in 2004-06.

Menopause is a natural phenomenon and occurs in every woman in her late forties or early fifties. This is a gradual biological process which culminates in the cessation of ovulation and menstruation. At the start of this period, less estrogen and progesterone hormones are produced by the body and eventually their production stops. Without the protective qualities of estrogen, and with the added effects of aging, women may be vulnerable to some serious health problems during the menopausal period. Some of them are hot

flushes, vaginal dryness, bladder infections, emotional change, fatigue, irritation and poor memory. These problems create more stress among these women and stress places an extra load on many body processes, influencing immune function, hormonal regulation, biochemical interactions, digestion, cardiovascular performance and nervous response (The Body Corporate Well News, 2002). "These changes can be traumatic and psychologically challenging for women" (India Together, 2009). Many of these problems can be prevented or delayed, and women can continue to live active healthy lives after the menopausal years if proper attention is given to their health needs.

Health risks and concerns change as a working woman ages during her life span. Many are natural consequence of the process of ageing such as low vision/blindness, deafness, loss of mobility and a general inability to care for oneself. In fact, all individuals suffer a weakening of physical and mental capabilities sooner or later. It is also a period characterized by decline in status at home and society, decline in decision making power, decline in social and friendship network, development of a feeling of loneliness and uselessness after retirement, development of a question of living arrangement, and development of economic and/or physical dependence. All these will have an adverse effect on their mental framework. Health seeking behaviour and compliance to treatment are significantly influenced by mental health status. Conversely, many physical illnesses can have a mental health impact.

After 60 years of age, older women become extremely marginalized groups of people, who hardly merit the attention of state protection. As women, they occupy a position which is more disadvantaged than older men, and as older people the additional vulnerability of dependency and support from others. In both instances, their contribution both economically and socially to the household and community is hardly recognized. Demographically, populations are displaying an aged complexion across the world. In terms of aggregate population in India, the proportion of elderly, those above 60 years of age, was 5.4 percent of the total population of this age group has also been higher than that of other contributing to its increasing proportion in the overall population. Further the proportion of women in the 60+ age group is higher than the male population (Bose, 2000). It is emphasized that official estimates of the retired older women is not available as there is no such statistical sources.

According to the National Human Development Report (2001), an aspect of the ageing problem, on which some data is available relates to the widows among the elderly females. The number of widows among the elderly is about three and a half times more than the number of widowers. While the percentage of widowers among the elderly males was about 15 percent, the widows among the elderly females were as high as 54 per cent as per the 1991 Census. More importantly at present, on an average, women of age 60 years are expected to live 1.8 years longer than males. This, coupled with the average age difference between men and women at the time of marriage, results in a situation where women surviving their spouses are likely to live about 6.5 years as widows. This is about one-tenth of the prevalent female life expectancy at birth and, more importantly, about 40 per cent of life expectancy of an elderly woman in the country. Thus, the time spent by the elderly women as a widow is considerable. The women in the States of Karnataka, Kerala, Maharashtra and West Bengal are likely to spend more years as widows than in other States, as differences in the male-female marriage age in these States are much larger.

Aged women are called 'wet leaves' in Japan, 'kankeri' (second childhood) in China and 'Shastipurthi' in Sanskrit (Gowry, 2003). In India older women are seldom part of the development agenda. Their contributions are slighted and discussions of their situations are usually afterthoughts. Their work is not considered as economically productive and their contribution throughout their lifespan is not quantified or valued (Ramachandran and Radhika, 2006).

Sati (1988) reviewed the Indian studies that were done on Ageing and retired people. He stated that the variations of the respondents' background such as of health incapacities, retirement age, intergenerational relationship, family composition, status in the society and family, the psychological problems of segregation, isolation and loneliness need to be studied within the cultural matrix of India. The author revealed that the studies also lack in investigation of some of the ageing problems of widowhood, effects of retirement, self-employed aged, physically and mentally disabled aged, retired women workers, and the problems of rural migrant aged settled in the urban settings.

CONCLUDING REMARKS:

Women are facing many of the problems as a weaker sex from her birth till death. Many of the studies were already conducted on the women's health problems at different stages. But, none of the studies were made to focus the health problems of working women, who are facing role conflict problems. As such, working women are facing psychological problems, which in turn affect their physical health. Many of the health ailments, such as Anemia, lower calcium, arthritis, psychological distress, mental tension, anxiety, etc are the results of outside work along with women's role in family. Of course, globalization

policies helped the Indian women in getting higher education and employment, but on the other hand, working women are facing many of the problems. Of these problems, health care is essentially needed the attention of all the working women and policy makers.

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