Vol II Issue XII June 2013

Impact Factor : 1.2018

ISSN No :2231-5063

Monthly Multidiciplinary Research Journal

Golden Research Thoughts

IMPACT FACTOR : 1.2018

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RNI MAHMUL/2011/38595 **ISSN No.2230-7850**

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Golden Research Thoughts
Volume 2, Issue. 12, June. 2013
ISSN:-2231-5063
Available online at www.aygrt.isrj.net

ORIGINAL ARTICLE

STRESS AND HEALTH OF WORKING WOMEN: A REVIEW OF THE STUDIES

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Abstract:

Globalization helped Indian women to achieve equality in education and employment, but on the other hand, the health aspects of working women are neglected due to occupational stress. Many of the studies were already conducted in India on occupational stress and health of working women. These studies are reviewed in the present paper. It is suggested to the working women to perform physical exercise and yoga and also eat nutritious food to maintain their health and control their stress.

KEY WORDS:

Stress , Health , Globalization , education.

INTRODUCTION

By and large, women were prohibited to take up work outside family in traditional India. Women who took up casual work for wages as labourers were looked down upon as inferior. With the advent of industrialization and urbanization the nature and character of work has undergone a radical change. Work is increasingly becoming more specialized and skilled. A large number of jobs and careers have come up in the field of teaching, administration and electronics which trained and educated women can handle with competency and efficiency. Besides, work in organized sector has relatively become financially secured and remunerative. As a result there are more favourable conditions for women's employment in modern society.

Opportunities for employment in both organized and unorganized sectors for women have widened after Independence. There is an increasing trend among educated women to seek gainful employment in offices, schools, colleges etc. Studies on career choices of girls revealed that most girls employed before marriage, resigned their jobs as per the wishes of their husbands. Women continued in their jobs only when their husbands permitted. But such attitudes were also changed in the twenty-first century.

HEALTH PROBLEMS OF WORKING WOMEN:

The health of Indian women is intrinsically linked to their status in society. Research on women's status has found that the contributions Indian women make to families often are overlooked and instead they are viewed as economic burdens. There is a strong son preference in India, as sons are expected to care for parents as they age. This son preference, along with high dowry costs for daughters, sometimes results in the mistreatment of daughters. Further, Indian women have low levels of both education and formal labor force participation. They typically have little autonomy, living under the control of first their fathers, then their husbands, and finally their While women in India face many serious health concerns, which are grouped into five key issues: reproductive health, violence against women, nutritional status, unequal

Title :STRESS AND HEALTH OF WORKING WOMEN: A REVIEW OF THE STUDIES
Source:Golden Research Thoughts [2231-5063] SHARANAGOUDA SUBHASHAGOUDA HIREGOUDA AND VIJAYALAXMI. BIRADAR yr:2013 vol:2 iss:12

treatment of girls and boys and HIV/AIDS. Because of the wide variation in cultures, religions and levels of development among India's 30 states and 5 union territories, it is not surprising that women's health also varies greatly from state to state. All of these factors exert a negative impact on the health status of Indian women.

Women's labour force participation rate is 25.6% compared to 57.95% for men (Census of India, 2001). Women contributed only 17.2% of organized sector employment in 2001. There are far fewer women in the paid workforce than there are men. The lack of appreciation for women's work—paid and unpaid, productive and reproductive—is an old problem. A pilot Time Use Survey conducted in 1998-99 by the Central Statistical Organization showed that 51% of women's work is not recognized as work. About 93% of women workers is in informal employment sectors (including agriculture), or is in low income jobs. Wage gaps between male and female labour persist and are greater in urban than rural India (Government of India, 2005). In urban areas, where 80% of women's work is in unorganized sectors like household work, sub-standard building construction and other petty trades, the work environment is hazardous. Moreover, the absence of security and welfare mechanisms make women vulnerable to serious health conditions, rape and other forms of sexual harassment. Carrying and lifting heavy loads often have serious health consequences for women, like menstrual disorders, prolapse of the uterus, miscarriage, and back problems, especially spinal problems (Sarojini, 2006).

Striking changes in the nature of families and the workforce, such as rising numbers of dual career couples and working mothers with young children, have increased the likelihood that both male and female employees have substantial household obligations as well as major work responsibilities (Allen, et al, 2000; Bond, et al, 1998). Under such circumstances, the women have dual role to play and in such cases, there are stress and mental tensions for working women. Due to stress, there may be ill health for the working women.

Vindhya, et al (2001) remarked that more women than men the world over are said to suffer from mental disorders. And yet psychological distress of women has not been articulated as a distinct agenda either by the academia or by the women's movement in our country. The marginalization of mental health concerns by the women's movement is understandable in view of the predominance of issues related to survival and identity on its agenda. First, the women's movement in our country, over the past two decades or so has had to deal with an enormously wide range of issues and problems that are largely consequences and effects of societal oppression of women. Issues of survival – for land, for work and wages, for protection of environment – have for the most part dominated the concerns of the women's movement in the past few years or so. In addition, issues like sexual and family violence, harassment and discrimination in places of work and working conditions, inequities in services like education and health care, and examining and challenging the various ways the state through the legal system operates either to promote the status quo or to oppose changes favourable to women – are a few examples of the interventions and initiatives of the women's movement. Furthermore, since the 1980s, it is questions of caste, religious community, nationality that the Indian women's movement has been engaged with and the impasses that these questions have often led to, have posed a bigger challenge to both theory and praxis of the movement. Mental distress has not figured on the agenda perhaps because it is viewed as a manifestation of an individual problem, not directly related to societal oppression, and not common to all women.

The causes for mental distress as stated by Dennerstein, et al (1993) the gender inequalities and the stresses that differentially affect women by virtue of their unequal social status have led to pervasive mental health problems for women. There is accumulating evidence that links mental disorders with alienation, powerlessness and poverty, conditions most frequently experienced by women. Due to stress and mental tensions, there are increasing health problems for women. The physical health ailments due to mental tensions and stress include Blood Pressure, Cardiac Problems, Brain Hemorrhage, infertility, Obesity, Diabetes, hypertension, acidity, migraine, paralysis, etc, which affect women's health adversely.

Health is socially determined to a considerable extent. Access to healthcare, is almost fully so. This being so, the 'lived experiences' of women in India are replete with potential risk factors that have implications for their lives and well-being. The multiple roles of household work, child rearing and paid work that women carry out has implications for their physical and mental health. A study on the impact of work and environment on women's morbidity in a sample population in Mumbai found that cohabiting women with children engaged in paid work had the highest morbidity rates (Madhiwalla and Jesani, 1997), higher than that of either single women or housewives. The types of morbidity experienced by the women included reproductive problems, aches, pain and injuries; weakness, fever, respiratory problems; problems in the gastro intestinal tract; skin, eye and ear problems and a residual category of 'other' problems. The study also found, quite significantly, that degraded living environment, as in a slum, has deleterious effects on people's health and that the morbidity rates were highest for those adult women with children who were living in slums and were engaged in paid work (Mishra, 2006). Another study of working and non working

women in the slums of Baroda found that though working women contributed significantly to the household income, yet they had to face a burden of household work and childcare (in addition to their paid work). Such women put in more hours of work to fulfill their numerous responsibilities and had less leisure time. Women in both the categories had lower nutritional intake than what is recommended, with the working women faring worse than the housewives. Similarly, in the case of nutritional deficiencies such as anaemia, mottled enamel, etc, both the categories of women fared poorly, with the working women being worse off. The mean number of clinical signs of nutritional deficiency was 2.8 for the working women in comparison to 2.2 for housewives. Interestingly, the study showed that working women had greater access and higher utilisation of antenatal care services (Khan, et al, 1990). There may be gendered risks to women's lives in the home environment. In India, a vast majority of the households rely on biofuels (wood, dung, etc) for cooking. Cooking being a female preserve in the household domain, the pollutants arising from the burning of such bio-fuels affect women (and young children) disproportionately, with consequences on their health - respiratory tract infections, blindness and asthma being some of the diseases that affect them (Parikh, et al, 1999; Gopalan and Saksena, 1999).

Nutrition is a determinant of health. A well balanced diet increases the body's resistance to infection, thus warding off a host of infections as well as helping the body fight existing infection. Depending on the nutrient in question, nutritional deficiency can manifest in an array of disorders like protein energy malnutrition, night blindness, iodine deficiency disorders, anemia, stunting, low Body Mass Index and low birth weight. Improper nutritional intake is also responsible for diseases like coronary heart disease, Hypertension, non-insulin-dependent diabetes mellitus and cancer are among others (Shetty, 2004). Nutritional deficiency disorders of different types are widely prevalent in the countries of South East Asia, with some pockets showing endemicity in certain types of disorders. Iodine deficiency disorder is endemic to the Himalayan and several tribal areas and anaemia is a pervasive problem across most socio-economic groups of the country. Economic prosperity alone cannot be a sufficient condition for good nutritional status of a population, the state of Maharashtra in western India being a prime example in this regard. Maharashtra has one of the highest per capita incomes among states in the country, but is marked by poor nutritional profile of its people. More than half the households in both the rural and urban areas of the state receive less than the prescribed adequate amount of calorific intake and the situation has worsened in the rural areas of the state in the past twenty years (Duggal, 2002).

The current understanding of women's health has gone beyond singular, individual, biomedical perspectives to include diverse factors such as the family, community, population, psychosocial, and cultural understandings. Social determinants of health also include such factors as education, income, employment, working conditions, environment, health services, and social support (Wuest et. al., 2002). Care giving and family responsibilities, economic insecurity and experiences of violence and abuse are common for working women.

Paid work coupled with childcare and household responsibilities result in role strains and little leisure for women. For women, the 'spillover' of family related stress on work related stress is higher than it is in the case of men (Parikh, et al, 2004). The workplace can also be a site where women are subject to sexual violence and gender discrimination. In addition, the specific situational contexts of their employment may engender numerous health risks in women. As Kaila (2004) writes, 'research evidence indicates that women face certain work related health problems such as psychosomatic symptoms, general health and women specific health problems, including menstrual disorder, anxiety, backache, anemia, depression, abortion, miscarriage and other gynecological problems' (Kaila, 2004).

Emerging evidence on occupational health point to a host of job specific occupational health hazards along with the role conflict and role strain that women experience. Nurses may suffer from workload, role ambiguity, problems in interpersonal relationships and death and dying concerns, as also emotional distress, burnout and psychological morbidity (Parikh, et al, 2004). In a study of women working in a small scale industry whose work entailed sitting cross legged on the floor for six to eight hours in a day, it was found that the prevalence of pain and discomfort among such women was higher than that in the control group of housewives. The pain experienced in the working women was more enduring and less amenable to amelioration from rest and it was inferred that work posture led to such pain among them (Desai and Gaur, 2004). For women managers, 'major stressors' include getting the work done, clashes with superiors, competition, dual responsibilities of household and job, meeting deadlines, and so on (Kaila, 2004b). A study of women construction workers revealed often long (10-12) hours of work in a noisy, dusty environment full of pollutants like tar and glass. Respiratory, eye and skin disorders as well as noise induced hearing loss were common. More than half the women (56%) reported of injuries that led to work loss. About three-fourths of the women reported gendered stressors like sex discrimination and balancing work and family demands, apart from 'general' stressors like excessive workload and under utilization of skills (Lakhani, 2004). Occupations like agricultural labour have been seen to be a 'significant factor' in risk of

sexually transmitted infections (STIs) (Prasad, et.al, 2005).

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.

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, on the one hand, women have achieved equality in education and employment to a greater extent now and on the other hand, working women are losing their health due to occupational stress. Hence, it is essentially suggested for the working women to go for the activities such as physical exercises, yoga, etc so as to maintain their health. Further, it is also suggested to the working women to go for nutritious food to avoid health problems.

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