The Process of Shift from Construction to Domestic Work and Its Implications for Women's Health: A Study of Slums in Cuttack City

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DOCTOR OF PHILOSOPHY

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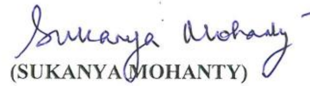
DECLARATION

I do hereby declare that the thesis entitled "**THE PROCESS OF SHIFT FROM CONSTRUCTION TO DOMESTIC WORK AND ITS IMPLICATIONS FOR WOMEN'S HEALTH: A STUDY OF SLUMS IN CUTTACK CITY**", submitted by me to the Centre for Social Medicine and Community Health, School of Social Science, Jawaharlal Nehru University, New Delhi for the award of the degree of "**DOCTOR OF PHILOSOPHY**" embodies the result of bonafide research work carried out by me and that it has not been submitted so far in part or in full, for any degree or diploma of this university or any other university/ institution.



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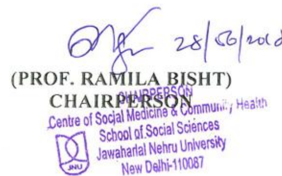

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Abbreviations

BPL	Below the Poverty Line
CAGR	Compound Annual Growth Rate
CDS	Current Daily Status
CSO	Central Statistical Organisation
CWS	Current Weekly Status
GDP	Gross Domestic Product
GEN	General (category)
GoI	Government of India
IAY	Indira Awas Yojana
IGDPS	Indira Gandhi Disability Pension Scheme
IGNOAPS	Indira Gandhi National Old Age Pension Scheme
IGNWPS	Indira Gandhi National Widow Pension Scheme
ILO	International Labour Organisation
KG	Kilogrammes
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MPCE	Monthly Per Capita Expenditure
NCEUS	National Commission for Enterprises in the Unorganised Sector
NREGA	National Rural Employment Guarantee Act
NSS	National Sample Survey
NSSO	National Sample Survey Office
OBC	Other Backward Classes
LFPR	Labour Force Participation Rate
ps+ss	Principal status + Subsidiary status
PDS	Public Distribution System
PWD	Persons with Disabilities

RAY	Rajiv Awas Yojana
RSBY	Rashtriya Swasthya Bima Yojana
SCs	Scheduled Castes
STs	Scheduled Tribes
SDH	Social Determinants of Health
SNA	System of National Accounts
UPSS	Usual Principal and Subsidiary Status
WCD	Women and Child Development
WPR	Work Population Ratio
WHO	World Health Organisation

Preface

When I went out for my field work as a young scholar of Master of Philosophy (M.Phil), I had no clue that I would take up a question from this work for my future doctoral research. It was during my M.Phil data collection on lives of women domestic workers in slums of Cuttack city in 2000-01 that I first came across women domestic workers who had previously worked as construction workers and had later shifted to domestic work for health reasons. They were domestic workers who lived in their own houses and not in employer's house. The question why did such employment shifts happen for women workers from construction to domestic work when construction work had a daily wage higher than domestic work lurked in my mind. Was it not the case then? How was the decision taken then? These not so old women had said they shifted for health reasons. How was it so?

The scale of health as a reason for such shifts from construction work to domestic work and the implications were not known by any study. There were few studies on live-in women domestic workers, particularly tribal women workers who worked in atrocious work conditions (Indian Social Institute, 1993). Feminisation of work, attributing domestic work as 'dirty work', political economy of health were known approaches to work and health. Health as a reason of work changes added to the market factors of demand and supply which were the driving force for employment. Work changes for health reason was intriguing, more so, when domestic work was not even a recognised work in terms of its contribution to country's Gross Domestic Product (GDP) and construction work was better paid than domestic work. The idea of health as a non-economic factor for employment shifts and work changes of women construction workers, the process how health and work changes unfolded in women's lives remained a question unanswered. Subsequently, I worked on this idea and developed it into my Doctor of Philosophy (Ph.D) research synopsis proposal in 2003 with Dr. Alpana Daya Sagar at Centre for Social Medicine and Community Health (CSMCH), Jawaharlal Nehru University (JNU). I decided to de-register from Ph.D. by end of 2003 for personal reasons. My work experiences at Jagori and Saahasee involving direct interaction with women from slums of South Delhi and North Delhi, which informed me that health reasons were cited even by Delhi women construction workers for their work changes. My work at Actionaid for a shadow

report submitted to the United Nations (UN), which involved listening as well as reading testimonies on various cases compiled by more than 150 non-governmental organisations and writing the case studies, particularly on women and urban poor informed me that policies in India lagged behind protecting women construction and domestic workers in many aspects. Policies on security of work, social security and safe work conditions were not in place whereas policies on minimum wages or maternity protection were many times violated in spite of being there.

In the meantime, in 2007 my previous supervisor Dr. Alpana Sagar had passed away of cancer. It was disheartening to come to terms with her early demise and I had lost my supervisor for my Ph.D research then. I had understood through secondary research by 2013 that the processes involving work changes of women construction and live-out women domestic workers was still not studied in India. The area of intersectionality and social determinants of health lacked studies on intersectional processes and the processes of exposures and vulnerabilities which shaped health, particularly in India such studies on women worker's health and work changes had not been done. My work as a researcher in two research projects on school children involving Integrated Child Development Scheme and Mid-day Meal Scheme at Azim Premji University (APU) and attending various lectures organised by APU notably by speakers Barbara Harris-Whyte, Gita Sen and Joseph Sitglitz pushed me further to pursue my Ph.D. Till then, I had not taken an active step towards going back to my Alma mater JNU and see how I could contribute towards the existing gap in these fields through my Ph.D study.

I was fortunate then to get the guidance of Prof. Ritu Priya Mehrotra for my doctoral thesis, who had herself worked on construction workers for her thesis and had a deep understanding of issues surrounding health. It was in 2013 that I started actively reworking my synopsis in the light of recent developments in theory and studies at a broad level. By mid of 2014 I was collecting data for my Ph.D using a grounded theory approach which would inform me of the social processes in the work changes of women workers and possibly would enhance the understanding within frameworks of Social Determinants of Health and Intersectionality. It was around the same time that I took a break from my work at Azim Premji University and focused on my doctoral work. I shifted my base temporarily to the place of my field work, Cuttack

city where I worked in the field for 7 months for my research. The field work was not just challenging, the experience at field was overwhelming. It required lot of preparedness for the moment to absorb all that was available in the field, the challenges of staying in Cuttack during summer and rains, especially and visiting the slums and attaining a certain level of confidence of women for them to consent for my interviews and survey were gradually overcome. The process of analysing the qualitative data took more than a year just to get a grasp over the data with iterative steps of going back and forth through the data. Only then I could delve deeper and notice emerging patterns. My published research papers on 'intersectionality' and 'exposures and vulnerabilities' have helped me put together my thoughts in a more effective and precise manner. This research work attempts to contribute towards understanding the intersectional processes of work changes and health reasons of women construction and domestic workers, the social determinants of women's health and agency of women's work decisions.

Publication Statement

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Chapter 1

Introduction

Background and Justification of the Study

Going by the dual model of economy, viz. formal and informal economy, there is a certain risk associated with informal work, be it insecurity of income or unhealthy work conditions (Basu 2009; Mehrotra 2007). "Informal work tends to occur in many different locations, such as construction sites, homes, and sidewalks. In such locations, the worker often assumes the risks of insecure, unsafe and possibly unhealthy work conditions. In formal work, the employer typically takes responsibility for managing these risks. The nature of employment relations among informal workers varies from occupation to occupation, but in most cases they are not covered by formal contracts and labour laws."[i] Basu (2009) finds two main characteristics of informal work that differentiate it from formal work and these two are the place of work, and the nature of employment relations. Harris-Whyte (2004) says that the fact informal economy "is not regulated by the state does not mean that it is not regulated at all, for there are many non-state means of regulation."[ii] Harris-Whyte put it forth that the kind of activity in informal economy 'has been seriously neglected in social and economic theory.'[iii] Besides casualisation of informal work becomes pertinent when work force is of substantial size and belongs to certain sections of society as revealed by National Sample Survey (NSS) data.Mehrotra (2007) specifies wage employment in informal jobs as without secure contracts, worker benefits, or social protection and occupies certain share of informal employment (outside of agriculture).[iv] Mehrotra (2007) presents the data on the enormity of informal sector in India. The data available and presented here is sectoral in its approach. He refers to 1993 data and says, "in India as much as 80.3 percent of the non-agricultural labour force is in the informal sector (with the remaining 19.7 percent in formal sector)."[v] As inferred of 80.3 percent of non-agricultural labour force, certain share is of wage employment. NSS wage employment data indicates variations according to geographical location, gender and class. NSS 68th round data (2011-12) shows that a higher proportion of overall population is engaged in regular wage/salaried employment in urban areas (43 percent) than the same (9 percent) in rural areas. In the rural areas, 10 percent of males were engaged in regular

employment than 6 percent of rural females. In the urban areas, almost equal proportion of men and women were engaged in regular employment.[vi]According to NSS 66th round data distribution of usually employed principal status + subsidiary status (ps+ss) by status of workers for each monthly per capita expenditure (MPCE) decile class at the all India level shows that in rural areas, the proportion of casual labourers is found to be higher in the lower MPCE decile classes and lower in higher MPCE decile classes. In urban areas, also casual labourers are found to be higher in lower MPCE decile classes and vice-versa. A reverse situation was found true for regular work, i.e., with higher MPCE decile class proportion of regular salaried employees was greater in rural as well as urban areas. In case of self-employed the trends differed.[vii] This trend signifies existence of multitude of intersectional positions based on variables of gender, geographical location and income, which exist just not as data based intersectional positions but are interspersed in discursive context of individual identities and experiences at multiple levels of existence. The data corroborates this by showing dependency of wage employment on these variables. The critique of dualistic modelas put forth by Harris and Todaro (1970) validates intersections and differences based on gender, class, geographical area and other associated variables (Note 1). Mehrotra (2007) puts this critique as "in particular dualistic models identified the function of the traditional (informal) sector in the economic system merely as a passive one with the labour force seen as reserve army, as a reservoir from which the expanding modern sector draws labour. In the dualistic models, the informal economy was depicted as a 'homogenous' entity disregarding the peculiarities and different dynamics within."[viii] This model overlooks issues of heterogeneity. In contrast, labour market is perceived as segmented by the 'labour segmentation approach' (Harris 1985). Harris (1985) refers to studies in Bombay, Ahmedabad and Coimbatore to further his approach, he says such studies indicate "the existence of compartments within labour market which are more or less self-contained and composed of non-competing groups of workers, whose options are severely constrained by social and institutional factors."[ix] However, labour segmentation or heterogeneity approach does not deal with issues of capital (state regulation) or labour agency and attributes this process to the market alone. Breman (2013) in his critique says that 'formal-informal construction of dualism' highlights the issues of informalilty in labour only, thereby downplaying the role of informality in capital or, portraying that capital belongs to 'the firm domain of formality'. He says

these are two sides of the same phenomenon and rather than merely asking questions on informal labour, there should be examination of capital in this globalisation era. Analysing informality of capital will raise questions on why economic transactions is not monitored, administered and regulated by the state.[x] Herod (2003) critiques neo classical perspectives as they solely focus on market forces, his ‘labour geography’ approach gives recognition to worker’s agency and conceptualises space as important in social processes related to work or capitalism. As Herod puts it forth "worker's lives are spatially embedded in the landscapes in which they live, that this spatial embeddedness may be enabling and/or constraining of their social praxis, and that workers will thus try to shape in particular ways the geographical structures and relationships within which they live their lives.”[xi] Herod does not view space as separate from social life, as they cannot exist without the other; he views space and social life as interlinked ontologically. However, within social life and worker’s identity, conceptualisation of women’s worker identity is only half-way through. This approach views “many women workers have much greater domestic responsibilities than do their husbands and, as a consequence, lead lives that are more closely tied spatially to the home and their children's routines than are men's.”[xii] But when women’s work is viewed in relation to lack of recognition and invisibility, then, women’s identity becomes central issue than merely labour agency in relation to work, space and social life. National Commission for Enterprises in the Unorganised Sector (NCEUS 2007) conceptualised women’s work in three dimensions; first, the larger issue of double burden of work, second, women workers and their invisibility, and third, conditions of work and discrimination. The committee says "the socio-cultural norms, double burden of work and limited opportunities limit employment possibilities for women in conventionally defined productive work. A woman, therefore, engages as a subsidiary worker, in part-time work and with considerable domestic duties, and yet is available for additional work.”[xiii] This could be one kind of explanation. Double burden of work arises as there is work done for employers that is paid and work that is done for family which is unpaid. Central Statistical Organisation (CSO 2000) provided official visibility to women’s double burden of work through a pilot study of utilisation of time by men and women in six states in 1998. The report classified the activities based on the 1993 System of National Accounts (SNA) into three categories: (i) those coming under economic activities that are included in the SNA; (ii) those that are not currently included in the SNA but are characterised as

extended SNA, which include household maintenance and care for the children, old and the sick in the household; and (iii) non-SNA consisting of the social and cultural activities, leisure and personal care. The study found that women spent a disproportionate amount of time in what is called extended SNA. On the other hand men spent a much greater time in SNA activities than women (Note 2). The result of this high work intensity was seen on the lower levels of health and well-being of the women compared to men.[xiv] Such data gives way for few inferences, first, women witness double/triple burden more than men, second, women's double/triple burden affects their employability and third, women's double/triple burden affects their health.

The area of enquiry of this study is the process of shifting for women construction and domestic workers due to health factors, this shift could be from previous construction or domestic work to any other work or, withdrawal from working status to non-working status. Health factors responsible for this shift or withdrawal constitute non-economic aspects responsible for employment shift or withdrawal in the labour market and pose research questions on processes which have been so far not studied. The study examines the reverse relationship, i.e. of health factors influencing women's economic activities. Non-economic reasons of employment shifts or withdrawal for construction or domestic workers, such as age or health have been identified by previous studies. However, the process through which health was responsible for work changes have not been studied. NSS 66th round shows that with increasing age more number of women left work than men. "65 percent of the aged males (60 years and above) in rural areas and 34 percent of the aged males in the urban areas were found to be in the labour force in comparison to 23 percent females in rural and 7 percent females in urban areas."[xv] Particularly in case of construction and domestic work, studies show non-economic aspects such as age (Dalmia 2012; Mehrotra 2010), ill health (Mehrotra 2000) and childbirth (Mehrotra 2010) responsible for shifts or withdrawal. Dalmia (2012) found that some women construction workers shifted to domestic work for reasons of age and other reasons in Delhi. "Women employed at construction sites in Delhi lamented that once they are in their 40s, they did not wish to continue, yet they had no supplementary skills to help contribute to the family's income."[xvi] In a large city like Delhi, they did not know where they could search for alternate employment or learn skills. The only alternate

option was to work in someone's home, but not everyone was happy with the salaries paid and often did not feel safe working in other's houses. Some women cited lack of basic toilet facilities for women at construction sites as the reason for shifting to another work.[xvii]Mehrotra (2010) observed that women who work as live-out part-time domestic workers were primarily migrants who moved to the city with their families or were former female construction workers who entered domestic labour when no construction work was available. At the same time, there was no guarantee of employment for domestic workers as employers could ask workers to leave with no prior notice or financial compensation.Instances of domestic workers losing their jobs due to childbirth or ill health were often reported. [xviii] Mehrotra (2010) concludes that women shifted from construction to domestic work due to lack of work availability in construction sector and ageing of women.[xix] Mehrotra (2000) found that many of the construction workers migrated back from Delhi within a few months due to difficulty in coping with the hard life or illness in Delhi. This resulted in breaks of work; other factors found for discontinuities in construction work were child birth, building assets in the village, 'got weary of life of a construction worker', and any prolonged illness amongst workers.[xx]

Health is an identified non-economic factor for work changes, the processes associated remain unknown. As brought forth through literature review, there are no studies in India that have looked into the process of employment shift or withdrawal for women construction and domestic workers due to health reasons and thereafter, implications for women's health. This process of shifting or withdrawal is enquired in this study by using the theoretical frameworks of intersectionality and social determinants of health. There is a gap with respect to studies on social processes, both in the area of intersectionality and social determinants of health, particularly in India. There are no studies which have at the processes of shifting for women construction and domestic workers in India due to health factors. Conaghan (2009) brings to notice the lack of intersectional studies on social processes and social relations, most of them focus on structure, identities and there has been lack of attention to historicity of unequal relations in intersectional studies. Hankivsky and Cornier (2009) and Dhamoon and Hankivsky (2011) attribute intersectionality as concerned with "simultaneous intersections of social difference and social identity and forms of systemic oppression at macro and micro levels in ways that are complex

and interdependent."[xxi] From such characterisation of intersectionality, Bauer (2014) infers the important distinction between social identities as source of related oppression or privilege, and the social processes or policies that may 'generate, amplify or temper inequalities between groups'.[xxii] The studies so far conducted in India on women construction or domestic workers and their health either associate domestic or construction work with certain intersections or narrate or categorise women's health symptoms. The exposures and vulnerabilities as part of these social processes with origins in intersectional position have not been looked at. Aspects of intermediate social processes of health reasons are exposures and vulnerabilities with structural causes and health consequences as put forth by Diderichsen, Evans & Whitehead (2001) and thereafter, by Sen & Ostlin (2007). There are studies which categorise the health issues found among construction workers or domestic workers, but there are no comparative studies. Baruah (2010) found that 13 percent of the men construction workers had sustained physical injuries, compared with 51 percent of women construction workers. Also, there was a higher percentage of women (89 percent) than men (74 percent) who said that they had physical problems associated with their work. For example, 70 percent of women reported of chronic backache.[xxiii] Mohankumar and Singh (2011) found that more than 64 percent of the labour households in the construction industry reported having undergone/undergoing economic stress driven psychological disorders, and turned to excessive drinking and smoking. Further, 55 percent of the labour households in the construction sector reported an escalation of domestic violence during the economic crisis period, the brunt of which fell mostly on women and children.[xxiv] Mehrotra (2012) in her study found that vulnerabilities of domestic workers were located in their lack of negotiating power in all aspects of their work.[xxv] Women domestic workers were found to be vulnerable to trafficking by agents and for being abused physically, psychologically and sexually. However, these studies have not situated health in the context of employment shifts or withdrawal even if, incidence of health has been brought forth.The intersectional theory is found more apt to look at women's identity, agency, processes and consequences with respect to health and work changes. Review of literature informs that there is a need for such study more so as there are few studies which have been conducted on social processes in the field of intersectionality and social determinants of health. This study attempts to contribute towards filling this gap.

Chapter 2 articulates the need of studies on social processes after identifying the existing gap in areas of intersectionality and social determinants of health. It cites relevant literature particularly, Dhamoon (2011); Hankivisky (2012) & Bauer (2014) who have pointed out the dearth of studies delineating the complexity of intersectional and health processes. It emphasises the relevance of such a study of social processes in the context of predominance of construction and domestic work among poor women, employment changes, dynamic health issues, and changes in intersectional position of women workers over time. Graham (2004) has called for a need to look at factors and processes of health. Her study of health policy documents of various countries found that this critical difference is usually overlooked while addressing health issues. In most of the studies, social factors influencing health status have been looked at as social determinants of health. However, Sen & Ostlin (2007); Diderichsen, Evans and Whitehead (2001) have delineated models of health which bring out the processes of social stratification, exposures, vulnerabilities or susceptibilities and health consequences. In India, review of studies on women construction and domestic workers Gothoskar (2013); Dalmia (2012); Mohankumar and Singh (2011); Baruah (2010); Mehrotra (2010) & Mehrotra (2000) reiterate that neither intersectional processes nor processes of exposures and vulnerabilities of women workers leading to a two-way relationship between health and work have been studied in any detail. Interrelated health and work changes constitute a significant phenomenon which is worth exploring given the gap or dearth of such studies.

Chapter 3 explains the rationale of study design, a mixed model research design inspired by Greene, Caracelli and Graham (1989) to study intersectional processes, exposures and vulnerabilities responsible for employment changes and health reasons. A survey method is followed by case studies to develop the understanding of employment shifts, wherein interpretivism underscores the epistemological framework. The chapter speaks of Strauss and Corbin's grounded theory (1990) as it forms the guiding principle of data collection and theafter, Charmaz's constructivist approach which was used in later part of the study for analysis. It lays out the principles and the understanding of these grounded theory approaches. Cuttack one of the oldest cities in state of Odisha was the location of the study. Some studies which have looked at slum areas and sanitation in the city and studies on prevalence of informal work and gender situation in Odisha have been drawn upon (Sahoo et.al

2015; GoI City Report 2013; Mitra 2006; Patel & Hans 2004). 12 slums from different areas in Cuttack city were purposively chosen for the study. 498 women were surveyed by random sampling and 33 women were interviewed by purposive sampling.

Chapter 4 begins with an understanding of socio-economic profile of women workers engaged in construction and domestic work, the women who shifted their work or withdrew from workforce and the women who particularly cited health as a reason of such work related changes. It starts off with examining the intersectional position of women workers and thereafter, categorising the women who had experienced work change and cited reasons differently, based on survey data of 498 slum women. It relates the survey data with the field notes taken to reflect on different experience of employment, work change of women workers and the social processes associated. It looks at the incidence of health phenomena as a reason of employment changes for women construction and domestic workers and its association with respondents' past work, years of past work and age during the shift in or withdrawal from work among the 498 women. The chapter puts forth the findings on intersectional position of caste, region of origin, gender and class and how it was found associated with women's residence, employment and its changes. It speaks of the intersectional position of gender and age and how it was related with women's work decisions including work hours, work days, and work changes.

Chapter 5 analyses the 33 case studies to develop an understanding of the processes by which intersectionality, health, and work changes are inter-related. In the course of analysis of case studies, it is realised that constructivist approach of grounded theory complemented Strauss and Corbin's approach in understanding the intersectional processes and intermediating processes of health. It speaks of the underlying similarities and differences of experiences of women construction and domestic workers who underwent work changes, particularly for health reasons. A deeper look at similarities reveals that common intersectional processes were interwoven into women's lives and work changes. It is while analysing women's lives and work changes, Charmaz's constructivist approach was found crucial for data analysis. The chapter brings forth the psycho-social and physical health exposures, the multiple processes or causal pathways of different exposure conditions and vulnerabilities of

such women workers who cited health as a reason for work change. The exposure conditions occurred on a regular/daily basis or during episodic events or during recovery phase from a health condition. These exposures were located in work, family, living and diet conditions and challenges in accessing health care. How these conditions criss-crossed and at what times were discovered through Strauss and Corbin's approach and Charmaz's approach. Accumulation of health risks and consequences was a key process which was inseparable from the processes of exposures and vulnerabilities. The vulnerabilities were rooted in gender and class wherein age, family and state support created differences in experiences of health and work changes. The identified health exposures and vulnerabilities give insight into the experiences and social processes associated with work changes and health reasons. This understanding helps in delineating the intersectional categories of gender, caste, region of origin and class and the differences of age, family support and state support.

Lastly **Chapter 6**, reviews the methodology of the study, particularly the grounded theory approach which was used for interpreting the case studies of work changes and mixed methods for understanding intersectionality and social processes. It looks back at the processes of exposure conditions, wherein women did/did not become vulnerable and the expression of agency in each of these social processes as it occurred to bring work changes. Understanding of women's agency and vulnerability form the backdrop of the discussion on the policy implications of women workers. The link between past, present and future was a logical conclusion to the study as it spoke of health reasons of work changes, the intersectional processes of women's lives, health implications and future policy implications for women construction and domestic workers. These interlinkages also brings forth the way the present study has adapted and extended gender based SDH by Sen & Ostlin (2007) while unravelling the processes responsible for women's work changes and health reasons.

Chapter 2

Frameworks for Understanding Processes of Health and Work Change

My field work on domestic workers and their health for my Masters of Philosophy dissertation brought forth approximately 10 percent of sample cases, as those who had shifted from construction work to domestic work for age and health reasons. This incidental finding invoked the first research question for the present study, which is how health acted as a determinant of women domestic workers' employment shift to construction work. This question was the starting point for my review of literature. To locate the context of shifts or withdrawal from construction or domestic work, I enquired into trends of labour market, worker position, work conditions in construction and domestic work and suitability of theoretical frameworks for the study. From these, the conceptual and analytical frameworks for the study have been developed.

I. Female Employment Trends

Economic Census 2012-13 reports of a loss in female employment in the period from 2004-05 to 2009-10; in rural areas, by usual principal and subsidiary status (UPSS) and current daily status (CDS) methods and in urban areas, by UPSS methods, there has been a decline in female employment. One of the possible reasons cited by the survey for this phenomenon was a significant number of women (137 million in 2009-10) opted not to work to continue their education.[xxvi] This possible explanation is not tested; simultaneous increase in enrolments for education and decrease in employment rates does not establish a causal relationship. Chowdhury (2011) contests this possible explanation of education being responsible for a decline in female employment. National Sample Survey (NSS) 66th round findings show a decline in Labour Force Participation Rate (LFPR) for women of all age groups above age of 15 in rural and urban areas. If education had been the reason, the LFPR decline would have been limited to the younger age group, who went for education (Note 3). But this could not be the case as there was an overall decline in women's employment including the older age groups. Chowdhury observes such processes suggest that not enough jobs

were available for women as older age women did not replace younger age women in employment. He points out that LFPR has been the lowest for women in 2009-10 since 1993-94. At the same time, Chowdhury compares the employment across sectors and finds that entire decrease in proportion of employment in the agriculture as well as the manufacturing sector has been compensated by an increase in employment in the construction sector, both in the rural (National Rural Employment Guarantee Act related) and in urban areas (growth in real estate). The services sector has remained stagnant with no decline or major change.[xxvii] Yet this growth in construction sector has not absorbed all the women facing declining employment opportunities. This is not straight forward as there is simultaneous loss of employment for younger and older women, growth in construction sector and casualisation of women's work in urban areas and there are multiple explanations. National Sample Survey (NSS) 68th round data (2011-12) shows Work Population Ratio (WPR) was low for females compared to males and urban females had least levels of employment (Note 4). WPR for persons of age 15-59 years in the usual status (ps+ss) was 57 per cent at the all-India level. This was 60 per cent in rural areas and 51 per cent in urban areas. WPR for rural males (82 per cent) and urban males (78 per cent) were considerably higher than rural females (37 per cent) and urban females (21 per cent). Likewise, according to current weekly status (CWS) approach and CDS approach, WPR for urban females was least at 20 percent and 18 percent respectively.[xxviii] In nutshell, work population ratio for urban females hovered around 20 percent. Among the women wage workers, less than half or 47 percent were casual workers. These women casual workers were mainly engaged in construction and manufacturing sectors, 39 percent and 29 percent respectively. A smaller proportion (20 percent) was engaged as domestic workers in private households. Majority of these women were clearly undertaking manual work in these sectors.[xxix] Trends indicate women being employed as casual laborers and less as regular workers compared to men.

The Economic Survey in 2004-05 shows an increasing trend of casualisation of labor force. The compound annual growth rate (CAGR) of employment on CDS basis for the period 2004-5 to 2009-10 was 1.11 percent per annum which was significantly higher than the growth of employment in UPSS terms. An increased intensity of employment is reflected by an overall increased availability of employment to workers based on CDS.[xxx] This indicates increase in employment by CDS methods

given the previous data which shows decline in female employment by UPSS methods in rural and urban areas. NCEUS (2007) observes a sharp growth of workers in the subsidiary statuscategory, but more so in urban areas than in rural areas (Note 5). This is a form of erosion in formal or full-time jobs and the increase in informal part-time jobs, and this has been true for both men and women. [xxxi] These explanations from different sources suggest a link between growth of workers in subsidiary status in urban areas, growth in construction sector and larger proportion of women getting employed as casual workers.

II. Studies Defining Women's Work

Studies suggest different processes associated with women's work such as vertical segregation, occupational segregation, and invisibility of domestic work, women intensive, exclusive constraints and greater time allocation for extended SNA activities. Studies also suggest casualisation of women labour force, wage inequalities between men and women, hinting at a link with these various processes. While job creation is located in opportunities to work, lack of recognition is associated with work/worker identity. Work availability, worker's available time for work and recognition of worker's work are different aspects related to women's work.

As mentioned earlier, NSS 68th round data shows that a higher proportion of overall population is engaged in regular wage/salaried employment in urban areas (43 percent) than the same (9 percent) in rural areas. This implies that geographical location for men or women determined their probability of getting regular employment. In the rural areas, 10 percent of males were engaged in regular employment as against 6 percent of rural females. In the urban areas, almost equal proportion of men and women were engaged in regular employment. There are differences between different sections of women, in other words, women are heterogeneous.

Sen & Ostlin (2007) found that women were typically employed and segregated in lower-paid, less secure, and 'informal' occupations.[xxxii] According to NCEUS (2007), women are often restrained by vertical segregation with in an occupation (Note 6). For instance, in the health sector as stated by the report, women are clearly concentrated as nurses, midwives and para-health workers, all likely to get lower

wages than men who are concentrated as physicians or in particular jobs even within the category of para-health workers.[xxxiii]

In India, substantial wage rate differences exist between men and women. For instance, in 2008 in agriculture, ploughing had an all India average wage rate of Rs.102.90/day, this task was usually done by men. If it was done by women worker, the average wage rate given was Rs.55.43, atleast a difference of Rs.45/day or more between wages of men and women existed. Wage rates for sowing, weeding, transplanting, harvesting and winnowing was substantially low compared to ploughing, but these tasks were usually done by women and the wage rates were in the range of Rs.65-Rs.68/day, the same works if done by male worker had a higher average wage rate in the range of Rs.80-90/day.[xxxiv] By 2013, in another 5 years, there was a wider wage difference existing. Average wage difference between male and female workers for ploughing was atleast Rs.72/day than the earlier Rs.45/day. Similarly for sowing the difference was atleast Rs.33/day than earlier Rs.15-20/day. The wage rates for sweeper and unskilled worker in urban area also as compiled by Labour Bureau in 2013, showed gender based differences. All India average wage rate for male sweeper was Rs.120.76/day and for female sweeper it was Rs.102.72/day. Average wage rate for a male unskilled worker was Rs.168.43/day and for a female unskiller worker it was Rs.127.34/day.[xxxv] These statistics not only reflect on wage differences, but also on occupational segregation for ploughing, masonry work, carpenter work, etc. In case, of carpenter and blacksmith, there was no data available for wage rates of female workers since there were none. There are similar evidences at international level; McGibbon (2010) cites the case of Canadian women who are less likely to be employed than men and they earn an average of 62 percent less (Statistics, Canada 2005).[xxxvi] Gender Development Index (GDI) is a composite index to measure any inequalities between men and women on life expectancy, education and per capita income. GDI in 2006 showed inequalities between men and women on education and income measures.[xxxvii] These inequalities lie at the surface level. Underneath lie gender biases, norms, lack of recognition of work, etc.

Chandrasekhar & Ghosh (2012) in their analysis of 66th NSS round data state that there has been a drastic decline in women's employment and there has been an increase in casual employment for men and women in age group of 25-59 years.

Reasons cited in their analysis for the decline in LFPR for women were inadequate job creation on a usual basis, and lack of recognition for women's work."[xxxviii]

NCEUS (2007) conceptualises women's work in three dimensions; first, the larger issue of double burden of work, second, is women workers and their invisibility, and third, is conditions of work and discrimination. The Committee says, "the socio-cultural norms, double burden of work and limited opportunities limit employment possibilities for women in conventionally defined productive work. A woman, therefore, engages as a subsidiary worker, in part-time work and with considerable domestic duties, and yet is available for additional work."[xxxix]

The CSO (2000) found that women spent 17 per cent more time in SNA plus extended SNA activities compared to men in six states, these concepts provided official visibility to women's double burden of work. The result of this high work intensity was seen on the lower levels of health and well-being of the women compared to men. Among women in the prime age group, 15- 59 years, 53 per cent in rural and 65 per cent in urban areas were engaged in domestic duties by principal status in 2004-05.[xl]

Domestic work at home is not taken into account when economic activity is enumerated; NSS classification excludes this. The term 'economic activity' as defined in the employment and unemployment survey of 68th round (2012) includes "all the market activities performed for pay or profit (this involves production of goods and services for exchange), and non-market activities (agriculture, fishing, etc. which result in some production) and non-market activities related to the own-account production of fixed assets (engaged as laborer in own account construction such as of wells, houses)."[xli] Domestic work at home remains an invisible work. "More than one third of these women engaged in domestic duties for the major part of the year by principal status reported that they would engage in productive activities if such work was available within the confines of their homes."[xlii] In 2004-05 only one-third of the women workers from non-agricultural force worked in conventionally designated workplaces. About 54 percent of all unorganised sector women workers (from the combined total of urban and rural areas) worked from their homes.[xliii]

Bisht (2004) found that 'women's labour was considered as family labour' in households of Garhwal, it lacked remuneration and recognition in spite of being 'crucial for men's migration' since women sustained households as they carried out work of traditional food systems in men's absence.[xliv] Women workers wanted to work from homes or worked from homes is indicative of the internalisation of gender norms, gender roles and invisibility of women's work.

The economic conditions often push many women to do additional work besides the strenuous work at their own homes. Kantor (2002) views gender norms imposing constraints on women's work as she categorises the constraints as women intensive and women exclusive. She says, "while all marginalised people are constrained in their economic opportunities, women face more difficult challenges due to constraints that are women intensive and/or women exclusive (Carr, Chen and Jhabvala 1996). Women-intensive constraints affect both poor women and poor men due to their position of relative poverty and powerlessness, but due to unequal power relations between men and women of the same class, they affect poor women more."[xlv] Kantor elaborates "women-exclusive constraints generally result from norms institutionalised at a macro level that affect women due to their gender. Some of the 'women exclusive constraints' could be restricted mobility or a more demanding role for women in the family. This division of labor evolves from the limited number of work locations available to women in South Asia, combined with women's lower human capital levels and traditions regarding what work is appropriate for women. Often, it is those activities that are most similar to domestic work that are more readily available to women, suggesting this work is perceived as unskilled and therefore is undervalued (Stichter 1990). These factors combine to ensure women are paid less than men for similar work or that they are segregated into lower-paying, lower- skilled activities."[xlvi]

III. Woman's Work and Gender Norms

As cited by Razavi and Miller (1995), Collier locates four distinct processes that account for why women face differential constraints upon economic activity — processes based on underlying "social conventions". First, the presence of discrimination outside the household which are in labour markets and credit markets; second, role models are gender-specific in markets, third, within the household there

are asymmetric rights and obligations between husband and wife, such that women have little incentive to increase their labour input and the fourth, is the burden of reproduction with its attendant demands on women's health and time (Collier, 1989).[xlvii] The four distinct processes unfold in so called private and public spaces; these processes are interwoven and ultimately influence women's employment and health. The gender aspect of reproduction is closely linked to the gender aspect of production. The domestic duties at home overstrain the women and reduce their chances of engaging in labour market. As a result, the economic structure and social structure represent the case of mutual reinforcement.

Gender norms permeate way of life in homes where girls are born, socialised, married and the larger community where they live. Chakravarti (1993) elucidates the subordination of women in brahmanical society in three ways, first, is the 'naturalised' subordination of women as they internalise the social control over them, second, is the authority given to male kinsmen such as fathers-in-law to control women's behavior in conjugal homes and the third, is the use of violence against women.[xlviii] The gender principles act in coordination with caste principles towards subordination of women. She states that caste and gender form the principles of organising the social order; in other words, these maintain and reproduce hierarchical relations. Chakravarti emphasises on the mechanism of internalised control and refers to Manu and Tryambaka to substantiate her point. Control over womens' sexuality was indirectly achieved by focusing on 'caste purity' and by attaching reverence to the ideologies of 'streedharma' or 'pativratadharma'. This reflects on internalisation of social control by women. The social and cultural environment shaped this internalisation of an ideal woman in a brahmanical society. She cites Tryambaka's text (similar to Manu's explanation); the text narrates how the ultimate social control is achieved when tension between 'nature' and 'culture' is resolved, as a result, women not only accept their subordination, but also consider their subordination as a mark of distinction in society.[xlix] The inference here is that these mechanisms of social control of patriarchy are not exclusive to brahmanical society; these could permeate different caste societies, and could act in coordination with various structures of domination such as of class, caste, etc. The use of force against women and authority of male kinsmen embody the external forces of patriarchy that operate to subordinate women. These need not be internalised by women to inflict miseries on themselves,

but internalisation of social control could keep away women from questioning or acting against any such kind of subordination.

Gender inequalities are manifested in certain gender practices. For instance, Fazio (2004) shares, "girls in some contexts are fed less, educated less, and more physically restricted. They are often viewed as less capable or able, and in some regions seen as repositories of male or family honour and the self-respect of communities."[l]

Garcia and Moreno (2006) witnessed restrictions on women's physical mobility, sexuality, and reproductive capacity as norms of society rendered these natural and normal; a form of expression of restrictions was violence against women. Sen (2007) states 'accepted codes of social conduct and legal systems condone and even reward violence against women'[li].

Folbre (1994) says "individuals are born into social structures that shape their sense of identity and ability to pursue their interests. Choice, in other words, is limited. A theory of social structures is key to any conceptualisation of the context in which choice takes place."[lii] In case of employment, the choices could become limited when individual from certain sections of society get confined to certain occupations and sectors. Individuals could be constrained or enabled when they enter or quit or shift employment, it depends on the case or groups of cases.

Marxist feminists ask for bringing women into the public labour force as a solution to what they call 'the woman question'. They recognise domestic labour's use value since its products are consumed within the family or, it has an exchange value in the economy outside; western advocates of wages for housework suggest that the state pay housewives as a solution.[liii] But this approach subsumes 'gender' question by attributing 'use value', 'exchange value' or 'surplus value' to labour done by women, it underplays the role of deep rooted gender norms and practices, and interlink between private and public spaces in bringing any meaningful change. In case of women from lower economic class where 'survival needs' force them to work in spite of the double burden and restricted mobility, 'the woman question' will not generate enough answers.

Harris-Whyte (2001) says, "domestic labour produces new labour power for the wage labour market and protects and sustains it when it is unemployed, incapacitated or

past coping with the physical toil. This labour is female." She is categorical about how "the process is not a straight subsidy between the genders because unpaid domestic labour cannot be reduced to a money equivalent. Reproductive strategy also varies with class position."[liv] Mohanty (1997) criticises the reductionist and homogeneous approach behind the idea of 'Third World Difference' or "Third World Women" produced under Western Feminisms. Her criticism brings forth the relevance of understanding differences within these homogeneously constructed categories, 'the fundamental complexities and conflicts that characterise the lives of women of different classes, religions, cultures, races and castes in these countries'.[lv]

IV. Shifts or withdrawal Identified in Construction and Domestic Work

Mehrotra (2010) found that women workers had shifted from construction to domestic work for both fluctuations in work availability in this sector as well as for women's age related issues that hindered their work. Majority of the domestic workers had either shifted their base from village to cities or had shifted from construction work.[lvi]

Mehrotra (2000) found discontinuities in women construction worker's work due to various factors which included reasons of illness, child birth and being worn or burnt out.[lvii]

Dalmia (2012) found that often domestic work was the only work option available for women in their 40s, once they left construction work. The reason for leaving construction work included age related issues and work conditions such as lack of basic toilet facilities for women at work sites in some cases. [lviii]

Mohanty (2001) found that 5 out of 46 women (more than 10 percent) had shifted from construction work to domestic work for health reasons.[lix]

Mohankumar and Singh (2011) state that education and acquired skill enabled workers to switch to alternative employment during a crisis period. However, they found that proportion of workers reported to have not attended schools was as high as 64 percent in the construction industry.[lx] A similar finding was also reported by Dalmia (2012).

Gothoskar (2013) found cases of Tamil women domestic workers who shifted from agricultural work post commercialization of agriculture to Delhi in 1970s. She says "combined with modern commercial agriculture, changes progressively ruined the living conditions of the poorer sections dependent on agriculture, with a consequent loss in land rights. These changes resulted in increasing mechanisation and a reduction in the need for agricultural workers."[lxi]

The trends for work conditions and work changes for construction work and domestic work differ.

V. Conditions of Construction Work

NCEUS (2007) observes that there is a trend of categorisation of women construction workers as unskilled workers, in a broad 'others' category. The Committee does not conclude of vertical segregation from this data, as women have some presence among the brick-layers and stone masons and tile-setters.[lxii] Presence of some women in these categories of masons and tile-setters is an exception and does not signify the trend for the majority, who were treated as unskilled and subordinates to male masons. Other studies on women construction workers show findings on vertical segregation of women construction workers; lower status and lower remuneration are associated with women workers. There is a higher probability of women construction workers being retrenched or paid less in the event of economic crisis.

Baruah (2010) found that in Ahmedabad 92 percent of the female respondents/construction workers identified themselves as 'unskilled', although a small number were engaged in semi-skilled tasks.[lxiii] She concludes from the findings of SEWA surveys in 1998, 2003 and 2007 that women in construction work were employed as casual laborers, mostly as head-load workers or as cleaners. She states that the construction labour market is segmented along gender lines in both developed and developing countries, with women concentrated in low-paid jobs, or working without remuneration, while men undertake the better-paid skilled work. She observes that there are barriers to women's entry into the skilled construction trades almost everywhere in the world (Little 2005; Price 2000, 2006).[lxiv]

Dalmia (2012) corroborates presence of vertical segregation in construction industry; she found that women employed at construction sites in Delhi did the 'unskilled work

of manual labourers'. They were responsible for tasks such as sweeping, picking up and throwing away the rubble from the site, assisting *meestris*/masons by carrying and handing out bricks and making the cement mix. These tasks did not require training and were classified as unskilled. Women were resigned to the work they did.[lxv] Women imbibed the gender norms of their expected subordinate roles than men at work place; there was some kind of internalisation of work norms.

Mohankumar & Singh (2011) identified some of the characteristics of construction industry which were gender based and discriminatory. Women workers were not allowed by tradition to assume the status of main mason. They remained mason's helpers irrespective of their experience and physical capability. Their male counterparts could however graduate to mason's status within 12-24 months of continuous work and to a main mason's status after few years. In addition, women were never paid the same as men. "The daily wage rate of a mason and carpenter in Jaipur city was Rs.250, while a mason's male helper received Rs.150, his female counterpart had to be content with Rs.130 (June 2009)."[lxvi] In the event of economic crisis and slow down of construction activity, master male helpers were preferred to female workers and the daily wage rate for males fell to Rs.130.

In a study by Basu and Thomas (2009) in Mumbai, of all the casual women workers, construction workers were the least satisfied with their work because of the long hours of arduous physical labour combined with a greater likelihood of being sexually harassed by employers and the lack of flexibility in terms of work hours.[lxvii]

Baruah (2010) found the issue of sexual harassment faced by women workers. Many women construction workers spoke of sexual harassment and rude behaviour by contractors. Women preferred to either go in groups to look for work to avoid any sexual harassment or stay back at home if none could accompany them that day.[lxviii] In many ways, gender norms and practices of vertical segregation, sexual harassment, and lack of safe toilet facilities affected women construction workers.

VI. Conditions of Domestic Work

Studies on domestic workers in India indicate the lower status of work and how it is predominantly left to particular class and group of women, especially poor migrant women workers. Gothoskar (2013) contexualises the history of emergence of women

domestic workers in India in course of certain events in 1970s, such as the access of men and a small section of women of the upper castes/classes to educational and employment opportunities and the denial to women of the lower castes/classes. This created an ideal situation whereby the women and some men from the lower castes/classes were available for work at the homes of the upper castes/classes. “This was ideal also because there was then some postponement of addressing the entire question of the sexual division of labour at least in these homes.”[lxix] She adds that the boys and the men not only get precedence over girls and women in terms of resources on education and training, but all income-earning resources and capital that belongs to the family is reserved for the men. The only possible resource women have access to is the gold that is often just dead capital with an ‘emotional value’. Women have little access to income-earning resources and capital vis-à-vis the men in family. Women's mobility and sexuality is controlled by limiting work opportunities outside and inside. All these create conducive conditions for women from certain sections being employed as domestic workers. Gothoskar declares categorically that ‘care work’ is confined to certain sections of society, be it based on gender, class, caste or ethnicity.[lxx] Mehrotra (2010) found that women from particular castes and sections usually do domestic work. In maximum cases, scheduled caste workers (mostly migrants to the city) worked as domestic workers. 18 percent of domestic workers were widows and separated women.[lxxi] Mehrotra says, “the most common form of domestic work done by part-time workers was sweeping and mopping (done by them in 75 percent of the households); washing dishes (in 60 percent households); washing clothes (in 35 percent households); dusting (in 16 percent households); and cooking (in 16 percent households). Other forms of work, though only in a small percentage of households (ranging from 0.1 percent to 2.5 percent) included chopping vegetables, washing bathrooms, folding clothes, taking care of children, ironing clothes, making dough, shopping, making rotis, doing *malish* (body massage) (0.2 percent) and preparing tea.”[lxxii] Non-payment of timely wages, absence of weekly leaves or holidays and verbal abuse by employers were some of the commonly found work conditions according to Mehrotra (2010). Getting sick leave for women depended on the good will of the employer.[lxxiii]

Evidences of discrimination towards domestic workers have been found by studies outside India too. Kaur (2010) found that primarily women were being employed as

domestic workers and they suffered from multiple disadvantages. The 'domestic servant' was not eligible for rest days, fixed hours of work, holidays and conditions of service, termination, lay-off and retirement benefits, among others.[lxxiv]

Lan (2003) looked at foreign immigrant domestic workers in Taiwan who stayed at employers' home. When the home became a workplace, both employers and workers redefined and safeguarded their private zones. She observed the contest that went on between women employers and women domestic workers or 'global cindrellas'; the interactive dynamics that went on to reproduce and negotiate social inequalities between these two sets of women.[lxxv]

NCEUS (2007) observes that the biggest problem faced by the domestic workers across the country is their non-recognition as workers. The domestic workforce was excluded from labour laws that enforce important employment-related issues such as conditions of work, wages, social security, provident funds, old age pensions, and maternity leave. They did not come under labour laws – had no right to workers' compensation, weekly holidays and minimum wages.[lxxvi] The International Labour Organisation (ILO) ratification no.189[lxxvii] that guarantees domestic workers decent and secure work has not been ratified by India.[lxxviii]

VII. Theoretical Frameworks Considered and Used

Intersectional Theory

Epistemologically, intersectionality contributes to a number of knowledge bases such as feminist philosophy, critical race theory and critical legal studies. In context of India, in addition, caste theories, migrant worker studies, ageing and informal women worker studies, are other such areas where it could contribute. Intersectionality is different from unitary approach which uses single categories for comprehending inequalities and is also different from multiple approach which uses multiple categories in an additive manner for explaining differences. Intersectionality is complex, borne out of interwoven identities of an individual and underlying social processes as well as social structures that dictate social relations and experiences. Hancock (2007) says going back to literature reveals that there have been slippages in use of multiple identities and intersecting identities.[lxxix] Multiple approach is bereft of the complexity that intersectional approach can focus on. Intersection is not simply

additive layers of multiple identities. To illustrate from the Indian context, it could be the identity of a lower caste single woman in an urban slum, wherein structures of caste, class and gender influence the social relations and processes of job availability, job seeking, remuneration, negotiations, control over earnings, etc. This is not the same as when one looks at job issues arising out of one's identity of being a woman, then from the identity of lower caste, slum inhabitant and then, from the single status. The latter approach is additive in nature and exemplifies multiple approach. In a global context, Groenmeyer (2011) illustrates intersectionality with an example, "using standard discrimination analysis, courts would fail to see that there is discrimination against those who are single, black and female. It is the singular identity of single-black-woman which is the subject of discrimination in the housing market. This is intersectional discrimination."[lxxx]

The conceptualisation of identity in intersectionality is complex, however there are different perspectives even on how complex this conceptualisation could be. There are differing views on where identities are located, in the material or discursive context. Material context is objective and discursive context is subjective, implying positivist and interpretative traditions respectively. Gitlin recognises the significance of discursive context and the possible repercussions if it is over emphasised. It runs the risk of marring social enquiry. Gitlin's critique sees "the construction of identity as a kind of mistake. He believes that a strong sense of group identification may be understandable but that an insistence on identity's political salience is ultimately irrational, often opportunist, and strategically disastrous."[lxxxi] Fraser is very critical of identity-based politics. She is critical of discursive contestations of identity, but does not dismiss it altogether. At the same time she discards the possibility of 'unselfconscious universalism' and implicates the existence of identity in material context to some extent. This is a middle position on where identity exists, even though it attaches greater relevance to the material context.[lxxxii]Conaghan (2009) highlights another type of dilemma that could exist between contexts of identities. She says "traditionally, and particularly in a Marxist context, class has been understood in 'relational' rather than 'locational' terms, that is, as an expression of 'objective' structures rather than 'subjective' located experiences. While identity analyses tend to highlight experiences of inequality and law's characterisation of and response to those experiences, class discourse tends to focus on the structured processes and relations

which produce and mediate experience. For similar reasons, identity discourse also limits the reach of gender inequality analysis. In a politics of identity framework, gender is positioned within a model of social relations in which different groups clamour for recognition and access to political power. As a result, the specificities of gender disadvantage, for example, the centrality of labour in structuring patterns of gender relations, is at risk of being overlooked or marginalised."[lxxxiii]

McCall (2005) outlines the intersectional locations of gender, race and class and inequalities based on her analysis of "regional labour markets" in four cities (non-metropolitan) representing industrial, post-industrial, immigrant and high-tech manufacturing scenarios in comparison to national data on the same indices of United States of America.[lxxxiv] She outlines three notions of and methodological approaches to study identity, which are anticategorical, intercategorical and intracategorical (McCall, 2005).[lxxxv] Each of these acknowledge the discursive nature of identities and power dynamics of constructing it. Anticategorical approach is skeptical of categories or identities since it recognises the politics behind it, the possibility of exclusion by demarcating categories and deconstructs the analytical categories. Intercategorical approach strategically uses or does not use categories for political or other purposes. The third, intracategorical approach even though uses categories of identities, is not bound by them and looks for differences with in or beyond such notion of categories. She cites Dill (2002), "people whose identity crosses the boundaries of traditionally constructed groups" is taken into account, while putting forth the relevance of intracategorical approach. She emphasises that intracategorical complexity tends to focus on particular social groups at neglected points of intersection in order to reveal the complexity of lived experience within such groups.[lxxxvi] In empirical research, this discursivity of identities needs to be kept in mind while categorising or questioning categories/identities which could explain different experiences of different groups. This discursivity applies to identities as well as creation of knowledge.

There are critics (post structuralists and post modernists) who believe any notion of categories hinders the growth of knowledge. Discarding all forms of categories theoretically and methodologically is one kind of intersectional approach. Smith (2009) states "categories and concepts such as race, class and gender must not limit thinking in social science enquiry and social science must go beyond such

concepts."[lxxxvii] Implicit in such anticategorical position is that there are no fixed categories that could explain issues, there are individual variations which keep evolving. The limitation of this approach is that it renders the terrain of enquiry undulated and absence of categories render macro analyses and generalisations difficult. The alternate position, as McCall names it 'intercategorical' approach believes in strategic use of categories when required. Use of categories, yet not a constricted view of limited categories paves way for nuanced analyses. However, it could choose not to use categories at all. This would give rise to similar issues as discussed with anticategorical approach. The 'intracategorical' approach which goes by categories, but is open to the differences within categories is best positioned to study intersectionality of women/women workers. Collins (2004) describes a model used by Cohen (1999) to examine the politics of intersectional identities, the consensus and crosscutting political issues. "Consensus issues affect all group members, although not necessarily in the same way. Crosscutting issues are perceived to affect one subgroup more than another."[lxxxviii] Hancock (2007) argues for 'new conceptualisations of categories and their role in politics' rather than discarding them completely. Such an approach is receptive to new categories and differences. The limitation of this approach is that methodologically, it focuses on identities, differences, categories, measures of inequality and ignores the intermediate social processes shaping inequalities between demarcated categories or emerging categories. For instance, this would imply the processes through which gender and caste inequalities are perpetuated and not just gender and caste identities and associated wage inequalities or housing inequalities or health inequalities. Dhamoon (2011) finds that four aspects of socio-political life are in the scope of in intersectional-type work, 'identities of an individual or social group that are marked as different (e.g., a Muslim woman or black women), the categories of difference (e.g., race and gender), the processes of differentiation (e.g., racialisation and gendering), and the systems of domination (e.g., racism, colonialism, sexism, and patriarchy). Some times these four aspects of analysis are distinct, and other times they merge into one another or a combination exists.'[lxxxix] These subtle differences in intersectionality need to be taken into account to understand the complexity. Bauer (2014) finds that 'without an emphasis on intervenable processes or policies, a quantitative intersectionality focused purely on intersecting identities or positions would run the risk of continuing to reinforce the intractability of inequity, albeit in a more detailed or nuanced way.'[xc]

There is a need to looking at identities, categories of difference in relation to the processes to understand the underlying power dynamics, but not getting restricted by these categories and remain open to new ones (Dhamoon 2011; Hankivisky 2012; Bauer 2014). Also, the identities could have objective dimensions, subjective dimensions. In other words, multiple dimensions of identity exist and there is a need to specify the dimensions through which identities and categories are studied. An intersectional perspective examines “the relationships and interactions between multiple axes of identity and multiple dimensions of social organisation—at the same time” (Dill 2002).[xci] These occur in relation to processes and systems which demands attention to the historicity of relations, processes and domination.

Social Determinants of Health (SDH)

The theoretical approach of social determinants of health recognises the causal determination of social inequalities in health by structural forces; it locates the health inequalities in systemic inequities and inequalities of social groups. By taking this position, it extends the argument that structural factors are crucial and causal for health outcomes. Differences in health could exist within and between countries, between various social groups. Krieger et.al (2010) find gaps in the approach of social determinants of health as it overlooks the political factors and addresses only social and economic environment as responsible factors of health thereby questioning de-politicised focus on social environment. The approach used for the study is inspired from the model of SDH that locates itself in how societies reproduce hierarchical relations, labour relations, inequities in the broader economic and political context to impact health and health inequities.[xcii] Krieger (2001) calls social determinants of health as “both specific features of and pathways by which societal conditions affect health and that potentially can be altered by informed action. As determinants, these social processes and conditions are conceptualised as essential factors that set certain limits or exert pressures, albeit without necessarily being deterministic in the sense of fatalistic determinism.”[xciii] It is important to take note of the difference between specific features and pathways, for instance, the same specific features of poverty and gender discrimination could criss-cross in various unique pathways to determine health. Krieger finds social production of disease/political economy of health refers to related (if not identical) theoretical frameworks that explicitly address economic and

political determinants of health and distributions of disease within and across societies, including structural barriers to people living healthy lives. These theories accordingly focus on economic and political institutions and decisions that create, enforce, and perpetuate economic and social privilege and inequality, which they conceptualise as root or "fundamental" causes of social inequalities in health.[xciv] The structural factors and sources of health inequality as embodied in social, economic and political systems are key to this framework.

Some of these inequalities are found in gender, race and class based differences in privilege and deprivation. Marmot (2008) acknowledges the pervasiveness of gender inequities in all societies. Biases in power, resources, entitlements, norms and values, and the way in which organisations are structured and programmes are run impact the health of millions of girls and women. “Gender inequities influence health in multiple ways, through discriminatory feeding patterns, violence against women, lack of decision-making power, and unfair divisions of work, leisure, and possibilities of improving one’s life.”[xcv]Doyal (2000) observes that income, geographic location and age have implications for health of women.[xcvi] This approach brings forth the cross-cutting issues within gender category. She says, there exists a complex interaction between social, psychological and biological dimensions of health. At the macro-level, there exists the material context within which women’s health is formed. There also exist the cultural constraints within which women make choices affecting their own well-being. Doyal’s view of women’s health raises the philosophical and methodological issue of understanding health inequalities along different interlinked dimensions of health. One can infer here that material context of women provides or denies opportunities for health care, work, rest and leisure for good physical and mental health which are located in political and economic systems. Alternately, cultural constraints are the restrictive notions of femininity and gender roles at home and at labour market located in social structures which affect women in multiple ways, including their material context. It is extrapolated here that the material context and cultural context point towards objective and subjective ways through which duality of structure and agency (Doyal uses the word ‘choice’) interact and women’s health is influenced along different dimensions (social, psychological and biological). It is through these material and cultural contexts, specific features and pathways traverse to produce multiple health inequalities. Doyal (1995) asserts of a need to

relate these broader issues to the physical and psychological state of individual women to their lived experience of health and illness. The house in which a woman lives will significantly influence her health, both directly and indirectly through its effects on her domestic labour. Of course, homeless women are usually at greatest risk, but provision of shelter alone is not enough; other associated factors of kind of shelter, surroundings and hygiene have health effects.[xcvii] She cites the example of the United Kingdom, where women in the lowest social class are much more likely to experience chronic illness than their more affluent counterparts. In a national survey, 46 percent of unskilled and semi-skilled women aged 45 and 64 reported a long standing illness compared with 34 percent of professional and managerial women. Women in the lowest social groups were also more likely than those in professional and managerial groups to report that illness limited their daily activities (30 percent in comparison with 20 percent) (Bridgewood and Savage 1993).[xcviii] The theoretical approach of social determinants of health is positioned on the importance of systemic inequities and inequalities for health inequalities. Graham (2004) has criticised health policy documents for speaking of factors and processes at the same time.[xcix] The environment or position would be different than the process associated. Diderichsen, Evans & Whitehead (2001) proposed a framework on globalisation and SDH that identified "four main mechanisms – social stratification, differential exposure, differential susceptibility, and differential health consequences– that play a role in generating health inequities in the larger social and political context, globalisation and differences in health systems."[c] Sen & Ostlin (2007) provided a framework for gender as a SDH, wherein they identified three important stages, the structural causes of SDH, the intermediary factors of SDH and the consequences of health. While social stratification and structural processes consisted of the structural causes, the intermediary factors of SDH were discriminatory values, norms, practices and behaviours, differential exposures to diseases, disabilities and injuries, biases in health systems and health researches. The complex of intermediary factors affected each other.[ci] The third stage is the health outcome. The structural causes of SDH and structure of intersectionality could mean commonality. Doyal (1995) observes that neither 'women' nor 'work' are homogenous categories. "Factors such as marital status, whether or not she is a single parent, the domestic division of labour in her household, her age, the number of her dependents, her skills and her attitudes to employment will all affect the influence of her work on her well-being, as will the

nature of the job itself."[cii] Such analysis is based on similar principles which define intersectional and social determinants of health approach.

Exposures and vulnerabilities: Intermediary Factors in Framework of SDH

Review of literature informs of the exisiting work on vulnerabilities and exposures, some of which has been cited here. Sen & Ostlin (2007) emphasise on the roles that biological and social bias play towards exposures and vulnerabilities for health conditions. They cite the example of haemophilia, which even though determined biologically could be aggravated by lack of access to good health care and the latter condition is a state of vulnerability. Social and biological bias could span out in different ways. Sen & Ostlin (2007) define vulnerability as one that "reflects an individual capacity to avoid, respond to, cope and/or recover from exposures. As such, one's ability to deflect or absorb exposures with differing health effects and social consequences depends on a range of normative and structural social processes."[ciii] As an inference from this work, these processes associated with recovery could be context specific, and exposure does not necessarily mean everyone exposed is vulnerable. Soucie (2000) puts this as people suffering from diseases from marginalised social backgrounds are more vulnerable with worse complications and survival rates than those from more privileged social backgrounds.[civ]As I understand from these study accounts, exposures and vulnerabilities together determine health and not just one of these. Krieger (2003) gives illustrations of gender relations that are conducive for exposure to certain health conditions among women. For instance greater prevalence of HIV/AIDS due to needle-stick injury among female health workers compared with male health care workers providing patient care. For the same health condition, gender relations as well as gender segregation of workforce are causal in nature as more women were found to be nurses and are prone to needle-stick injury. Gender based occupational segregation and occupational exposures result in certain health conditions such as HIV in this case. Krieger highlights another case of earlier age at onset of peri-menopause among women experiencing greater cumulative economic deprivation over the life course.[cv] This health condition of women even though is sex-linked, is accelerated by life-long poverty; this underlines socio-economic conditions over a period of time. Sen & Ostlin (2007) point to the source of vulnerabilities and exposures as values. They elaborate, "gender biased values

translate into practices and behaviour that affect people's daily lives, as well as key determinants of wellness and equity such as nutrition, hygiene, acknowledgement of health problems, health-seeking behaviour, and access to health services to the extent that the latter are in the hands of communities. Health equity and wellness can be affected through the preferred sex of children, and practices surrounding coming of age and menarche, adolescence, sexuality and marriage, childbirth, widowhood and divorce."[cvi] In each situation, women are vulnerable to certain health outcomes. These studies show gender segregation of workforce, gender relations, and poverty as source of exposure for health of women. The dual work or double burden of women is a unique condition of exposure with health outcomes. Doyal (1995) explains that most women continue motherhood and their domestic responsibilities with economic activities both inside and outside the home. In poorest parts of the world, it is the physical strains of household labour that become more visible as women's workload intensifies against the backdrop of social upheavel, economic recession and ecological deterioration.[cvii] McGibbon (2010) found similar evidence. The majority of women combined paid employment and unpaid domestic work to maintain themselves and their households. Such a situation had profound implications for their health and well-being, more so when the nature of their relationship with the labour market was precarious. McGibbon points to the structural, rather than individual-based lifestyle as roots of women's ill health.[cviii] Doyal points to the conditions responsible for illness which emerge from structure, she says illnesses can be traced back to women's daily living conditions. Health outcomes are determined by health inputs, such as food, water, shelter, physical and psychological security.[cix] Each of these health inputs are affected by gender norms and practices and create multiple points of exposure for women's health.

Ostlin (2001) states even where men die earlier than women, most studies on morbidity from both high and low income countries show higher rates of illness among women. Thus, women's potential for greater longevity rarely results in their being or feeling healthier than men during their lifetimes. Women lose more DALYs (disability adjusted life years) when it comes to HIV, reproductive infections and cancers. There is significant increase in this loss of DALYs when morbidity, disability and mortality related to maternity are taken into consideration. Other health conditions where women lose more DALYs than men are related to eye sight,

migraine, mental health (including insomnia), muscle and bone strength, ageing (dementias), nutrition and burns. [cx]

Gender discrimination and biases affect access to health services and treatment, this has been extensively documented (George, 2007b, Iyer, 2007). "Gender, interacting with poverty and other factors, directly affects how health systems and services are structured and organised and how and which individuals are able to access them" (Barker et al., in press).[cxi]

A number of studies on relationship between structural factors and health consequences, such as HIV/AIDS among women have been conducted by various researchers including Wingood and DiClemente (2000) and Zierler and Krieger (1997). Connell's social structural theory of gender and power (1987) has been used to identify the exposures and risk factors for HIV infection among women (Wingood and DiClemente 2000). Connell theorises three structures that characterise gendered relationships between men and women. "The sexual division of labor works to allocate to women different and unequal positions compared to those it affords to men, which contributes to economic exposures (e.g., living at the poverty level) and socioeconomic risk factors (e.g., being an ethnic minority) for infection. The sexual division of power contributes to men having more authority and control in relationships and women experiencing more physical exposures (e.g., having a history of sexual or physical abuse) and behavioral risk factors (e.g., poor condom-use skills) for infection. Finally, the structure of cathexis serves to define appropriate sexual behavior for women, thereby contributing to social exposures (e.g., having an older sexual partner) and personal risk factors (e.g., having limited knowledge of HIV) for infection.[cxii]

VIII. Health of Women Workers linked to Exposures and Vulnerabilities

The review of literature informs on certain health issues of women or women workers that arise from specific exposures and vulnerability.Chronic fatigue among women in India in general due to excess work and lack of adequate food has been evidenced. Patel, Kirkwood, Weiss, Pednekar, Fernandes, & Pereira (2005) in their study on women in Goa found that older participants living in households with more than three children under the age of 18 and those facing socio-economic difficulties, likewise

participants affected by spousal violence and husband's extramarital relationships or substance use habits were more likely to experience chronic fatigue. The study showed a strong association between gender disadvantage and chronic fatigue. Excess physical work and gender disadvantages in access to food are perhaps the most likely explanation for the association of fatigue with low body mass index. Mental health factors had the strongest associations with chronic fatigue.[cxiii]

Baruah (2010) found that higher percentage of women had sustained physical injuries and had physical problems associated with their work. And there were no accident insurance, basic sanitation and first-aid facilities.[cxiv]

Mohankumar and Singh (2011) found that more than 64 percent of the labour households in the construction industry reported having undergone/undergoing economic stress driven psychological disorders, and turned to excessive drinking and smoking. Further, 55 percent of the labour households in the construction sector reported an escalation of domestic violence during the economic crisis period, the brunt of which fell mostly on women and children.[cxv] Dalmia (2012) found that women construction workers lost their savings or entered into debt during illness in family. This could be just one dimension of vulnerability.

Mehrotra (2012) in her study found that vulnerabilities of domestic workers were located in their lack of negotiating power in all aspects of their work including wage negotiation, number of holidays, getting a cup of tea and snack or getting gifts and bonus.[cxvi] Women domestic workers were found to be vulnerable to trafficking by agents and for being abused physically, psychologically and sexually.[cxvii]

Gothoskar (2012) found that occupational diseases such as skin diseases, particularly eczema are reported among cleaning women. Rheumatic complaints due to repeated immersion of hands in water or working in hot work areas, tenosynovitis such as housemaid’s knee; lumbago, backaches were relatively common among domestic workers. There is a possibility of infection from affected employers or their family members and visitors for domestic workers. Their health problems had to be dealt with on their own as there are no medical or sickness benefits for domestic workers. Gothoskar says that such health condition results either in domestic workers paying a large part of their wages on health-related expenses or, alternatively they tend to

totally neglect their ailments, often resulting in major illness or even early onset of old age or even death.[cxviii] The latter is particularly critical, an early onset of old age for women domestic workers.

IX. Gaps Identified

Aspects of intermediate social processes are vulnerabilities (Sen, Ostlin, George, Cook, Keleher, Dwyer & Krantz 2007), constraints (Kantor, 2002) and exposures (Ostlin 2007; Soucie 2000). There have been some studies globally though very few in India, which show the intermediate processes of vulnerability and exposure with multiple unique pathways as responsible for health, and point to the structural causes of such vulnerability and exposures of health issues (Sen & Ostlin 2007). But there have been no studies that study exposures and vulnerabilities in detail with respect to health reasons cited for employment shifts/withdrawal, particularly in case of informal work with insecure and unhealthy work conditions, including construction and domestic work. There are no studies that use mixed methods to study the social processes of health issues associated with work changes of women construction and domestic workers using frameworks of intersectionality and social determinants of health. Qualitative research techniques could address the issues left unattended by quantitative research techniques in intersectionality such as social interactions and social processes. Bauer (2014) cites the work of Bowleg (2008) and how quantitative research on intersectionality tends to ask questions inherently additive. Bauer states that "while sometimes conflated, there is not necessarily concordance between one's personally held identity and a social position one occupies, as indicated either by objective measure (e.g. income or wealth) or the way one is perceived and treated by others (e.g. racialisation). These are complexities of understanding intersectional identities. So, even if qualitative research tends to answer questions on social processes and relations, it need not be sufficient for research on intersectionality. Difference could exist between the way objective and subjective notions of intersectionality influence events and this needs to be checked. Studying intersectionality in its complexity remains a challenge. There are suggestions like reducing it to single dimension for each category while studying intersectionality (Mc Call 2005), but at the same time there have been critiques of reducing it to single dimension (Krieger 2003). For instance, reducing gender to one dimension or caste to

one dimension may ignore the complex interactions. But at the same time it is methodologically difficult to consider 'n' number of dimensions of a single category. It is best left to the researcher to decide on the number of dimensions of a category based on research questions formulated. The benefit of such a stance in this study helps as it leaves scope for gathering experiences in totality and in turn, understand the social processes and relations implicated. Hancock (2007) delineates intersectionality as intermediate between 'yin of structural research' and 'yang of individual-level microanalyses'. She states that intersectionality recognises the 'various terrains on which politics plays out structural and interpersonal.'[cxix] There are very few studies on micro social processes and social relations, most of them focus on structure, intersectional position and differences. Exceptions are Hankivsky and Cornier 2009; Dhamoon and Hankivsky 2011 who focus on both.[cxx] There has been lack of attention to historicity of unequal relations in intersectional studies. Conaghan (2009) says, "one striking contrast is the relative lack of historical attention in contemporary intersectionality analyses, echoing what Lynn Segal suggests has become a broader tendency in feminist theory. Modern intersectionality scholarship is much less concerned with tracing the root causes of inequality manifestations. It is more a discourse of representation than origins, one which sees the possibilities for future transformation in interpretations of the present rather than interrogations of the past."[cxxi] The link between past and present intersectionality is underrepresented in studies. Dhamoon says, "while some of these models illustrate how one set of interactions might occur and how differences can be unequal in importance, none of these indicate that there are contingently formed relationships and patterns between multiple and differing sets of interactive processes and systems, and none adequately capture how these relationships might vary at different levels of life and across time and space."[cxxii] The processes vary over time and space. There are not many studies on intersectional processes, especially in India. For instance, Ayyar (2013) looks at displacement and resettlement of families based on intersection of caste, religion and region, wherein she speaks of social processes of identifying with certain identities, segregation from others and interaction among own kind, insecurity in relation to other groups and crime, conflicts over decisions related to cooperative housing societies, etc.[cxxiii] But this study does not look at the issue of employment changes for health reasons. In Indian context, two examples of intersectional study with respect to employment and health have been discussed below.

Coelho, Venkat & Chandrika (2013) in their study of urban domestic labour market found factors such as location, distance, travel and time as crucial. They found for a particular intersection of women such as the 'unskilled women primarily of the lowest castes and disadvantaged communities' 'domestic work' remained the few available avenues when they needed to earn. The opportunities in market for these women were influenced by skill levels, domestic role of women at home and gender attributes associated with domestic work in labour market. "Significant constraints came between the available opportunities and the ability of women to access or retain these jobs."[cxxiv] They found that health and age played a major role in constraining employment possibilities in Kannagi Nagar, Chennai. Another determining factor of employment, as identified by the study was relocation of women. While overall levels of unemployment were high in Kannagi Nagar, they were particularly high among women, many of whom had dropped out of the labour force because of relocation. Workers in wage work sectors, mostly women, were hardest hit by the relocation compared to self-employed workers or petty commodity producers. The limitation of this study is that qualitative data does not elaborate on the relationship between constraints and employment decisions, questions such as where health and age are located, at individual (micro) level or at a macro level, what is the cause of such causes, how are these caused and how do they influence social processes which affect job-seeking, remain unanswered.

Kumar, Kumar & Mitra (2009) studied well-being of different social categories in slums of 4 cities of India. They looked at conditions of vulnerability based on socio-economic and demographic variables to score well-being. The researchers acknowledge that the status of a caste would vary according to region, place of origin and destination. This indicates that the study approach was intersectional. In other words, the study found intersectional category of caste, religion and place as influential. Income, employment and vulnerability were considered as intermediate variables on which social categories differed and accordingly their well-being varied. The study found a positive relationship between well-being and regular employment of head of households. Well-being of female headed households was low which implies absence of regular employment in such households. Regular employment was the lowest for Muslims (General or Other Backward Classes) and Hindu Other Backward Classes households. There was predominance of regular employment

among Hindu Scheduled Castes and Scheduled Tribes, even though low income was highest among these categories. Social processes of caste networks and positive discrimination helped these categories in getting regular employment. There was low incidence of daily wage employment in a city like Ludhiana and higher incidence of daily wage labour in Jaipur. Causal relationship between vulnerability and social categories based on caste and religion identities showed that higher and lower social categories were vulnerable, reasons could be different. Caste reservation need not necessarily help reduce the vulnerability. Intra category differences existed such as female headed households vis-à-vis male headed households in the same category showed differences in well-being. Female headed households scored less and were more vulnerable. Structures of systemic seclusion, location, occupation by religion or caste and social relations worked as social processes for well-being. In-depth exploration of these processes or vulnerabilities and interconnections, the complexities have not been shared, as the study positions itself in the methodological frame of quantitative research techniques. This is a limitation of the study.

Such intersecting identities could be of age, culture, (dis)ability, ethnicity, gender, im/migrant status, race, sexual orientation, social class and spirituality. Intersections of identities determine systemic oppressions and inequalities. [cxxv] There could be synergies of certain conditions as these identities intersect. The theory helps understand and explain a phenomenon in the light of multiple structures of domination. For instance, the gender, caste, class and age intersection for women domestic workers or other unknown category of workers could be different from that of women construction workers. There could be specific conditions that emerge in each context. The intersectional theory acknowledges the other forms of oppression than patriarchy by taking into consideration the differences of social class, race, etc. One of the fundamental premises of this theory as McGibbon puts forth is "local, regional, national, and international systems of inequity are inextricably linked and cannot be ameliorated without an analytic focus on how these complex systems act together in a complex web of larger systems."[cxxvi] McGibbon points out limitations of intersectional theory as it falls short of describing the interactions within this web of larger systems, particularly the health and social service systems that coalesce to produce growing health and social inequities for women. This renders a gap in the theoretical approach. Reduction of health inequities requires a dedicated and

consistent analysis of the systemic oppressions that cause them.[cxxvii] The assumption is that women located at particular intersections have certain conditions, particularly health conditions. Women's health conditions are outcomes of certain exposures and vulnerabilities at social and economic levels particular to that intersection of women. Alternately, health conditions could also result in social and economic vulnerabilities.

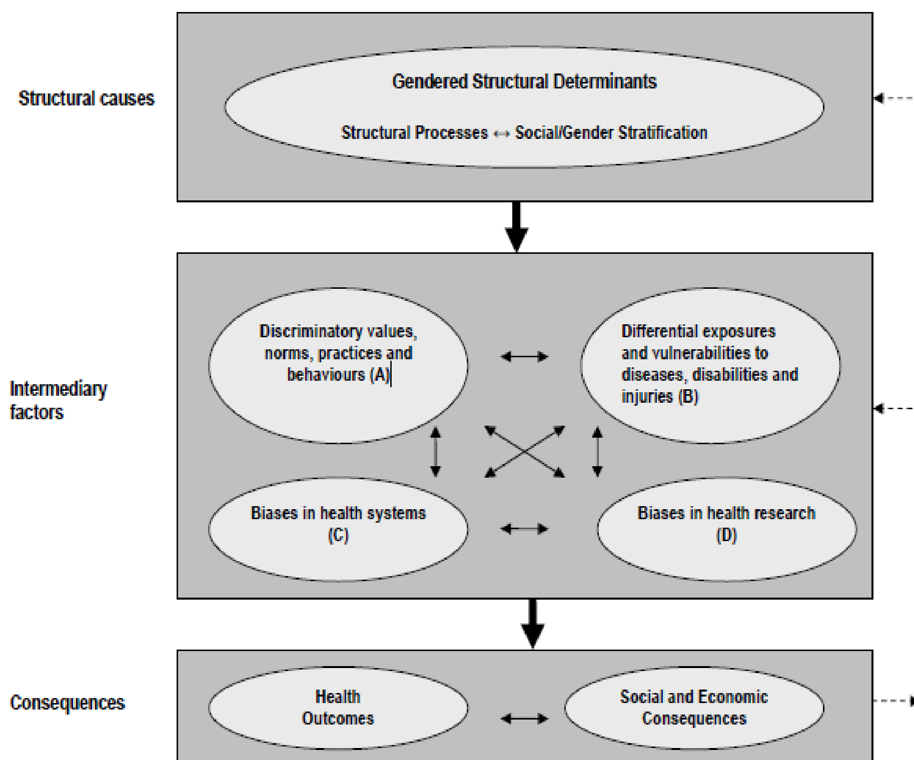
X. Conceptualising the Study

Put forth as a study on employment shift/withdrawal from construction work to domestic work or any other work or, from domestic work to any other work due to health reasons is, particularly located in the frameworks of intersectionality and social determinants of health. The cohorts of women construction worker and domestic worker and their employment shifts or withdrawal is the starting point. The present study looks at the past experiences of employment and health to understand employment shift or withdrawal in relation to intersectionality and determinants of health. It sees the determinants of health in relation to the past as well as present intersectional identities. The epistemological assumption is that knowledge is mediated and interpreted. Reality is not existential, but is empirical in nature, and reality needs to be interpreted. Reality is mediated when interpreted from the narrated or identified aspects, and is discursive in nature. Reality needs to be interpreted as it is through transactions and interactions of the individual that shape her life. Constructing the context implies constructing the knowledge of the context in relation to different concepts of structure, identities, agency, processes, and consequences. The analysis constructs as it looks for the underlying circumstances, interaction and position of the agent or the individual.It is not post-modernist in its approach as plurality of meanings is not its premise. It interprets meanings in relation to the context, where not plural meanings but multiple dimensions are explored. The enquiry is grounded in the interpretive paradigm. It looks at the processes through which employment shifts or withdrawal occurred in women's lives due to health reasons, but is not limited to micro level understanding. The study reckons intersectionality as the mid-point between micro level and macro level understanding. It starts with identities or social positions and associates identities with social processes and social structures to explore causal relationships and implications between employment and health.The study explores social relations and processes of present and past in relation to

employment and health. The study uses qualitative research techniques to handle the complexity of studying the intersections of identity and social processes, exposures, vulnerabilities and multiple dimensions of health. The study uses survey method to capture the objective dimensions of identities and the incidence of health reason for work change. The study looks at specific dimensions of categories based on relevance to research questions in the survey, but is open to multiple dimensions of the same during the case studies and recognises that categories are dynamic.

At the macro level, structural factors would imply labour market trends and work opportunities as well as the social structures underlying the identities. The framework considers the social structure as represented by identities of gender, class, caste, age and other variables. The processes would be the way in which these interact. Additionally, employment choice and shifts along with a complex of economic and social processes could influence health outcomes in the lives of women. Differential exposures and vulnerabilities to health issues was the focus of the study (refer Figure 1, this gender based SDH framework has influenced the conceptual framework of this study). However, the biases in health systems and health research (also in Figure 1) is not under the purview of the study.

Figure 1: Sen & Ostlin's Framework on Gender based SDH[cxxviii]



Two broad areas of investigation in this framework emerge on the area of employment shifts of women construction and women domestic workers. These could be seen as objectives of the study. First, is the relationship between intersectional location, intersectional processes of women construction and women domestic workers who undergo work change. This recognises that the category of 'women' is not homogenous and the reasons will vary. Second, is the relationship between health and work changes via exposures and vulnerabilities inducing health ailments. These objectives bring forth the research questions of multiplicities of exposures and vulnerabilities which shaped women's health, which could arise from different structural sources and how health acted as one of the causes (the independent variable) of the phenomenon of employment shift or work change (or the dependent variable). Since the study enquires the social processes of this phenomenon of health and work change, it also looks at the implications and consequences. The study use the lens of social determinants of health and intersectionality.

This conceptualisation brings in the troubling question of structure and agency of worker in work change. As mentioned earlier Hancock (2007) sees intersectionality as intermediate between macro and micro level analyses and Sen & Ostlin (2007) consider social processes relevant for micro and macro level understanding of social determinants of health. So, I look here at work done in area of structure and agency and how analytical framework could be enhanced by it, besides the theoretical frameworks of intersectional theory and social determinants of health. I also look at grounded theory approach for developing analytical framework in the methodology chapter.

Different notions of structure and agency have been examined here. For Levi-Strauss (1963), structure refers to the set of rules that enables binary oppositions to be ordered into myths.[cxxix] Structure as binary oppositions is restrictive as it is not merely at the deep structural level. Giddens (1984) talks of duality of structure, "analysing the structuration of social systems means studying the modes in which such systems, grounded in the knowledgeable activities of situated actors who draw upon rules and resources in the diversity of action contexts,are produced and reproduced in interaction. Crucial to the ideaof structuration is the theorem of the duality of structure."[cxxx] Giddens talks of structure and agency as entwining aspects, the concern

is he does not speak of the differences embedded in agency or change. Bourdieu speaks of possible change in structure. King says, “while the habitus is inadequate to the explanation of social change and, in fact, presupposes the kind of interpretive virtuosity of "practical theory," social change is intrinsic to Bourdieu's "practical theory."[cxxxi] There exists a difference between notions of structure as portrayed in Bourdieu’s practical theory and habitus; both have implications for how one understands the structure in relation to change. King (2000) says Evens (1999) was first to point out how in spite of trying to overcome the duality of subject-object, Bourdieu returns to objectivism, which is reflected in oscillation between Bourdieu’s objectivist habitus and change oriented practical theory. “Engaging with Bourdieu, Evens tries to point toward a non-dualistic social theory founded on intersubjective, meaningful practice.”[cxxxii] King (2000) says that Bourdieu’s practical theory overcomes the dualism in spite of his macro level depiction of objective structures in habitus. He states that Bourdieu's" practical theory" highlights the mutual negotiation of social relations between individual. Negotiations and interaction overcome the dualism. The debates on dualism extends to macro and micro accounts of social theory. Sewell’s definition of structure is dual in nature. Structures could be both constraining or enabling, limiting or widening individual’s choice, both Giddens and Sewell have mentioned it. Sewell quotes Giddens as "structures must not be conceptualised as simply placing constraints on human agency, but as enabling" (Giddens 1976).[cxxxiii] “Such enactments of structures imply a particular concept of agency, one that sees agency not as opposed to, but as constituent of, structure. To be an agent means to be capable of exerting some degree of control over the social relations in which one is enmeshed, which in turn implies the ability to transform those social relations to some degree.”[cxxxiv] It implies exerting control through agency could bring in change in structure, however it does not point out the collusion of structural domination with individual’s agency or resistance against norms. Einspahr (2010) talks of structural domination. She observes, “stated differently, individuals are always to some degree participants in the production of structures, whether they turn out to be 'winners' or 'losers' in the struggle, so that agency is not even equivalent to resistance, much less to freedom. At the same time, the structures that are created through processes of repeated enactment will determine to a large degree what the range of our possible actions will be, and individual agents will be constrained or enabled differently in this process depending on their locations within various

structures; the ongoing reproduction of structures produces more freedom for some than for others."[cxxxv] Einspahr treats choice as not a subject question, but as a question of the structure. She puts this as "what would it mean to look at freedom not as a 'subject question', but as a question about the structure of the world in which we live." [cxxxvi] In some ways, treating freedom as a 'structure question' concedes the domination of structures, even if agency exists. But it does not foreclose the option of structure as enabling. Einspahr talks of the context of choices, she not only talks of freedom or suppression of action that is possible, but also of the possible collusion of the individual's thinking with domination of structures. This notion of structure implicates structural domination, but also has scope for choice or agency with some freedom.

What is clear from these notions is that structure is abstract, virtual, can exist at macro and micro levels, could be constraining or enabling agency, and undergoes change. More importantly structure and agency are mediated by processes of domination, reproduction, negotiation and change. As extrapolated from this literature, understanding employment shift or withdrawal of women in their social, economic and political context, their intersectional position, health and work decisions also have implications for understanding the individual agency in its structural context.

To refer Ridgeway, "many feel a theoretical tension between micro-interactional approaches, evocative as they may be, and more structuralist explanatory leanings. There are lingering questions about how to fit the micro-interactional account into institutional structure and how much weight to give the micro account. Micro accounts are appealing and add richness to our understanding, but do they really matter?"[cxxxvii]

This Chapter has brought forth the problem of the study, the theoretical frameworks of intersectionality and SDH which have been used and the theoretical tensions between micro and macro approaches which are embedded in these frameworks. The following Chapter delineates the methodology of capturing the complexities of intersectionality and health issues, wherein there is scope for approaching the problem from a macro as well as micro perspective.

Chapter 3

Methodology for Capturing Processes of Women's Context, Location and Agency

As discussed in the previous chapter, it is a challenge to capture multiple identities, the social interactions and social processes in its complexity (McCall 2005). Capturing these are essential to understand intersectionality and its processes involved in health and work changes. While it is difficult to avoid treating these multiple identities in terms of predefined dimension/indicator by quantitative research techniques, qualitative research techniques need not necessarily look at the objective dimensions of identity because they ask questions in an open ended manner where in it could be missed out, such as financial income as an indicator or dimension of class. Essentially, qualitative methods consider identities as subjective and fluid (Dhamoon 2011). At the same time, quantitative methods measure certain objective dimensions of identity and often, end up treating these as additive and static identities which is not what is experienced (Dhamoon 2011; Bowleg 2008). If multiple identities are attended to than additive notions of it, the researcher can better interpret intersectionality. This could be then elaborated by an understanding of intersectional identities through qualitative methods. Dhamoon (2011) says, "in examining the form and character of political life (ontology), investigating what can be known (epistemology), and developing and deploying tools of analysis (methods), intersectionality specifically operationalises interpretivism and critical theory rather than positivism, whereby realities and knowledge are treated as complex, fluid, subjective, discursive, socially constructed, products of and productive of power, and subject to individual and social action."[cxxxviii] The challenge while doing this study is to capture the complexity of intersectionality over time, and not just space. The study recognises that categories representing identities are not static, these are dynamic in course of time and space. The understanding of links between past and present and the processes will be dependent on how well over time identities are captured. The drawback of quantitative techniques while collecting data on identity from past and then, the present is just not about identities getting reduced to restricted dimensions, but also the recall of these limited dimensions such as age during past work change becomes difficult over time. Qualitative techniques have the potential to explore and

construe identities in past as well as present in its complexity and also extend the understanding to the processes that are interlinked. Hankivisky (2012) specifies three essential requirements as 'theoretical tenets of an intersectionality research paradigm', which are 'the destabilisation of apriori primacy and stability of singular categories', 'the avoidance of additive lists', and 'the focus on the fluid and interactive nature of multi-level complex processes and systems that shape health inequities.'[cxxxix]

The present study delves into the past experiences of employment, family structure, social relations, migration and health to understand intersectionality, health and work change.

Study Objective

- To understand the relationship of health and work change among women construction and domestic workers in Cuttack city of Odisha.

Sub-objectives

- To find the processes involved by which health of women workers influences their employment shift or withdrawal from work.
- To find out the intersectional location and intersectional processes of women construction and domestic workers who undergo work change.

Research Questions of the Study

- How does the intersectional position of women construction workers and domestic workers affect their work choices?
- What is the incidence of health as a reason of work change for women workers, particularly construction and domestic workers?
- What, how and why do exposures and vulnerabilities act as determinants of health? What are the future implications for health of women workers?
- If there are instances of changes in the women's life over a period of time, such as employment shifts or withdrawal, then to what extent do they reflect woman's agency, whether it is restricted or enabled?

Hypotheses

1. Change of work is not an individual decision taken for individual priorities, but is a decision determined by the structural forces of economy, gender, caste and class.
2. Social and economic factors influence women's health conditions by exposing them to health risks and vulnerable to health issues.
3. Social, economic and health factors interact in multiple pathways to employment shifts.
4. The gender relations at home and employment market reinforce each other.

Study Design

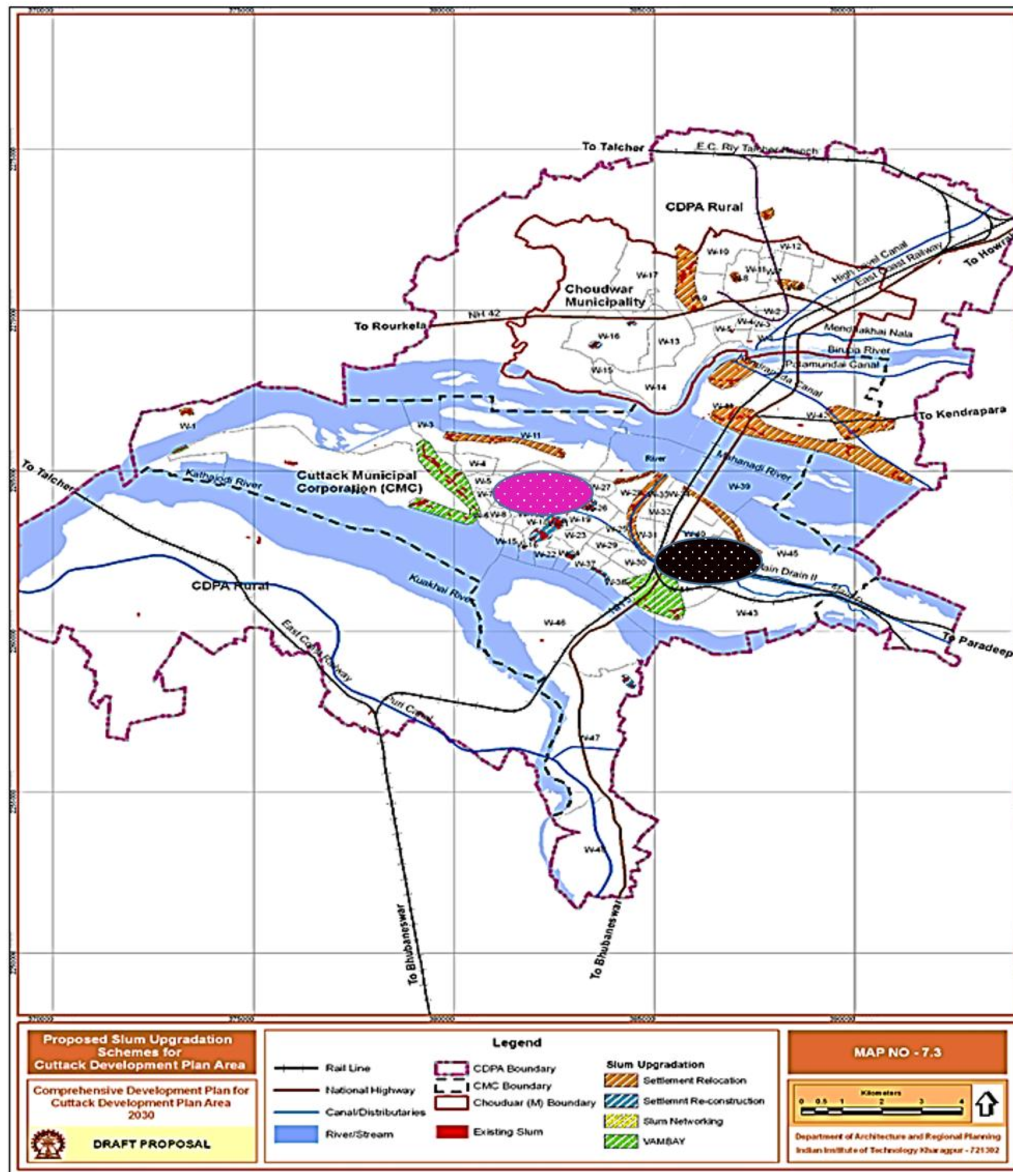
A multi-method or mixed model framework has been adopted for the research design, with use of both quantitative and qualitative methods. The idea of corroborating the evidence for the same conceptual phenomenon or what is called as 'triangulation' is not the main purpose. Rather, the research questions to be answered by each set of methods (quantitative or qualitative) are different, with the quantitative being used to identify intersectional location through predefined dimensions of identity, work change reasons including health and subsequently, the qualitative extending of this understanding to the processes underlying the work changes and health. In other words, it uses the strategy of 'development' i.e., findings of one method inform the findings of the other and the strategy of 'complementarity' which is to elaborate, illustrate and clarify the results of one method with the help of results from another method. Greene, Caracelli & Graham (1989) explain this use, "in a complementarity mixed-method study, qualitative and quantitative methods are used to measure overlapping but also different facets of a phenomenon, yielding an enriched, elaborated understanding of that phenomenon. The context of the phenomenon will be understood in greater detail. This differs from the triangulation intent in that the logic of convergence requires that the different methods assess the same conceptual phenomenon."[cxl] However, triangulation is not completely ruled out, at some points same phenomenon will be studied by different methods to get accurate results such as health reasons of work changes. Creswell and Clark (2007) define mixed methods research as "a research design with philosophical assumptions as well as methods of

inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems that either approach alone."[cxli]

The research design here will use both quantitative and qualitative methods to answer particular nature of research questions only to understand the phenomenon better. The use of quantitative and qualitative methods will be sequential, i.e., will be followed one after another in a particular sequence. In the sequential use of qualitative and quantitative methods, the first method is used to help inform the development of the second.[cxlii] It is a retrospective cohort study of women construction workers and domestic workers, sequencing first the survey data collection and there after conducting the interviews. It is retrospective as it goes back to past events in personal history. For the research study, quantitative methods will be used to study the 'what' part of the employment shifts, i.e., present work, work hours, work days, earnings, immediate past work, reasons for employment shift or withdrawal if there, husband's work, family earnings, etc. Qualitative methods will be used to understand the 'how' and 'why' questions or the unique intersectional processes and causal processes of health issues which were involved in employment shifts and withdrawal of women construction and domestic workers due to health reasons. It tries to understand the exposures and vulnerabilities of the health conditions, the causal pathways in which social processes acted and the agency/freedom of individual worker vis-à-vis the structural factors that influenced the employment shifts or withdrawal. Since triangulation has not been ruled out completely to know health conditions of respondents, the survey will be used for knowing the extent of the identified reality, which is health as a reason identified for employment shift or withdrawal. At the same time, the interviews will be used for knowing the complex dynamics underlying this reality. Both the incidence and dynamics, are crucial to answering the research questions of the study. The inquiry is rooted in an interpretive paradigm, grounded in the intracategorical approach of intersectionality.

Place of Study: Cuttack City

Figure 2: Cuttack Map



[Note: Ward and slum areas in pink circle represent Pattapol, Odiya Bazaar slums and those in black circle represent Ranihat Das sahi, Ranihat Sagadia sahi and Chattra Bazaar slums under Cuttack Municipality Corporation. These areas were selected for the study which lie in two different directions of the city.]

One of the main reasons for choosing Cuttack has been that earlier I had conducted a research on lives of slum based women domestic workers in the same city during 2000-2001 for award of my Masters of Philosophy degree. Five slums adjoining Pattapol slums were then taken for the study, which were Sutahat Tantisahi, Sutahat Hadisahi, Golibidhisahi, Burlabidhi sahi and Satyaraobadi (Mohanty 2001).[cxliii]

Cuttack is a tier-II city, a twin city to Bhubaneswar, the state capital of Odisha. "Cuttack is more than thousand years old flanked between the river Mahanadi and Kathajodi with an area of 192.50 sq. km (Municipal Area) with a current Population of 6,06,007 (as per 2011 census) and slum population of 2,35,980 lakhs (2011 census). As of 3rd February 2012, according to Implementing Agency Cuttack Municipal Corporation, City Level Technical Cell, Cuttack there are a total of 309 slums, consisting of 200 authorised, 104 unauthorised and 5 tenant slums."[cxliv]

A report by Ministry of Urban Development, GoI (2013) says, "Cuttack has been a major centre of political, socio-cultural and economic activity. The urban administration has been neglected, resulting in a skewed population-to-services ratio. The rapid urbanisation, influx of people to city in search of employment opportunities resulted in mushroom growth of slums. Cuttack is the largest slum populated city in the state. The Municipal Corporation following the Below Poverty Line (BPL) survey conducted during 2004-2005. The level of urban basic services declined rapidly, leaving the city's poor with more than 180 persons per tap and more than 40 percent of them without necessary sanitation facilities. Public wells and community bore wells are source of water supply for the residents. Only 60 percent of slum population has toilet facilities."[cxlv] Sahoo, Hulland, Caruso, Swain, Matthew, Freeman, et.al. (2015) also corroborate the status of sanitation in Cuttack (includes slums) and other districts with their study findings. Cuttack district includes Cuttack city. They describe it as private latrines were present, but uncommon, in all study areas, barriers to ownership of private latrines included space, land ownership and cost, there was less frequent use if structural damage or if construction was incomplete (no door, roof), public latrine facilities were found only in urban areas and this was the only infrastructure alternative for people without a private latrine. Most public latrine facilities were pay-per-use, with costs prohibitive particularly for urination. Shared public latrine facilities were poorly maintained, covered in faeces, or lacking doors, other barriers included long wait times during morning hours, closed at night, inconsistent water supplies and open defecation sites were common in all locations, even among respondents with access to a latrine. Open defecation sites were utilised when there were fewer people around; however, women avoided open defecation at night and mid-day due to fear of isolation. Urination was usually done closer to the home, such as just behind or beside the house.[cxlvi]

Mitra (2006) highlights that the share of informal enterprise workers as a percent of total workers in Odisha was 87.5 percent in rural areas and 41.1 percent in urban areas, in year 2000. This share was the highest of all 15 states compared in rural areas, and way greater than all India figure of 55.2 percent for rural areas and in urban areas, the share was close to all India figure of 46.8 percent (Absolute number of informal sector workers are taken from Informal Sector in India, 1999-2000, Salient Features, NSS 55th round (1999-2000), Report No 459(55/2.0/2).[cxlvii] NCEUS (2007) cites the percentage of female workers in unorganised sector in Odisha was 93.9 and that of female informal workers was 97.7 percent in year 2004-05. The all India figures of percentage of female unorganised sector workers and informal workers were 91.3 and 95.9 respectively.[cxlviii]

At the regional level, (includes the Cuttack city) studies have also corroborated gender segregation within occupation and concentration of labour in few sectors, wherein informal sector has a major share, level of regulations varied from occupation to occupation within informal sector.

Das, Das & Mohanty (2012) found that in construction industry which is a large employer of casual labour, women tend to perform the less skilled and less paid casual work, even if both husband and wife work in same industry. Domestic work was the least regulated informal work. Women as domestic workers worked without any contract or any leave. The survey was conducted with a sample of 600 women in Cuttack, Keonjhar and Mayurbhanj district of Odisha.[cxlix]

A Report by Bharat Jyoti (2011) found that Cuttack city had the highest rate of landless women domestic workers (70 percent) in comparision to the other cities of Berhampur, Rourkela, Bhubaneswar and Sambalpur.[cl]

CSO, India had conducted a time use survey (July 1998-June 1999) in six selected states namely, Haryana, Madhya Pradesh, Gujarat, Orissa, Tamilnadu and Meghalaya to capture the work pattern of both men and women within and outside the households. According to the National Commission for Women (NCW), the findings on average time spent weekly (in hours) for urban females in Orissa was 8.37 for SNA activities and 37.61 for extended SNA activities whereas for rural females it was 19.03 for SNA activities and 35.28 for extended SNA activities. For males in rural

and urban areas of Odisha, extended SNA activity did not exceed 5.00.[cli] As is evident the ratio of SNA activities to extended SNA activities was more skewed for females in urban areas than rural areas. It is inferred that women carried double burden as they combined paid work with unpaid work.

Sampling: Slums, Survey and Case Studies

The slum areas for the study were purposively chosen based on slum residents' opinion or assessment on major occupation of their women. I visited Maria Bazar slum, Tinkonia Bagicha slum, 10 slums in Pattapol, 2 slums in Odiya Bazaar, 4 slums in Ranihat, 2 slums in Mahanadi settlement, a slum in Deer Park settlement, a slum in Panchamukhi Hanuman Mandir settlement, 2 Press Chakka slums, 3 Chattra Bazaar slums, and 2 slums in Buxi Bazaar before finalising the slums for the study. In total, I visited 29 slums, in 11 different slum areas of Cuttack city. I found that domestic workers were present in all slums excepting 2 slums in Mahanadi settlement, which was located almost outside the city. Construction workers were present predominantly in Ranihat, Chattra Bazaar and Odiya Bazaar slums, even though slums in Press Chakka and Panchmukhi Hanuman Mandir settlement had some construction workers. Also 7 out of 11 slum areas which I visited in Cuttack city had Telugu habitants. Telugu immigrants in Cuttack city was a common feature of most slums. Finally, 4 slum areas were chosen based on presence of construction workers and the slum location, since it was given that domestic workers were present in 10 slum areas. 2 slum areas of the study, Pattapol and Odiya Bazaar are located in one direction of the city than the other 2 areas selected for the study, namely Ranihat and Chattra Bazaar located in another direction. Pattapol and Odiya Bazaar slum areas are close to Netaji Subhas Chandra Bose birth place museum and Ranihat and Chattra Bazaar slum areas are close to 1869 established Ravenshaw College in the city. 12 slums have been chosen as place of the study from these locations of Cuttack city. For the purpose of keeping a distinction between Ranihat Das sahi and Ranihat Sagadia sahi under the same ward, which were separated by a water canal and a road with different caste and region of origin composition, later in the study I treat these as two separate slum area.

Ranihat Pilgrim Road Das sahi and Chattra Bazaar Pola Telugu sahi were located just next to water canals. The canals were used by residents not only for toilet purposes,

but also for bathing, usually after monsoon when the canal overflowed with water. These slums were swamp areas being close to the water body. The slums had public pay toilets which were not used by all residents regularly as they had to pay for the services. Both the slums had handpumps as main source of drinking water and for other purposes. Often clothes were washed by women on the walking road (*kuccha*) inside the slum, it was normal to see soap water on the walking space in the afternoons. Women also used common areas (cemented, usually 4 feet by 4 feet, sometimes even smaller) in front of handpumps to wash their clothes, utensils. Women of the slums shared that during day time they could not use the canal for toilet purpose, neither could they use it in dark. They shared that they had to control their nature's call and time it only in early mornings as both day and night was not safe for them. In extreme cases, they used the public toilets by paying money. In hot summers when the temperature shot up to a 40 degree Celsius, bathing was at least twice a day for most residents. The handpumps in the slums were gender segregated, with women folk taking bath at a particular time of the day near specific handpumps. The male members of the slums did not go there then, and instead used handpumps in the area reserved for them. During the rains, which was usually heavy rains, the slums would have a stream of mud water flowing on its roads. Post rains the pot holes on slum roads of Ranihat Das sahi and Chattra Bazaar would be fuller with mud water because the roads were neither mortar based nor cemented, it was *kuccha*. The houses were a mix of cement walls with asbestos roof and houses which were *kuccha* or wrapped with plastic sheets, the inside of it was some kind of log of wood, bamboo put in the four corners of the room, wrapped with plastic and then, the thatch roof. These houses were one room usually, which were of varying size, but usually small than 8 feet by 8 feet. Sometimes the house was just used for sleeping because these *kuccha* or plastic sheet wrapped houses/makeshift arrangement did not have floor. It was the surface same as the slum, a *kuccha* surface with kind of mud plastering and then, a mat was used for sleeping on it. At times, one had to bend in and enter the house as it was of low height. The cooking, bathing and cleaning happened in open, not inside the house. Houses with cement walls with concrete roof were few.

Ranihat slum clusters of Sagadiasahi, Teli sahi, Dhobasahi had some similarities in living conditions with Odiya Bazaar slum clusters of Baunsagali and Gaudasahi. The houses were located along the sides of middle class Telugu, Muslim and Odiya

families. The obvious benefit of this was the roads were not swampy, these were *pucca* roads, had better access and vehicles could ply on main roads. One could distinguish the slum clusters by the way the families lived. In slum clusters, there would be 4-5 or even 10-15 families staying one after another in one stretch of a narrow lane where only one person or maximum two persons (in some lanes) could walk together. Such families would have a demarcated area (cemented) for them or a common space for cleaning, washing and bathing. These families stayed in one room, and all families of a particular lane had a common toilet and water tap. Most of them had rented it. These houses were made of cement walls and asbestos roof or concrete roof with one room of varying sizes, usually about 4 feet by 5 feet, 6 feet by 6 feet.

The slum clusters of Pattapol were located in the heart of the city. Pattapol slum clusters populated with lower caste Telugus had *pucca* houses mostly, some of these particularly in Mochi sahi and Ghantlidhi sahi, were constructed by the Government under various schemes such as Indira Awas Yojana (IAY). These houses were usually located in two storeyed buildings, each floor had some 8-10 families living in. One house had 2 rooms, a kitchen area, but did not have toilets or water facility inside the house. It depended on the residents how they used the house, sometimes the property was divided between siblings and each sibling got one room for his/her family. Or put it on rent for income. But families in 4 other slums of Pattapol were mostly staying in rented houses. Few had their own house. The houses were also mostly *pucca* or concrete cement single room houses of about 7-8 feet length by 4-5 feet width size with some common space (cemented) used by 10-15 families for cleaning and washing. There were common toilets and bathrooms built by the Government which were free of cost. Some landowners had provided common toilets. I had visited this slum area in 2000 for my M.Phil study. There were very few *pucca* houses then in the whole area. When I enquired about this change, many replied that the disaster of 1999 supercyclone had made the residents of Pattapol push themselves, take loan and make their houses *pucca*. They did not want their families to suffer once again.

A common feature of houses in these 5 slum areas was that people cooked outside, bathed in common spaces (at times, these were open but gender segregated), did their cleaning and washing in common spaces, houses were one room of small size and mostly without windows. In few cases houses, were without doors and plastic sheets

served this purpose. In most cases, this one room was small and was used by many family members, which made the space cramped for taking proper rest.

Before collecting the suvey data, I conducted a pilot survey in areas of Pattapol and Ranihat Das sahi with the help of two *anganwadi* workers, a social activist and her daughter. This helped in reflecting on my survey questions, modifying the questions and responses. Such as I added new response categories of 'work demands at home' and 'problem of commuting' for the question on reasons of their work change, or a new response category capturing the work of marriage helpers for the questions on her main work and secondary work. In marriage processions, these helpers did the work of light loading or they cleaned utensils in the feast ceremony. I kept the question on time of commuting which was originally there, but I had to put a new question on mode of commuting for the different ways of commuting to workplace besides walking. It helped in finalising response categories of work days, work hours, income and work type. This exercise also helped me tell the community members even before I conducted the study that I would visit them to conduct a study and my study will be non-interferring excepting requiring their time and consent for interviews. Since the *anganwadi* workers, the social activist and her daughter were known to the community and agreed to accompany me intially, that helped me gain trust of the community. In future, this trust was reciprocated by the friends and neighbours as they saw their neighbour participating in the survey. During the pilot study and later, before conducting the survey I informed each of them that am not representing any political party or Government or any profit or not-for profit organization. And am doing this for my Ph.D study, for their understanding I added the word 'for my degree'. This was a standard information that I gave since invariably every slum resident (women, men) first asked me this question during the pilot survey. And this was an absolute necessity not only from ethics point of view, but also gaining for their familiarity gradually. I had to inform the local corporator particularly in 2 areas where they were staying in the slum that I am conducting a study in their political constituency, since they would want to know the purpose of my data collection, was it political in purpose, any other political party or by the Government or it was for some non-governmental organisation. I had to clarify that this was not the case, I told them about the study and its purpose of award of a degree right from the beginning. In the third slum, the corporator used to visit the slum and

wanted to know about the study. In the other two areas, I could never meet the corporator during my visits.

Women from almost all households were surveyed in 8 slums identified namely Pattapol Mamdi beedhi sahi, Pattapol Goli beedhi sahi, Odiya Bazaar Baunsagali, Odiya Bazaar Gouda sahi, Chattra Bazaar Pola Telugu sahi, Ranihat Sagadia sahi, Ranihat Teli sahi, and Ranihat Dhoba sahi. Wherever the respondent refused for the survey (refusal rate was low at 2 percent or less of the all inhabiting households), the house was found uninhabited in a broken condition or, the same family usually with sons and daughter-in-laws was using two houses, but stayed as a joint family with common kitchen in the same slum or, the respondents were unavailable for some reason such as, they were sick or had gone to village on a long leave, in such cases the woman in the household was not interviewed. In 4 slums, namely Pattapol Ghantalidhi sahi, Pattapol Mochi sahi, Pattapol Batamangala sahi and Ranihat Pilgrim Road Das sahi, women from at least 50 percent of the slum households were interviewed for the study. The sampling was 50 percent of the total in these four slums either for reasons of large size of the slum or due to the initial difficulties in rapport building while conducting the study. The rapport building at the initial stage was found difficult, more so for the dynamics that arose from differences of mother tongue of the researcher (Odiya) and the respondents (Telugu). Every alternate house was picked up for survey without any bias of the interviewer. Wherever the respondent refused or she was unavailable for some reason, the respondent available from the next adjacent house was interviewed. In many cases, women also volunteered to be included in the survey, hence the respondent number was not necessarily limited to 50 percent of the total. In other words, at least 50 percent sample of households in these selected slums was chosen by systematic random sampling of alternate households. Whenever a household had joint family and two women were residing in, the preference was based on whether she was working and earning at the time of survey or in the past. If both the women were found earning then, the elder amongst them was chosen. Case studies were selected based on previous work and reasons cited for work change by the respondent. Case study interviews were conducted in at least three different sittings with prior appointment from each respondent, each sitting ranged between 30-60 minutes.

A minimum 50 percent of the slum population were surveyed in the chosen slums of the Cuttack city, finally getting a sample of 498 women workers. 33 women have been chosen as the sample for the interview based on the reasons cited for employment shift or withdrawal, age and previous employment of the respondent. Method of case study was used to know her health and other associated conditions of work change.

Ethical Considerations

Ethics mattered at the stages of data collection and dissemination of this research (critique of 'procedural ethics' by Guillemin & Gillam (2004) cited by Kaiser)[clii]. The study motive was declared or disclosed before seeking consent. The respondent was briefed that the study is not sponsored by Government or non-Government organization and was conducted as a part of my doctoral study. And that it would not cause them any harm by any intervention. Their voluntary participation and time was sought for survey as well as the case studies. Ground rules followed during data collection were informed consent and voluntary participation of respondents. For case studies, prior appointment was taken for each sitting of the interviews. Anonymity and confidentiality of respondents ('convention of confidentiality' as explained by Baez (2002) cited by Kaiser)[cliii] has been maintained in dissemination; the name, photo or video identifying the person have been avoided in use, only text in specific context with pseudo names or meta data level have been used. Risks of distress by recalling past has been minimised by spacing interviews, stopping interviews for the day when the respondent showed discomfort. Respondent's consent was crucial; in cases where respondents refused to participate, other members in the same slum or another slum were chosen. During obtaining informed consent, in many cases the woman respondent asked her husband or son before speaking for the survey or case study interview. Indirectly, consent of male family member was required also. In few cases, the respondents wanted the survey or interviews initially to be conducted before their male family members or neighbor-cum-friend. In subsequent visits of case studies, this inhibition was reduced and they spoke alone. The indirect consent of male family members taken in the present study is similar to what Sachs, Hougham, Sugarman, Agre, Broome, Geller et.al (2003) found and reported as, "investigators

often need the cooperation or "buy-in" of clinicians caring for patients who are potential subjects of trials."[cliv]

In spite of consent for interviews, few respondents did not answer specific questions such as a question on their specific food meal. Their silence was interpreted as they did not have anything to eat for that meal. Throughout the case studies interviews, one of the ways was to recapitulate what was earlier said and shared by the respondent. In a way this was also a kind of implicit consent every time on the kind of data that would be shared about them in future. The American Anthropological Association, 1998 in their ethical guidelines say, "Researchers must determine in advance whether their hosts/providers of information wish to remain anonymous or receive recognition, and make every effort to comply with those wishes. Researchers must present to their research participants the possible impacts of the choices, and make clear that despite their best efforts, anonymity may be compromised or recognition fail to materialise."[clv]

Sample Size

498 women from slums in Cuttack city have been surveyed. 33 women, a sub-sample of the original 498 sample have been interviewed. Since these interviews were carried out in multiple sittings, whenever any family member of the respondent was present during the interviews and wanted to participate in the respondent's interview, the family member's remarks were also recorded for consideration. 2 slum corporators (elected ward leader), 1 social activist and 3 *anganwadi* workers, in nutshell who are the key persons in the slum area have been approached to understand the slum area and slum population. Some respondents or family members also informed about the slum area, which happened during the interaction of pilot survey.

Sample for the study was taken from Ranihat (Das sahi & Sagadia sahi), Chattra Bazaar, Odiya Bazaar and Pattapol slum areas, four different locations in Cuttack city. 12 slums were picked up from these slum areas. 19 households in Ghantalidhi sahi (32 households identified is slum population), 34 households in Mochi sahi (55 households identified is the slum population), 28 households in Batamangala sahi (52 households identified is the slum population), 37 households in Goli beedhi sahi (almost all households covered), 28 households in Mamdibeedhi sahi (almost all

covered excepting one or two houses) 72 households in Ranihat Sagadia sahi, Teli sahi, Dhoba sahi (83 households identified is the slum population), 173 households in Ranihat Pilgrimroad Das sahi, (358 households identified is the slum population), 67 households in Odiya Bazaar Baunsagali and Gaudasahi (70 households identified is the slum population), 40 households from Chattra Bazaar Pola Telugu sahi (almost all households covered) were surveyed for the study.

Figure 3: Sample Composition of Survey

Slum Area	Predominant Occupation	No. of sample households/women	% of total sample (498)
Pattapol	Domestic work	146	29.32
Ranihat Das sahi	Construction and domestic work	173	34.74
Ranihat Sagadia sahi	Construction and domestic work	72	14.46
Odiya Bazaar	Construction and domestic work	67	13.45
Chattra Bazaar Pola	Construction work	40	8.03
Total		498	100

For the survey, while contacting the families, earning woman of the household was chosen. In case, there were two earning women in the same household, the elderly woman was surveyed. Employment status and age was used as an inclusion criteria for sampling of the survey.

For the interviews, respondents who cited health as a reason for employment shift or withdrawal/status change were chosen more in the sample. However, few cases who cited child birth or work demands at home as reason were also interviewed.

Study Bias

There is a possibility of selection bias of the sample respondents for interviews, as I probe the health factors of employment shift or withdrawal. Selection bias has been minimised by including/interviewing women who did not cite health as a reason, they had cited child birth or family work demands as the reason. Also respondents from different age groups have been interviewed for minimising the bias. There is possibility of recall bias of respondents as the study is retrospective, it goes in to past

events history and respondents need not recall it correctly for whatever reasons. Recall bias has been minimised by two techniques. First, by repeating certain questions at different points of time in different sittings, and second, by recapitulating the events understood from previous interviews before the respondents and soliciting their reaction and validation.

Methods of the Study

The study uses mixed methods of survey and case studies along with field notes taken during the data collection.

1) Survey method was used to know women's employment history, past work, present work, income, family profile, migrant status, the age at which they changed work and the major reason cited by women for such shifts. Survey schedule with close ended responses was used here.
2) Case studies method was used to know the shifts, withdrawal, double burden of women, their everyday living conditions and work conditions, health issues, exposures and vulnerabilities. In-depth interviews were used here.
3) Field notes were taken during survey as well as case studies data collection, whenever some observation was there which was in addition or, different and striking or, routine and mundane to be noticed, but essential part of women's lives.

The study was conducted in slums of Cuttack city, in Odisha state of India from June 2014 to February 2015.

Methodological Issues of the Study

There were certain measurement issues of the survey. Main work and secondary work was differentiated on the basis of number of days of work in a month and number of months in a year, but in few cases the occasional secondary work such as marriage function helper had become the sole work and was then, captured as main work. When respondents helped in family business, this has been listed as a work category which included unpaid work of a helper. But helping in family business did not get them earnings for which this has not been considered as an occupation or work with source of income. Husband's earnings per month as measured did not mean he

contributed everything to the family, most of them spent considerable money from their earnings on alcohol. This was known later during the case studies. Age of the respondent was in most cases an estimate based on the age of eldest child and age of the respondent at the time of marriage, gap between attaining puberty and marriage, age of puberty, since the respondents did not know their age. Health was conceived as one of the reasons of work change and was included in the close ended responses in the survey along with other reasons such as work demands at home, marriage, and more income. However, as the survey progressed, these responses were found restrictive when respondents cited reasons such as sexual harassment, son started earning, commuting issues, etc. These were later accommodated as separate categories. Different response categories were added during coding for main work, secondary work too since the varied responses outnumbered the response categories.

The methodological challenge is the multidimensionality of the phenomenon to be studied, which includes the social determinants of health and intersectionality of employment shifts. This required use of diverse methods, both quantitative and qualitative, to understand the phenomenon in greater detail and help inform the findings of one method to that of the other. Health, with multiple dimensions influencing the various dimensions of health issues, was not attempted to be captured through the survey keeping in view the complexity of health issues. During the field work of survey, any additional information while sharing health as a reason was written down as field notes.

Temporality of the research topic viewing the present in relation to past of the phenomenon, i.e., the employment shift or withdrawal that has happened in past, the health issues in past and their influence on employment shifts or withdrawal, the health issues in present, etc. required constant orientation and conceptual clarity while collecting data.

Analytical Framework

The qualitative method used a grounded theory approach within the tradition of interpretive framework. Grounded theory was initially developed by two researchers – Glaser and Strauss (1967). Later, due to bifurcation of the theory, two fundamental schools for grounded theory which are the Glaserian School and the Straussian School

emerged. The following figure gives a snap shot of key positions of both the schools.[clvi]

Figure 4: Comparative Picture of Glaserian and Straussian Approaches of Grounded Theoryclvii

'GLASERIAN'	'STRAUSSIAN' (used for the study)
Beginning with general wonderment (an empty mind)	Having a general idea of where to begin
Emerging theory, with neutral questions	Structured questions
Development of a conceptual theory	Conceptual description (description of situations)
Theoretical sensitivity (the ability to perceive variables and relationships) comes from immersion in the data	Theoretical sensitivity comes from methods and tools
The theory is grounded in the data	The theory is interpreted by an observer
The credibility of the theory, or verification, is derived from its grounding in the data	The credibility of the theory comes from the rigour of the method
A basic social process should be identified	Basic social processes need not be identified
The researcher is passive, exhibiting disciplined restraint	The researcher is active
Data reveals the theory	Data is structured to reveal the theory

The Straussian model of grounded theory or Strauss and Corbin's approach was used for qualitative methods in this study. Ramalo, Adams, Huggard & Hoare (2015) state that "Strauss and Corbin (1990; Corbin & Strauss 2015) recognised that a researcher brings to the research not only his/her personal and professional experience, but also knowledge acquired from literature that may include the area of inquiry."[clviii] The broad frameworks of intersectional theory and social determinants of health informed on the key areas which were adopted in the context of employment shifts, from wherein semi-structured questions of inquiry shaped up. But a free flowing conversation with minimum questions was the approach kept in mind during the interviews. In general, the respondent was asked to speak about herself, life, family, work. In specific, respondents were asked about what really happened since they

withdrew from previous work or shifted to current work. Some of the respondents spoke on their own a lot on these general and specific questions. There were probe questions such as, tell me about your daily schedule or who all are there in your family or were you ever sick and hospitalised or did you take a loan ever, if yes when? These probe questions helped establish a rapport and seek information on study research area, during the conversation specific queries were put up depending on the particular response by the respondents. The text and the subtext that emerged from the field on the structured areas of inquiry required interpreting and then structuring to inform the larger theory to explain the work changes of women workers for health issues. But later during analysis, reflecting on the data helped see new interlinkages through Charmaz's approach which were earlier invisible to analysis done by through Strauss & Corbin's approach. In that sense, reflexivity has been a part of this research, before, during and after the data collection. I chose the Strauss & Corbin approach because my mind was not in an empty state, there was a general awareness of public health, social, political and economic conditions being causative of health issues.It was expected that inductively theory would be formed by looking at the sequences, patterns, similarities, differences, frequencies, correspondence, relationships and the causal processes of health and the associated intersectional processes would be discovered (Saldana 2009). Reflexivity during data collection kept me cautious throughout while asking the questions and let the conversation remain free flowing with minimum probe questions with the respondents speaking on their own. And finally, during data analysis, I ended up using two grounded theory approaches in this process of reflexivity. Hsiung (2008) cites Mauthner and Doucet (2003) who describe "a process of deliberate retrospection in acquiring reflexivity in data analysis. Their process of retrospection involved revisiting data analyses they had conducted several years previously in order to examine how their subjective insights were either suppressed or overshadowed by institutional, epistemological, and ontological influences operating at the time. Their own intellectual growth since originally analysing the data allowed them to reveal new "truths" about the data, which were previously invisible to them."[clix] Reflexivity is defining and crucial for critical qualitative inquiry as Charmaz recommends. Charmaz (2006) says in the context of preconceptions of qualitative researchers, "I advocate developing methodological self-consciousness to turn a deeply reflexive gaze back on ourselves and the research process as well as on the empirical world."[clx] She defines

constructivist grounded theory approach as ‘bringing in doubt into analytic process systematically’ and coming up with ‘methodological strategies’ to discover what is later discovered.[clxi] She finds that Glaserian approach overlooks the preconceptions and thereby, forecloses the path of critical inquiry. In Charmaz’s words, “the most important preconceptions to excavate are ones we take for granted, such as those concerning individualism. Hidden preconceptions stem from class, gender, race, age, health, and professional statuses. Because Glaser and his followers overlook all these sources of preconceptions, they close a valuable route into critical inquiry.”[clxii]

The understanding gained through Strauss & Corbin’s grounded theory approach and Charmaz’s constructivist grounded theory approach while analysing the study findings have been explained in detail in Chapters 5 and 6. In brief, the Strauss and Corbin approach helped in understanding the structural causes, the multiple causal processes of exposures and vulnerabilities of health and the consequences of work and health. The Charmaz’s approach helped in enriching what was understood before as it unfolded the complexity of the processes, the notion of time, the continuity and the unique possibilities of intersection.

The following Chapters 4 and 5 present the findings of the study emerging from this research design and the analytical framework.

Chapter 4

Intersectional Location of Women Workers and Work Changes

The survey of women respondents in the selected 12 slums of Cuttack provides a profile of slum based women workers in relation to their region of origin, caste, religion, marital status, education and income. It covered one woman from each of the 498 households surveyed. The data obtained was analysed so as to understand the socio-economic background of women workers who inhabit the slums and the nature of their occupation. The survey tried to understand the background of women workers who faced work changes i.e., underwent work shifts or withdrew from work due to health reasons based on their employment in past and the present, the number of work years of past work, the age at which they underwent work changes, the incidence of health as a reason for work changes vis-à-vis other reasons among these workers and the present conditions of family in terms of family income, husband's earnings, number of earning members in the family and other family members.

I. Socio-Economic Profile of Sample

Women workers from Odisha and Andhra Pradesh, approximately 42 percent and 52 percent respectively from these regions of origin dominated the survey sample (refer Figure 5). Approximately 61, 22 and 16 percent belonged to lower, backward and upper caste respectively (refer Figure 6). Hindus predominated, being 98 percent of the respondents (refer Figure 7). Approximately 68 percent were married and stayed with their husbands while 31 percent approximately were either widowed or were separated from their husbands (refer Figure 8). Approximately 60 percent of the respondents had a family income of less than Rs.6000 and 40 percent of them above that (refer Figure 9). For a family of four to six, on an average Rs.100 was spent for at least one meal for buying dal, oil and vegetables which implied a monthly expenditure of Rs.3000 just for one meal, say lunch. A dinner would mean another Rs.50-100 per day which was an expense of Rs.1500-3000 every month. There was a given expense of rice, which was adjusted in case the respondent had access to Re.1per kilogramme (kg) of rice through ration card. A family of four to six had to buy additional rice of around 5-40 kilogrammes (kgs) beyond the supply of usual 25 kgs of rice and the

market rate of rice was Rs. 25-30 per kg. This additional rice intake varied depending on the age of family members, working members or children who ate outside home for certain meals at work place or school. The respondents usually spent Rs.5-10 on tea every day which was shared with another family member which added up to Rs.150-300 expenses every month. An average rent of Rs.500-800 was common among slum households. Considering these expenses, a minimum of Rs.6000 was taken as cut off for this analysis where in Rs.6000 guaranteed at least two meals a day, if not the third or the breakfast meal. Most of the husbands were in wage labour and did not have pension (Figure 10).

Figure 5: Region of Origin

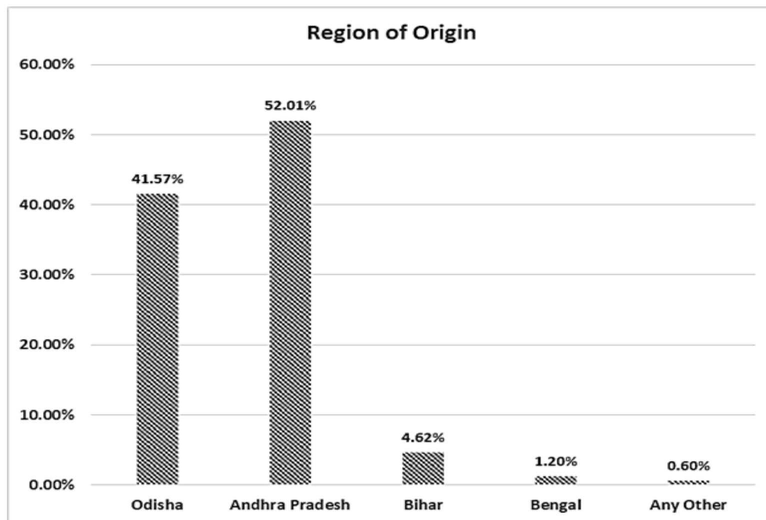


Figure 6: Caste Distribution

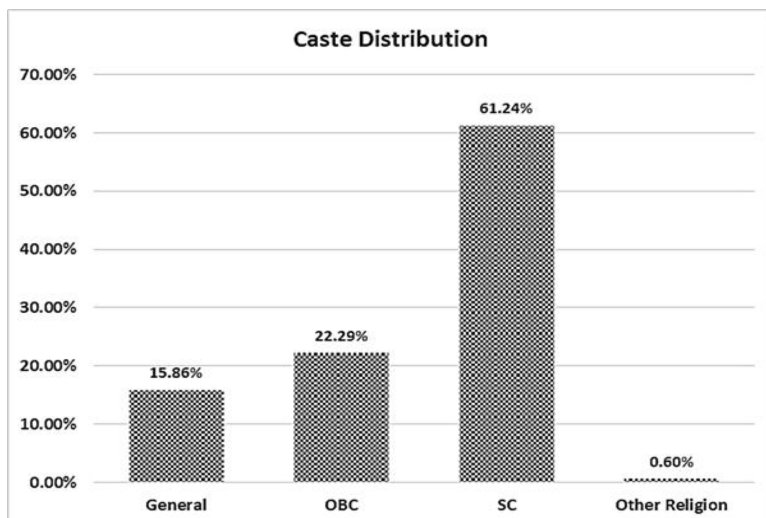


Figure 7: Religion Status

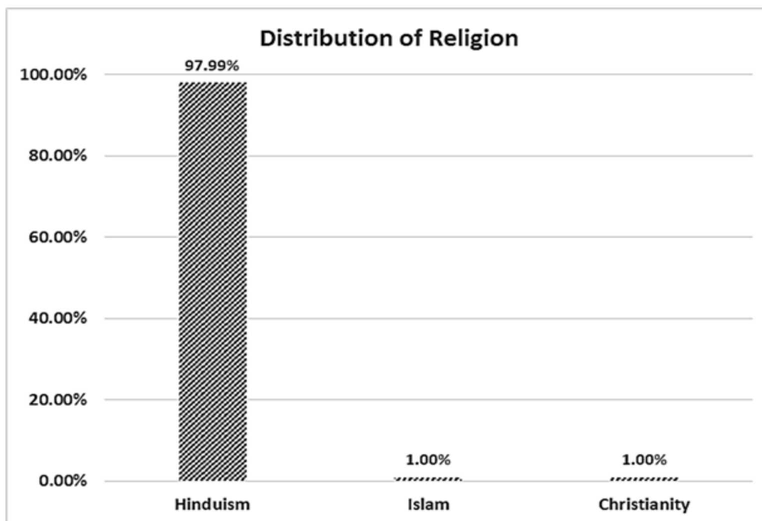


Figure 8: Marital Status

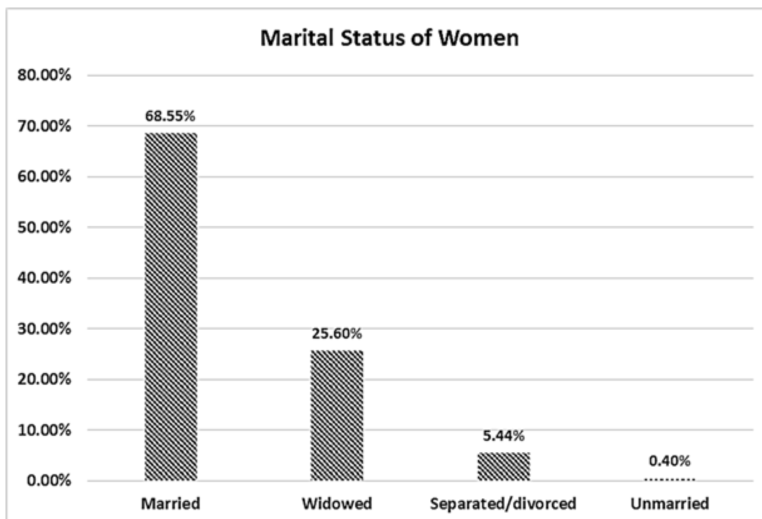


Figure 9: Family Income Distribution

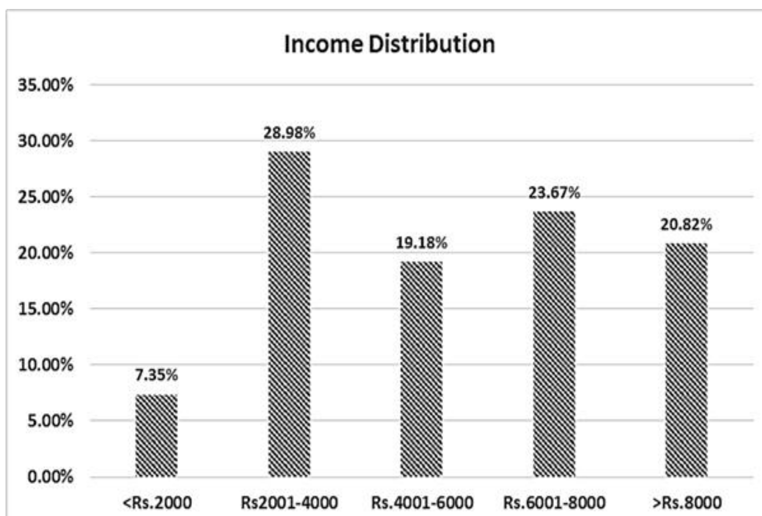
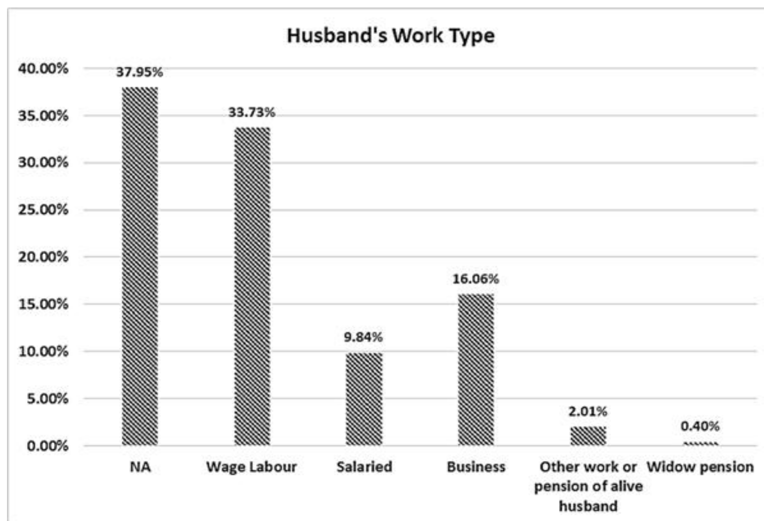


Figure 10: Husband's Work Type Distribution



II. Work Profile of Sample

Women's main work was captured with reference to the previous one year as 'usual status' (Table 1.3). Women in the slums were found to be currently employed in construction work, paid domestic work, food vending, marriage/social function helper work, school/college/nursing home sweeper/helper work, municipality sweeper work, hotel helper work, rag picking work, mill (*godam*) helper work, tailoring work, masseur work and paid cooking work. Work conditions typical of informal work defined the available work opportunities for slum women. Of the 498 women, 96 percent were employed in informal work including construction and paid domestic work, which had insecurity of work either in terms of availability of work or the employer having the discretion to terminate the work contract without pay or notice or had witnessed arbitrary fluctuations while negotiating the pay. These workers had no social security benefits of life insurance, health insurance and pension money. Only 4 percent of the women worked as municipality or school/college or hospital sweepers and this implied some written or verbal rules for termination of contract and a monthly income till the contract was terminated usually with a period of notice. Women's main work and work categories were captured as different since the main work implied necessarily paid work with reference to previous year and women's work category implied work done by women which was either paid or unpaid because it was done as a part of family business. This work was different from the unpaid domestic or care work. There were 12 such women who were unpaid for work done

for family business, they worked from home. The unpaid work for family business seemed to blur the distinction between paid and unpaid work, home based paid work, home based unpaid domestic work and home based unpaid work done for commercial purpose. The other studies which have found presence of such work are by Kumar (2006), who says "women do three kinds of work, paid, commercial work, their unpaid share of the family's professional work and domestic work".[clxiii] Even the extended SNA activities (CSO classification) which was done with an intent to bring visibility to women's work only includes household maintenance and care for the children, old and the sick in the household.

The surveyed 498 women have been categorised into 5 depending on the terms of remuneration as wage workers, salaried workers, vending business women, women helpers in family business, domestic help with remuneration in kind and those who identified themselves with no earnings as non-workers (paid). Women have been categorised as wage workers when they were paid a daily wage and as salaried workers when they were paid on a monthly basis, when they owned the business and handled their earnings they were treated as business women and when they helped family business and did not handle or receive any earnings, they were listed as helpers in family business. 23 percent of women approximately were engaged in wage labour, 34 percent approximately were employed in salaried work, 6 percent approximately ran their own businesses, 3 percent helped in family business and 34 percent of women identified themselves as non-working (refer Table 1.1).

Table 1: Women's Work Categories and Current Main Work

1.1 Work categories of surveyed women	n (%)
a) salaried work (paid domestic workers, school/hospital helpers/sweepers, municipality sweepers)	169 (33.93%)
b) wage work (construction workers, marriage helpers, rag picking work)	113 (22.69%)
c) business (self-employed food vending, tailoring work, run solely by her)	31 (6.22%)
d) helps family members in business (not run by her rather she helps male family members mostly in street food vending, small paan shop, it includes paid (2) and unpaid (12) helpers)	14 (2.81%)
e) remuneration in kind for domestic help	1 (0.20%)

f) Women who identified themselves as non-working during the survey (this does not include 12 members who helped in family business and were unpaid since they identified themselves as working and so have been put in the category of helps family members in business)	170 (34.13%)
Total survey sample women	498 (100%)
1.2 Women as paid and unpaid workers	n (%)
a) At home and unpaid workers (since source of income was the criteria of listing current occupation, this 182 includes 12 members who helped in family business and were unpaid even if they identified themselves as working)	182 (36.55%)
b) Total paid workers during the time of survey	316 (63.45%)
1.3 Current main work or woman's paid work (her main source of income)	n (%)
a) construction work	96 (30.38 %)
b) domestic work	139 (43.99%)
c) marriage helper work	4 (1.27%)
d) home-based work	4 (1.27%)
e) food vending business (tea, banana, *vada*, *idlis*, paan)	30 (9.49%)
f) municipality sweeper work	5 (1.58%)
g) hospital sweeper work	7 (2.21%)
h) school or college helper work	8 (2.53%)
i) cooking work	4 (1.27%)
j) ragpicking work	3 (0.95%)
k) *godam* helper work	1 (0.32%)
l) masseur work	4 (1.27%)
m) hotel helper work	3 (0.95%)
n) tailoring work	3 (0.95%)
o) any other	5 (1.58%)
Total	316 (100%)

Approximately 82 percent of the working women who were receiving a salary on a monthly basis were paid domestic workers. Rest were employed as sweeper or helper at schools, colleges and hospitals. 85 percent approximately of the women earning daily wages were employed in construction work. Rest were marriage function

helpers or *godam*/mill helpers. What was interesting was women's identifying themselves as workers, even when they were unpaid and this has been captured in women's work category in the survey, the way women identified themselves. 12 women who helped in family business and did not receive any share of business earnings identified themselves as workers, but when it came to their own earnings, it was nil. This difference has been retained by listing the women with earnings as workers and specifying their work and rest of the women with no earnings have been listed as non-workers under the current occupation category in the survey. The basis for this classification by the women themselves is clearly evident in a crosstab between current work and work relationship. (refer *Annexure I* Table).

More than 95 percent of the domestic workers as well as construction workers in the sample had worked for more than 6 months in the survey year (refer Table 2). This implied that they were employable for majority of the time in last 12 months. 96 percent of rest of the women worker respondents were also found working for more than 6 months in the last year (refer Table 2).

Table 2: Work Months in Last 12 Months

Women workers	Work months last year		Total N (%)
	6 months or more n (%)	less than 6 months n (%)	
Construction workers	92 (95.83%)	4 (4.17%)	96 (100%)
Domestic workers	136 (97.84%)	3 (2.16%)	139 (100%)
Marriage helpers	2 (66.67%)	1 (33.33%)	3 (100%)
Rest of the workers	75 (96.15%)	2 (3.85%)	77 (100%)
Total	305 (61.37%)	10 (2.21%)	315 (100%)

[Note: One value is missing which is that of a marriage helper. Her work was occasional and she could not recollect the months of work during the 25 minutes of survey interview. 315 available data of 316 working women with earnings]

It is necessary to look at the work days in last month of these 316 workers since it brings in the issue of availability of work or the opportunity to earn for these employed women. The issue of availability of work came forth when data on

women's work months in the last year and work days in the last month was collected. It was noteworthy that one construction worker from 25-35 years age group and one domestic worker from 35-45 years age group said that work was not available in the last month. Work availability and not their age related health issues were a hindrance. Issues such as construction work was not available during monsoons or marriage helper work was restricted to certain seasons of marriage were also shared by respondents during survey which were captured as field notes. For them, distance of work site mattered for taking up construction work available since it added up to the total time spent outside home. Women made decisions either not to take up distant work sites at all or took up such work adjusting their domestic chores schedule and other family concerns. Distance of employer's house from respondents' homes was determining when women domestic workers settled for a monthly salary based paid work. Walking time to and from employer's house was kept to the minimal to save their time and energy. Marriage helper work was more of a seasonal secondary work for majority of respondents and was not a main source of income excepting very few. Such work was available during the marriage season or particular months in a year.

More than 85 percent of the domestic workers, masseurs, sweepers at municipality or hospital, helpers in school or colleges and petty business owners worked at least 26-29 days a month and at least 75 percent of cooks and home based workers worked the same. 26-29 work days in the last month implied a regular engagement in work. Of the domestic workers, 41 percent approximately worked for 30-31 days in the last month that hinted at lack of scope for rest for these workers. Only 2 percent and 8 percent of women construction workers worked for 30-31 days and 26-29 days in the last month. 58 percent of women construction workers approximately worked for 10-15 days in the last month or even less at the time of survey. Since the survey was done in June-August which witnessed summer and thereafter, rains, it was interpreted that work was not available or women were unable to go to work due to extreme heat. The impact of summer had its influence on women's ability to work continuously in a week since women felt exhausted after two to three days of continuous construction work in heat even if work was available. And also the fact that 3 women construction and domestic workers had not worked in last month/ two months for own illness makes an important observation. Women need not have shifted or withdrawn from

previous work, but were experiencing impeding health issues in some form which was affecting their paid work.

Table 3: Women Workers' Work Days in The Last Month

Work days	Construction workers n (%)	Domestic workers (n %)	Marriage helpers (n %)	Rest of the workers (n %)	Total
30-31 days	2 (2.08%)	57 (41.01%)	0 (0%)	42 (52.5%)	101 (31.97%)
26-29 days	8 (8.33%)	62 (44.60%)	0 (0%)	22 (28.57%)	92 (29.11%)
16-25 days	27 (28.12%)	9 (6.47%)	0 (0%)	6 (7.79%)	42 (13.29%)
10-15 days	43 (44.79%)	2 (1.45%)	0 (0%)	5 (6.49%)	50 (15.83%)
Less than 10 days	12 (12.5%)	3 (2.16%)	4 (100%)	1 (1.30%)	20 (6.33%)
Did not work last month for illness in family	1 (1.04%)	0 (0%)	0 (0%)	0 (0%)	1 (0.32%)
Did not work for more than 6 months due to own illness	1 (1.04%)	1 (0.72%)	0 (0%)	0 (0%)	2 (0.63%)
Did not work last month/ 2 months due to own illness	1 (1.04%)	2 (1.44%)	0 (0%)	0 (0%)	3 (0.95%)
Took a work break of one month	0 (0%)	2 (1.44%)	0 (0%)	1 (1.30%)	3 (0.95%)
No work was available	1 (1.04%)	1 (0.72%)	0 (0%)	0 (0%)	2 (0.63%)
Total	96 (100%)	139 (100%)	4 (100%)	77 (100%)	316 (100%)

At the time of survey, a woman construction worker could earn a minimum of Rs.200-250 in a single day and up to Rs.4000-5000 per month if work was available for at least 20 days in a month and she availed it. Average monthly salary of a domestic worker was less than Rs.2000/month wherein she worked in one to two houses with two shifts of work.

The survey found that 45 percent of the women construction workers earned approximately Rs.4000 or more every month whereas only 1 percent of women domestic workers earned so. Approximately 65 percent of women domestic workers and 7 percent of women construction workers earned less than Rs.2000 per month (refer Table 4).

Table 4: Women Construction and Domestic Workers' Earnings (per month)

	< Rs.1000	Rs.1000< Rs.2000	Rs.2000< Rs.3000	Rs.3000< Rs.4000	Rs.4000 or more	Total
Construction workers	1 (1.05%)	6 (6.32%)	16 (16.84%)	29 (30.53%)	43 (45.26%)	95 (100%)
Domestic workers	30 (21.58%)	60 (43.16%)	33 (23.74%)	14 (10.07%)	2 (1.44%)	139 (100%)
Rest of the workers	16 (20%)	20 (25%)	11 (13.75%)	14 (17.5%)	19 (23.75%)	80 (100%)
Total	47 (14.97%)	86 (27.39%)	60 (19.11%)	57 (18.15%)	64 (20.38%)	314 (100%)

[Note: Value of a construction worker and value of a vending business woman are missing, only 314 values are given since 2 values are missing. These women found it difficult to point out the earnings in last month since their work was uncertain and earnings everyday was a question mark in hot summer month.]

III. Intersectional Location of Slum Area, Caste, Region of Origin and Women's Current Work

The survey was conducted in 12 slums from 5 geographically separate slum areas within Cuttack city. Before choosing these slums, by speaking to key persons in these areas such as *anganwadi* workers, social activist, corporators and elderly residents, it was known that rarely any upper caste Telugu family resided in Ranihat Das sahi or Pattapol. By doing so upper caste Telugu families stayed away from scheduled caste families; 'lower caste' or scheduled caste Odiya and Telugu families were the predominant population of Ranihat Das sahi and Pattapol respectively. Telugu upper caste families stayed in Ranihat Sagadia sahi area dominated (implying influential) by Odiya backward caste families or in Chattra Bazaar Telugu sahi dominated by upper caste Telugu families. In Odiya Bazaar, Telugu upper as well as backward caste families resided along with Odiya and Muslim families. Both Odiya Bazaar and Ranihat Sagadia sahi were mixed neighborhood of lower class and middle class families unlike other 3 slum areas where lower class families formed the majority of

dwellers. Survey data analysis corroborates this link between slum of residence, work, caste and region of origin (refer Tables 5, 6 and 7).

Table 5: Slum Area, Caste and Region of Origin of Women

Slum area		Caste status (Hinduism)				
		General n (%)	OBC n (%)	SC n (%)	Other religion n (%)	Total n (%)
Pattapol N=146	Odisha	0 (0%)	3 (2.05%)	1 (0.68%)	0 (0%)	4 (2.74%)
	Andhra Pradesh	2 (1.37%)	3 (2.05%)	137 (93.84%)	0 (0%)	142 (97.26%)
	Total	2 (1.37%)	6 (4.11%)	138 (94.52%)	0 (0%)	146 (100%)
Ranihat Das sahi N=173	Odisha	18 (10.4%)	19 (10.98%)	103 (59.54%)	1 (0.58%)	141 (81.50%)
	Andhra Pradesh	1 (0.58%)	1 (0.58%)	2 (1.16%)	0 (0%)	4 (2.31%)
	Bihar	1 (0.58%)	22 (12.72%)	0 (0%)	0 (0%)	23 (13.29%)
	Any other	2 (1.16%)	2 (1.16%)	1 (0.58%)	0 (0%)	5 (2.89%)
	Total	22 (12.72%)	44 (25.43%)	106 (61.27%)	1 (0.58%)	173 (100%)
Odiya Bazaar N=67	Odisha	0 (0%)	1 (1.49%)	3 (4.48%)	0 (0%)	4 (5.97%)
	Andhra Pradesh	9 (13.43%)	22 (32.83%)	28 (41.79%)	1 (1.49%)	60 (89.55%)
	Any other	1 (1.49%)	1 (1.49%)	0 (0%)	1 (1.49%)	3 (4.48%)
	Total	10 (14.92%)	24 (35.82%)	31 (46.27%)	2 (2.98%)	67 (100%)
Chattra Bazaar N=40	Odisha	9 (22.5%)	1 (2.5%)	2 (5%)	0 (0%)	12 (30%)
	Andhra Pradesh	21 (52.5%)	6 (15%)	1 (2.5%)	0 (0%)	28 (70%)
	Total	30 (75%)	7 (17.5%)	3 (7.5%)	0 (0%)	40 (100%)
Ranihat Sagadiasahi N=72	Odisha	6 (8.33%)	17 (23.61%)	23 (31.94%)	0 (0%)	46 (63.89%)
	Andhra Pradesh	9 (12.5%)	12 (16.67%)	4 (5.5%)	0 (0%)	25 (34.72%)
	Any other	0 (0%)	1 (1.39%)	0 (0%)	0 (0%)	1 (1.39%)
	Total	15 (20.83%)	30 (41.67%)	27 (37.5%)	0 (0%)	72 (100%)

Slums in Pattapol slum area were synonymous with lower caste Telugu families since upper caste Telugu women identified the slum area as inhabited by lower caste families. Only 2 upper caste Telugu families and 3 backward caste Telugu families were found staying here in the survey sample in comparison to 137 lower caste Telugu families (refer Table 5). 95 percent of respondents from Pattapol slums area were lower caste Telugu women (refer Table 5). Lower caste Telugu women inhabiting the slum identified themselves as 'Mala'[clxiv] castes, who were cobblers or 'mochi'/ 'chamar'[clxv] by caste based profession. Some of them identified themselves as scheduled caste Telugus and their caste as 'Arjun', I could not find Arjun in the SC list, the closest were 'Aray mala' and 'Arwa mala'[clxvi]. The caste identities were reiterated by these respondents which was earlier spoken by upper caste respondents from different slum area. They called the other streets or 'beedhi' as 'Ghantalidhi' sahi, 'Mamdi' beedhi sahi and 'Goli' beedhi sahi which also had predominant population of scheduled caste Telugu families. 'Mochi' sahi was named after 'mochi' caste. Pattapol Batamangala sahi was named after the Goddess worshipped inside the street. The survey went by whatever the respondents identified their castes as. 80 percent of all lower caste Telugu families in the survey sample were found staying in Pattapol, it signified a kind of geographically demarcated area for lower caste Telugu families inside Cuttack. Their lives were tied to this area and the people in neighbourhood, though marriages either took place inside the slum or with some relatives in coastal districts of Andhra Pradesh. 78 percent of lower caste Odiya families in the survey sample were found staying in Ranihat Das sahi. 'Das' sahi literally meant street of 'Bauri'[clxvii] or 'Dasa', a scheduled caste Odiya population who do cleaning activities, etc. by caste based profession. 59 percent approximately of Ranihat Das sahi respondents were lower caste Odiya women and some families from Bihar stayed here too (refer Table 5). Das sahi was predominantly populated by Odiya lower caste families. Ranihat Sagadia sahi had greater presence of backward caste Odiya (24 percent) and lower caste Odiya (32 percent), backward caste Telugu (17 percent) and upper caste Telugu (12.5 percent) families than upper caste Odiya (8 percent) or lower caste Telugu (5.5 percent) families (refer Table 5). This slum had greater number of upper caste and backward caste Telugu families than lower caste Telugu families residing. This corroborated the presence of caste based segregation for Telugu families which was seen in Pattapol. Chattra Bazaar also showed caste based segregation for Telugu families, in fact this had a majority of upper caste

families (75 percent), 52.5 percent were Telugu upper caste and 22.5 percent were Odiya upper caste families (refer Table 5). Odiya Bazaar 'Gouda' sahi was named after Odiya cow herders, an Odiya backward caste (OBC).[clxviii] Odiya Bazaar baunsagali literally meant a street/'gali' of bamboos or 'baunsa'. It implied a street of 'badheis' or carpenter caste families who dealt with bamboos. Odiya Bazaar was the only slum area where in such caste demarcation among Telugu families was not visible. Odiya Bazaar had a mix of Telugu upper caste (14 percent), Telugu backward caste (33 percent) and Telugu lower caste (42 percent) families (refer Table 5) and they comprised the majority of population. Few Odiya lower caste families were there too (5 percent, refer Table 5).

Odiya upper caste families were not found here during survey sampling though there were Odiya backward caste (OBC) families staying in here. This could be possibly because middle class Muslim families too stayed in this locality. This slum area had a similar spread out like Ranihat Sagadia sahi, however it was unique with not just its mix of middle class and lower class inhabitants, but also Hindu and Muslim families and upper caste, backward caste and lower caste Telugu families staying in the same area. Odiya upper caste families avoiding settlement here hinted at a subtle religion wise segregation for slum based upper caste Odiya families. They probably stayed away since Muslim families stayed in the slum.

Each of the 5 different slum areas in the study and the links found between work and intersection of caste and region of origin have been discussed in detail in the following section (refer Tables 6.1 to 6.5).

Pattapol

41 percent of the Telugu lower caste women, 40 percent of the total lower caste families and 64 percent of the total working women approximately worked as paid domestic workers in Pattapol. 12.5 percent approximately of the working women ran their own businesses. 40 percent of the total women were not engaged in paid work (refer Table 6.1). Women who ran their own business, mostly engaged in food vending of cooked items like *vada* or *idli* or selling of pan, tea, candies, biscuits and some readymade snack items. The predominance of paid domestic work and absence of construction work as a work opportunity here was striking compared to other areas.

The women here went for 'paid domestic work' unlike Telugu upper caste women. They preferred paid domestic work since it had scope for flexible work timings depending on employer houses and offered them opportunity to earn. They worked in all kinds of households, including upper caste Odiya and Marwarhi families, which hints at effects of urbanisation on caste identities when employers hired domestic workers.

Table 6.1: Pattapol

Origin	Caste status				Total
	Main work	General	OBC	SC	
Odisha	NA	0	3	0	3
	Municipality sweeper work	0	0	1	1
	Total	0	3	1	4
Andhra Pradesh	NA	1	2	52	55
	Domestic work	1	0	56	57
	Marriage helper work	0	0	2	2
	Business	0	0	11	11
	Hospital sweeper work	0	1	2	3
	School/college helper work	0	0	6	6
	Cooking only	0	0	2	2
	Masseur work	0	0	2	2
	Tailoring work	0	0	1	1
	Any other	0	0	3	3
	Total	2	3	137	142
Pattapol Total		2	6	138	146

[Note: In Pattapol, there were no other religion respondents in the survey sample]

Ranihat Das Sahi

Usually, by caste tradition in Odisha the 'bauri' or das do not touch any food item or water used for cooking in an upper caste household, which could be a consideration while employing a 'bauri' caste woman as a paid domestic worker in some upper caste Odiya households. But the data does not corroborate this unless the homes had a

cleaning area outside which did not require the worker to come inside the kitchen. Odiya lower caste working women were found engaged in construction (40 percent) as well as domestic work (34 percent) more or less equally (refer Table 6.2). More number of Odiya upper caste working women here were found engaged in domestic work (30 percent) than construction work (20 percent). This was also true for Odiya backward caste working women here, 18 percent and 63 percent of them worked as construction and domestic worker respectively (refer Table 6.2). The work trends of Odiya upper caste and backward caste working women does not imply a caste based segregation of occupation, rather it highlights the prominence of class and region of origin factor in this intersection of caste, region of origin, class and gender. For the Odiya upper or backward caste women, staying in the slum itself was defining their identity as a poor woman in their native state unlike Telugu counterparts for whom the slum area mattered than slum per se, since they defined themselves as migrant upper caste communities with a higher status than migrant lower caste communities. This distinction was under the same class category (slum population), with caste and region of origin being given priority differently.

Women belonging to families from Bihar were mostly present in Ranihat Das sahi and they did not do paid work. 87 percent of women from Bihar residing in these slums did not do paid work, the highest percentage of women from any community who had no paid work (refer Table 6.2). But 48 percent of them actually worked from homes without pay (refer *Annexure I* Table). Conversation during survey data collection reveals that they helped their husband's business from home, but did not go outside their homes. Their husbands were into *panipuri* (Indian fast food) business mostly, and their women helped in preparing *panipuris* at home. 11 out of 23 such women from Bihar (48 percent approximately) helped their husbands in their business from home, they did not earn a wage or salary for their labour and had identified themselves as working in the survey in spite of not earning anything. Women from Bihar origin had strong identification with gender norms of mobility, roles and norms of region of origin as they worked from inside of homes as helper to male members. These families had agricultural origins and before coming to Cuttack city, their husbands worked as agricultural labourers in villages of Bihar.

Table 6.2: Ranihat Das Sahi

Origin	Caste status					Total
	Current main work	General	OBC	SC	Other religion	
Odisha	NA	8	8	36	1	53
	Construction work	2	2	27	0	31
	Domestic work	3	7	23	0	33
	Marriage helper work	0	0	2	0	2
	Business	3	1	7	0	11
	Municipality sweeper work	0	0	1	0	1
	Hospital sweeper work	0	0	4	0	4
	Ragpicking work	1	0	1	0	2
	Masseur work	0	1	0	0	1
	Hotel helper work	1	0	0	0	1
	Tailoring work	0	0	1	0	1
	Any other	0	0	1	0	1
	Total	18	19	103	1	141
Andhra Pradesh	NA	1	0	1	0	2
	Domestic work	0	1	1	0	2
	Total	1	1	2	0	4
Bihar	NA	0	20	0	0	20
	Construction work	1	0	0	0	1
	Domestic work	0	1	0	0	1
	Godam helper work	0	1	0	0	1
	Total	1	22	0	0	23
Any other	NA	1	0	1	0	2
	Construction work	0	1	0	0	1
	Business	1	0	0	0	1
	Ragpicking work	0	1	0	0	1
	Total	2	2	1	0	5
Ranihat Das sahi Total		22	44	106	1	173

Ranihat Sagadia Sahi

3 slums in this area taken for the survey were called as Ranihat Sagadia sahi, Ranihat Teli sahi, and Ranihat Dhoba sahi. 'Sagadia' sahi literally meant street of bullock carts (which were handled by agricultural caste people), 'teli' sahi or street of families who those who make oil from seeds and 'dhoba'[clxix] caste or those who wash clothes by caste based profession, a listed Odiya scheduled caste (SC). 'Teli' caste is listed as Other Backward Class (OBC).[clxx] Odiya upper caste working women were employed more as construction workers (67 percent) than domestic workers (33 percent) whereas Odiya lower caste working women were employed more as paid domestic workers (50 percent) than construction workers (35 percent). Odiya backward caste working women were found engaged in construction (31 percent) as well as domestic work (38 percent) more or less equally here (refer Table 6.3). These trends showed some caste based segregation of work for upper caste and lower caste Odiya women, unlike Ranihat Das sahi. The possible reason could be this slum area was spread out adjoining Odiya middle class homes, staying here was not perceived as equivalent to staying in Ranihat Das sahi or Chattra Bazaar or Pattapol, since Ranihat Sagadia sahi area was not exclusively inhabited by lower class families. These families stayed in clusters here. For native Odiya slum population here, caste acted as a defining part of their intersectional identity to some extent when they took up paid work.

Table 6.3: Ranihat Sagadia Sahi

Origin	Caste status				Total
	Current main work	General	OBC	SC	
Odisha	NA	3	4	3	10
	Construction work	2	5	7	14
	Domestic work	1	4	10	15
	Business	0	1	0	1
	Municipality sweeper work	0	0	1	1
	School/college helper work	0	0	1	1
	Cooking only	0	1	1	2
	Masseur work	0	1	0	1
	Tailoring work	0	1	0	1
	Total	6	17	23	46

Origin	Caste status				Total
	Current main work	General	OBC	SC	
Andhra Pradesh	NA	1	1	1	3
	Construction work	6	10	2	18
	Domestic work	1	0	1	2
	Business	0	1	0	1
	Any other	1	0	0	1
	Total	9	12	4	25
Any other	NA	0	1	0	1
	Total	0	1	0	1
Ranihat Sagadia sahi Total		15	30	27	72

[Note: In Ranihat Sagadia sahi, there were no other religion respondents in the survey sample]

Odiya Bazaar

Odiya Bazaar had Telugu upper caste, backward caste and lower caste staying together unlike Pattapol or Ranihat Sagadia sahi or Chattra Bazaar. But their work lives still showed caste based segregation since greater number of Telugu upper caste working women were employed as construction workers (57 percent) than domestic workers (14 percent), whereas Telugu backward caste and lower caste working women worked more as a domestic worker than as a construction worker. There were 24 percent and 33 percent approximately of Telugu backward caste and Telugu lower caste working women as construction workers here than 48 percent and 61 percent approximately of the same working as domestic workers (refer Table 6.4). This finding corroborates the earlier observation of link between caste, region of origin and work, particularly for Telugus.

Table 6.4: Odiya Bazaar

Origin	Caste status					Total
	Current main work	General	OBC	SC	Other religion	
Odisha	NA	0	1	1	0	2
	Municipality sweeper work	0	0	2	0	2
	Total	0	1	3	0	4
Andhra Pradesh	NA	2	1	10	0	13
	Construction work	4	5	6	0	15
	Domestic work	1	10	11	1	23
	Home-based work	0	4	0	0	4
	Business	1	1	1	0	3
	School/college helper work	1	0	0	0	1
	Hotel helper work	0	1	0	0	1
	Total	9	22	28	1	60
Any other	Domestic work	1	1	0	1	3
	Total	1	1	0	1	3
Odiya Bazaar Total		10	24	31	2	67

Chattra Bazaar

Chattra Bazaar ‘Telugu’ sahi/basti was named after Telugu residents. In Chattra Bazaar slums, Odiya as well as Telugu families stayed. There were other separate demarcated areas based here which have not been taken up for the study such as ‘macchua’ sahi or street of fishermen, ‘behera’ sahi or street of Odiya sweepers (SCs). Upper caste Odiya working women and upper caste Telugu working women from Chattra Bazaar worked as construction worker in 80 percent and 79 percent of the cases, respectively. None of the Telugu upper caste women worked as domestic workers. 20 percent of Odiya upper caste working women worked as domestic workers (refer Table 6.5).

Table 6.5: Chattra Bazaar

Origin	Caste status				Total
	Current main work	General	OBC	SC	
Odisha	NA	4	0	1	5
	Construction work	4	0	1	5
	Domestic work	1	1	0	2
	Total	9	1	2	12
Andhra Pradesh	Construction work	11	0	0	11
	Domestic work	0	1	0	1
	Business	2	0	0	2
	NA	7	5	1	13
	Hotel helper work	1	0	0	1
	Total	21	6	1	28
Chattra Bazaar Total		30	7	3	40

[Note: In Chattra Bazaar, there were no other religion respondents in the survey sample]

The intersectional category based on caste and region of origin was found associated with Telugu women's slum of residence (refer Table 5 and Tables 6.1-6.5). However, caste and region of origin were not enough for explaining the residence pattern of Odiya families in slums. Lower caste families and backward or upper caste Odiya families stayed together in Ranihat Das sahi. The lower caste Odiya families, being a majority in Ranihat Das sahi did not oppose upper caste non-Odiya families staying there. This kind of residence was a taboo amongst majority of upper caste Telugu families. But it was okay for their Odiya counterparts or even backward caste families from Bihar in the sample to stay with Odiya lower caste families. It could be inferred that it was their poverty and need to find a residence in the city that overrode caste considerations of being upper and backward caste. Odiya upper caste families avoided Odiya Bazaar slums which could be explained by the underlying religion factor (Muslim families staying there) than just the intersection of caste and region of origin.

Table 7: Caste, Region of Origin and Women's Work

Caste status	Region of origin	NA	Construction work	Domestic work	Marriage helper work	Rest of the workers	Working total	Total
General caste	Odisha	15	8	5	0	5	18	33
	Andhra Pradesh	12	21	3	0	6	30	42
	Bihar	0	1	0	0	0	1	1
	Any other	1	0	1	0	1	2	3
General caste Total		28	30	9	0	12	51	79
OBC	Odisha	16	7	12	0	6	25	41
	Andhra Pradesh	9	15	12	0	8	35	44
	Bihar	21	0	1	0	0	1	22
	Any other	0	1	1	0	2	4	4
OBC Total		46	23	26	0	16	65	111
SC	Odisha	41	35	33	2	21	91	132
	Andhra Pradesh	65	8	69	2	28	107	172
	Any other	1	0	0	0	0	0	1
SC Total		107	43	102	4	49	198	305
Other religion	Odisha	1	0	0	0	0	0	1
	Andhra Pradesh	0	0	1	0	0	1	1
	Bengal	0	0	1	0	0	1	1
Other religion Total		1	0	2	0	0	2	3

There was no glaring difference between Telugu and Odiya women in terms of unemployment, since 33 percent (86 out of 259) of Telugu women and 35 percent (73 out of 207) of Odiya women approximately did not work (refer Table 7). 28 percent of Telugu upper caste women did not engage in paid work which was higher than that of the Telugu backward caste (20 percent) who did not do paid work and lower than the Telugu lower caste women (38 percent) who remained away from paid work. My

field notes helped in analysing this trend. The comparatively higher rate of Telugu lower caste women as non-workers could be possibly explained by the fact that houses in Mochi sahi and Ghantalidhi sahi, 2 of 6 slums in Pattapol slum area had self-occupied houses by owner families; these houses were built as a part of Indira Awas Yojana by the Government some 20 years back. Own house saved these many households of rent expenses in comparison to Telugu upper caste and backward caste families who stayed in rented houses as tenants. Also Telugu upper caste women owned land back home in villages of coastal districts of Andhra Pradesh and went there once or twice a year for which they needed more money to spend and could not afford not working and not earning. The Telugu backward caste women had lesser number of non-workers than Telugu upper caste women since they had less inhibition to join domestic work when opportunity was available. There were no Telugu women working as municipality sweeper even if their men worked so. 4 percent approximately of Odiya working women were found working as municipality sweeper (refer Table 7). As discussed earlier (refer Tables 5 and 6.1 to 6.5) Telugu upper caste women considered domestic work as lower caste work, implying the lower status of domestic work and thereby, its association with pollution and not purity and asserted how by belonging to upper caste they were associated with purity by not doing paid domestic work. The work trend for Odiya upper caste women was different than that of their Telugu counterparts. 45 percent, 39 percent and 31 percent approximately of Odiya upper caste, backward caste and lower caste respondents respectively were non-working women. This was possibly because gender based norms of mobility and its internalisation was strongest among upper caste Odiya women than the other two groups. Also as my field notes inform me, some land ownership in native village of upper caste Odiya families being an upper caste and thereby, a financial back up of food grains cannot be ruled out as a supporting reason for not joining paid work. But when Odiya upper caste women decided to join paid work, survey data reveals that caste based inhibition to do paid domestic work was stronger among Telugu upper caste women than Odiya upper caste women (refer Tables 6.1-6.5). 44 percent and 28 percent approximately of working Odiya upper caste women worked as construction and domestic workers respectively (refer Table 7). Rest of them were engaged in petty business, rag picking work and hotel helper work. It supports the earlier finding (refer Table 5) on negligible caste based segregation of residence among Odiya upper caste and backward caste families than their Telugu counterparts. This difference between

Odiya and Telugu groups based on caste and region of origin existed for their current main work as well as slum of residence. Greater number of backward caste Odiya women worked as domestic workers whereas Telugu backward caste women preferred construction work over domestic work. 28 percent and 48 percent approximately of Odiya backward caste working women were found working as construction and domestic workers respectively and 43 percent and 34 percent approximately of Telugu backward caste working women were found working as construction and domestic workers respectively. A careful analysis of these findings leads to the inference that caste based inhibition to do paid domestic work was less prevalent among backward caste women irrespective of region of origin since they were positioned in the middle of the caste hierarchy than upper castes; this was found among Telugu as well as Odiya backward caste women. Overall, 35 percent and 40 percent approximately of backward caste working women worked as construction and domestic workers respectively. For the working Odiya women, it could be inferred that Odiya upper caste and backward caste women identified themselves first as poor and then as a member of an Odiya caste community. It was so since they shared the slum of residence with lower caste Odiya families and did not hesitate to engage in paid domestic work when they had to. They were natives of Odisha unlike migrant Telugu families and this was crucial with whom they interacted; their social interaction was more influenced by their native poor or slum inhabitant identity than just their caste identities in their own state. According to the survey data, none of the upper caste or backward caste women of Odisha or Andhra Pradesh origin did marriage helper work as the main work (refer Table 7). This was not further implored, whether caste norms affected this decision. But conversation during survey with respondents about marriage helper work revealed that it was considered as 'night work' particularly, by younger women who did not want to risk their safety at night. Conversation with women revealed that some of them got construction work or domestic work at the behest of a *meestri* or a common friend from their slum. Some women grew up watching their family member doing the same work. These observations and sharings associated with neighbourhoods of respondents have been captured through study field notes. Slum of residence meant social interaction and neighbourhood networks for employment and other possibilities such as marriage. Neighbourhoods were also associated with sharing common water source and common defecation area. For instance, the backward caste and upper caste Odiya

women, the backward caste women from Bihar shared community space for collecting water, washing clothes, bathing, attending to nature calls with lower caste Odiya women in Ranihat Das sahi.

Based on findings from survey (refer Tables 5, 6.1-6.5 and 7) distribution of employment and distribution of slum of residence for sample women were based on their intersectional location in a similar manner. Gender, class, caste and region of origin together revealed the differences in the work and slum of residence in most situations, excepting Odiya Bazaar where religion also played a subtle role (refer Table 6.5). Intersectional processes of greater internalisation of gender norms by certain castes, greater identification with caste norms by women of certain region of origin, greater identification with slum inhabitant identity than caste norms by women of certain region of origin and neighbourhood networks based on class, caste, region of origin and gender explained current employment and slum of residence of survey sample to a large extent. This was the beginning of understanding intersectionality and its role in women construction and domestic worker's lives as revealed by survey data.

Looking at the previous main work of these respondents before their present work or work status will further explain this link between certain intersectionality and employment.

IV. Intersectional Location in Past, Present and Work Changes

Women's employment history implied differences of rural or urban location at the time of past employment. The immediate previous work was recorded from which the respondents had moved on to the current work or work status. Survey data on previous work informs that women's work opportunities at village was predominantly agricultural labour whereas in the city it was mostly informal work (refer Table 8). Geographical region, caste, gender, class and region of origin influenced work decision for these women when they were located in village and later, in the city via neigbourhood networks. Neighbourhood networks were discussed in the previous section as women shared how they got introduced to their work.

Past work of women reveals that except Pattapol, women in rest of the slum areas had 16-36 percent of working women who had worked as agricultural labourers. Ranihat

Sagadia sahi, Odiya Bazaar, Chattra Bazaar and Ranihat Das sahi had 36 percent, 23 percent, 20 percent and 16 percent of women who were agricultural workers. Work opportunity in agricultural fields was available as these erstwhile women workers had migrated from rural areas, these respondents were from Telugu upper caste, backward caste and lower caste families, also Odiya backward caste and lower caste families and backward caste families from Bihar (refer Table 9). This also implies that they had worked either as a labourer in their own land or land of others as landless labourers. Survey data informs that they were first generation migrants in Cuttack city, who had settled in Ranihat Das sahi, Odiya Bazaar, Chattra Bazaar and Ranihat Sagadiasahi slum areas. They had come from villages in Andhra Pradesh and Odisha.

60 percent of the women did not do paid work in the past (refer Table 8) whereas only 36 percent of the women did not do paid work during the time of the survey (refer Table 1).

Ranihat Das sahi had 55 percent of women who had worked in past; this was the highest rate in comparison to Ranihat sagadia sahi, Odiya Bazaar, Pattapol and Chattra Bazaar which had 35 percent, 33 percent, 32 percent and 26 percent of women who had worked in the past, respectively (refer Table 8). Ranihat Das sahi had almost equal number of women whose past work was either construction (29 percent) or paid domestic work (26 percent). But this was not so in other areas. This trend has been also been seen in case of women’s current work in this area and has been discussed earlier (refer Table 6.1). Pattapol had the highest percentage of women domestic workers (43 percent) who had undergone work change compared to other slum areas. These were Telugu lower caste women who had shared that they preferred domestic work. This was corroborated by the finding that 22 percent approximately of women from Pattapol had a work history of construction work, whereas none of them worked as a construction worker during the survey reference year (refer Table 8). In Pattapol, the households were second or third generation Telugu migrant families in Odisha or Cuttack city. Only one woman had worked as an agricultural labourer before.

Odiya Bazaar had the second highest or 40 percent of its women whose immediate past work was paid domestic work and this was also greater than 14 percent of women who were previously construction workers (refer Table 8). By referring to the caste and region of origin of each of these previously domestic workers from Odiya

Bazaar, it was known that all of them belonged to lower caste (SC) Telugu families. This reiterates the earlier finding that there existed caste based segregation of work among Telugu women. Besides, agricultural work, weaving work was also the previous occupation for 14 percent of women here. These women belonged to Telugu 'tanti' caste families who were weavers by caste based profession and were engaged in weaving at some shop or factory. They left weaving since the employer closed the shop/factory and then, looked for other work options available (refer Table 9).

Chattra Bazaar had 50 percent of its women or the highest percentage of women whose past work was construction work. And checking back their caste and region of origin revealed that they either belonged to Telugu upper caste families or Odiya upper caste and backward caste families. There were not any Telugu upper caste or backward caste women here who had worked previously as domestic worker either, though there were Odiya upper caste women who had worked so. Ranihat Sagadia sahi had the highest percentage of women (36 percent) whose past work was agricultural work (refer Table 8).

Table 8: Women's Past Work and Slum Area of Residence

8.1	Slum area code					Total
Past work	Pattapol n (%)	Ranihat Das sahi n (%)	Odiya Bazaar n (%)	Chattra Bazaar n (%)	Ranihat Sagadiasahi n (%)	
Non-workers	99 (68.28%)	78 (45.09%)	44 (66.67%)	28 (73.68%)	47 (65.28%)	296 (59.92%)
Workers	46 (31.72%)	95 (54.91%)	22 (33.33%)	10 (26.32%)	25 (34.72%)	198 (40.08%)
Total	145 (100%)	173 (100%)	66 (100%)	38 (100%)	72 (100%)	494 (100%)
8.2 Past Work distribution						
	Pattapol n(%)	Ranihat Das sahi n(%)	Odiya Bazaar n(%)	Chattra Bazaar n(%)	Ranihat Sagadia sahi n(%)	Total
Construction work	10 (21.74%)	28 (29.47%)	3 (13.64%)	5 (50%)	7 (28%)	53

Domestic work	20 (43.48%)	25 (26.32%)	9 (40.91%)	2 (20%)	4 (16%)	60
Marriage helper work	0 (0%)	1 (1.05%)	0 (0%)	0 (0%)	0 (0%)	1
Home-based work	0 (0%)	1 (1.05%)	0 (0%)	0 (0%)	1 (4%)	2
Business	2 (4.35%)	4 (4.21%)	0 (0%)	0 (0%)	1 (4%)	7
Municipality sweeper work	1 (2.17%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1
Medical sweeper work	1 (2.17%)	2 (2.10%)	1 (4.54%)	0 (0%)	0 (0%)	4
School helper work	3 (6.52%)	1 (1.05%)	0 (0%)	0 (0%)	0 (0%)	4
Cooking only	0 (0%)	0 (0%)	1 (4.54%)	0 (0%)	0 (0%)	1
Ragpicking work	0 (0%)	2 (2.10%)	0 (0%)	0 (0%)	0 (0%)	2
Godam helper work	0 (0%)	11 (11.58%)	0 (0%)	0 (0%)	2 (8%)	13
Agricultural helper work	1 (2.17%)	15 (15.79%)	5 (22.73%)	2 (20%)	9 (36%)	32
Weaving work	0 (0%)	0 (0%)	3 (13.64%)	0 (0%)	0 (0%)	3
Tailoring work	1 (2.17%)	0 (0%)	0 (0%)	1 (10%)	0 (0%)	2
Any other	7 (15.22%)	5 (5.26%)	0 (0%)	0 (0%)	1 (4%)	13
Working women total	46 (100 %)	95 (100%)	22 (100%)	10 (100%)	25 (100%)	494

[Note: 4 values of past work are missing, these respondents did not specify their past work]

Table 9: Women's Past Work and Intersection of Caste Status and Region of Origin

Caste status	Past work	Region of Origin				
		Odisha	Andhra Pradesh	Bihar	Any other	Total
General	NA	19 (57.57%)	24 (60%)	1 (100%)	1 (33.33%)	45 (58.44%)
	Construction work	2 (6.06%)	6 (15%)	0 (0%)	0 (0%)	8 (10.39%)
	Domestic work	7 (21.21%)	0 (0%)	0 (0%)	0 (0%)	7 (9.09%)
	Business	1 (3.03%)	0 (0%)	0 (0%)	0 (0%)	1 (1.30%)
	Any other	2 (6.06%)	0 (0%)	0 (0%)	0 (0%)	2 (2.60%)
	Medical sweeper work	0 (0%)	2 (5%)	0 (0%)	0 (0%)	2 (2.60%)
	Ragpicking work	0 (0%)	0 (0%)	0 (0%)	1 (33.33%)	1 (1.30%)
	Godam work	1 (3.03%)	1 (2.5%)	0 (0%)	0 (0%)	2 (2.60%)
	Agricultural work	0 (0%)	7 (17.5%)	0 (0%)	1 (33.33%)	8 (10.39%)
	Tailor	1 (3.03%)	0 (0%)	0 (0%)	0 (0%)	1 (1.30%)
	Total	33 (100%)	40 (100%)	1 (100%)	3 (100%)	77 (100%)
OBC	NA	26 (63.41%)	31 (72.09%)	12 (54.54%)	3 (75%)	72 (65.45%)
	Construction work	7 (17.07%)	3 (6.98%)	0 (0%)	1 (25%)	11 (10%)
	Domestic work	2 (4.88%)	0 (0%)	0 (0%)	0 (0%)	2 (1.82%)
	Business	1 (2.44%)	0 (0%)	0 (0%)	0 (0%)	1 (0.90%)
	Any other	2 (4.88%)	1 (2.32%)	0 (0%)	0 (0%)	3 (2.73%)
	Godam work	1 (2.44%)	1 (2.32%)	0 (0%)	0 (0%)	2 (1.82%)
	Agricultural work	2 (4.88%)	4 (9.30%)	10 (45.45%)	0 (0%)	16 (14.54%)

Caste status	Past work	Region of Origin				
		Odisha	Andhra Pradesh	Bihar	Any other	Total
	Weaving work	0 (0%)	3 (6.98%)	0 (0%)	0 (0%)	3 (2.73%)
	Total	41 (100%)	43 (100%)	22 (100%)	4 (100%)	110 (100%)
SC	NA	66 (50%)	110 (64.33%)	0 (0%)	1 (100%)	177 (58.22%)
	Construction work	22 (16.67%)	12 (7.07%)	0 (0%)	0 (0%)	34 (11.18%)
	Domestic work	20 (15.15%)	31 (18.13%)	0 (0%)	0 (0%)	51 (16.78%)
	Marriage work	1 (0.76%)	0 (0%)	0 (0%)	0 (0%)	1 (0.33%)
	Home-based work	2 (1.51%)	0 (0%)	0 (0%)	0 (0%)	2 (0.66%)
	Business	3 (2.27%)	2 (1.17%)	0 (0%)	0 (0%)	5 (1.64%)
	Municipality sweeping work	0 (0%)	1 (0.58%)	0 (0%)	0 (0%)	1 (0.33%)
	Medical sweeping work	1 (0.75%)	1 (0.58%)	0 (0%)	0 (0%)	2 (0.66%)
	School helper work	1 (0.75%)	3 (1.75%)	0 (0%)	0 (0%)	4 (1.31%)
	Cooking only	0 (0%)	1 (0.58%)	0 (0%)	0 (0%)	1 (0.33%)
	Ragpicking work	1 (0.75%)	0 (0%)	0 (0%)	0 (0%)	1 (0.33%)
	Godam work	9 (6.82%)	0 (0%)	0 (0%)	0 (0%)	9 (2.96%)
	Agricultural work	4 (3.03%)	4 (2.34%)	0 (0%)	0 (0%)	8 (2.63%)
	Tailoring work	0 (0%)	1 (0.58%)	0 (0%)	0 (0%)	1 (0.33%)
	Any other	2 (1.51%)	5 (2.92%)	0 (0%)	0 (0%)	7 (2.30%)
	Total	132 (100%)	171 (100%)	0 (0%)	1 (100%)	304 (100%)

Caste status	Past work	Region of Origin				
		Odisha	Andhra Pradesh	Bihar	Any other	Total
Other religion	NA	0 (0%)	1 (100%)	0 (0%)	1 (100%)	2 (66.67%)
	Any other	1 (100%)	0 (0%)	0 (0%)	0 (0%)	1 (33.33%)
	Total	1 (100%)	1 (100%)	0 (0%)	1 (100%)	3 (100%)
Grand Total		207	255	23	9	494

[Note: 4 values of past work are missing, these respondents did not specify their past work]

Sixty percent of the survey sample did not do paid work in the past. So these women did not experience any change either by shifting or withdrawing from work. The change some of them experienced was from non-working status to working status, which is not under the purview of the study. The past work and present work status when compared gives a picture of the type of work changes for women construction and domestic workers (refer Table 10).

Table 10: Women's Past Work and Current Work

Past work	Current work					
	NA	Construction work	Domestic work	Marriage helper work	Rest	Total
NA	91	57	99	0	49	296
Construction work	20	0	22	2	9	53
Domestic work	31	15	3	2	9	60
Marriage work	0	0	1	0	0	1
Home-based work	1	0	1	0	0	2
Business	4	0	1	0	2	7
Municipality sweeper work	1	0	0	0	0	1
Medical sweeper Work	4	0	0	0	0	4
School helper work	2	0	2	0	0	4
Cooking work only	1	0	0	0	0	1

Past work	Current work					
	NA	Construction work	Domestic work	Marriage helper work	Rest	Total
Ragpicking work	0	1	0	0	1	2
Godam work	3	7	2	0	1	13
Agricultural work	16	13	3	0	0	32
Weaving work	0	0	2	0	1	3
Tailoring work	1	0	1	0	0	2
Any other	7	0	2	0	4	13
Total	182	93	139	4	76	494

[Note: 4 values of past work are missing, these respondents did not specify their past work]

Of 198 who had undergone work change, 103 women or 52 percent approximately had shifted from one work to another and 91 women or 46 percent approximately had withdrawn from work, 4 women or 2 percent approximately had withdrawn from work temporarily or quit work for some reason, but had gone back to the same work (paid domestic work) after some time. This temporary work change event was recorded in the survey. The other cases were employment shifts or withdrawal from work.

Of 494 women, 198 women had cited different reasons for their employment shift or withdrawal from work (refer Table 10). The major preceding events identified by women during the survey for employment shift or withdrawal from work were marriage, health, work burden at home and closure of factory or change of employer's residence. Taking 198 or 40 percent as point of reference (the main focus of the study), of these 31 percent approximately cited marriage reasons, 27 percent approximately cited health issues, 12 percent approximately stated income motive, 10 percent approximately expressed work demands at home, 5 percent approximately faced employer discontinuing employing them since they had to close their shop or factory, 2 percent approximately cited reasons of child birth and 13 percent approximately attributed it to other reasons such as difficulty in commuting, sickness in family, son's earnings, sexual harassment, etc. (refer Table 11).

Table 11: Women's Past Work & Reasons Cited for Change

Reasons	Past work				
	Construction work	Domestic work	Marriage work	Rest	Total
More income	1 (1.89%)	11 (18.33%)	0 (0%)	11 (13.09%)	23 (11.62%)
Work demands at home	4 (7.55%)	11 (18.33%)	0 (0%)	5 (5.95%)	20 (10.10%)
Marriage	9 (16.98%)	16 (26.67%)	0 (0%)	37 (44.05%)	62 (31.31%)
Health reasons	31 (58.49%)	13 (21.67%)	0 (0%)	9 (10.71%)	53 (26.77%)
Problem of commuting	0 (0%)	0 (0%)	0 (0%)	1 (1.19%)	1 (0.50%)
Sexual harassment	2 (3.77%)	0 (0%)	0 (0%)	0 (0%)	2 (10.10%)
Closed	0 (0%)	0 (0%)	0 (0%)	10 (11.90%)	10 (5.05%)
Childbirth	2 (3.77%)	1 (1.67%)	0 (0%)	1 (1.19%)	4 (2.02%)
I don't feel like	0 (0%)	0 (0%)	1 (100%)	0 (0%)	1 (0.50%)
Son/s started working	0 (0%)	0 (0%)	0 (0%)	1 (1.19%)	1 (0.50%)
Health of child or any family member	0 (0%)	1 (1.67%)	0 (0%)	0 (0%)	1 (0.50%)
Any other	4 (7.55%)	7 (11.67%)	0 (0%)	9 (10.71%)	20 (10.10%)
Total	53 (100%)	60 (100%)	1 (100%)	84 (100%)	198 (100%)

Health was the second most cited reason by women for work changes, either for shifting from one work to another or quitting work. During the survey, health reason was cited with accompanying words such as 'age', 'stamina', 'knee ache', 'cannot climb stairs', 'cannot see' 'handache' and 'brain malaria'. This additional information available besides the response to main question on reason of work change was recorded as field notes. It informed that women construction workers as well as domestic workers shared certain health issues. The field notes informed that both of

them underwent work changes for such health issues. Survey data revealed that more number of construction workers had cited health reason than domestic workers for work changes. 58 percent approximately of previously women construction workers and 22 percent of women domestic workers had cited health reason (refer Table 11). Overall figures show that 40 percent and 53 of all women who had cited health reasons had worked for 4-10 years and more than 10 years respectively (refer Table 12). Years of work is relevant because it highlights that women worked these many years with all their capacity when their health permitted. Less than 10 percent cited health reasons when they had worked for less than 4 years. The close ended responses for the survey question on reasons of work change were marriage, health, work demands at home, more income and any other. With data collection there were other reasons such as sexual harassment and closure of factory. These were then included as new response categories. But as the data collection went out there were numerous others, including child birth, problem of commuting, not up to working and son started working. These issues emerged extensively as part of intersectional processes in women's lives when case studies were analysed.

Table 12: Years of Past Work and Reasons for Change

Reasons for changing occupation	Years of past occupation						
	NA	Less than one month	1 month< 1year	1year <4years	4-10 years	>10 years	Total
NA	296						296
More income		0 (0%)	2 (8.69%)	7 (30.43%)	9 (39.13%)	5 (21.74%)	23 (100%)
Work demands at home		0 (0%)	0 (0%)	10 (50%)	4 (20%)	6 (30%)	20 (100%)
Marriage (relocation)		0 (0%)	2 (3.28%)	26 (42.62%)	32 (52.46%)	1 (1.64%)	61 (100%)
Health reasons		0 (0%)	3 (5.66%)	1 (1.89%)	21 (39.62%)	28 (52.83%)	53 (100%)
Problem of commuting		0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)	1 (100%)
Sexual harassment		0 (0%)	0 (0%)	0 (0%)	1 (50%)	1 (50%)	2 (100%)
Closed		0 (0%)	2 (20%)	3 (30%)	4 (40%)	1 (10%)	10 (100%)
Childbirth		0 (0%)	0 (0%)	0 (0%)	3 (75%)	1 (25%)	4 (100%)
I don't feel like		0 (0%)	1 (100%)	0 (0%)	0 (0%)	0 (0%)	1 (100%)
Son/s started working		0 (0%)	0 (0%)	0 (0%)	1 (100%)	0 (0%)	1 (100%)
Health of child/any family member		0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (100%)	1 (100%)
Any other		1 (5%)	1 (5%)	8 (40%)	4 (20%)	6 (30%)	20 (100%)
Total	296 (60.04%)	1 (0.20%)	11 (2.23%)	56 (11.36%)	79 (16.02%)	50 (10.14%)	493 (100%)

[Note: 5 values are missing since the respondents were unable to point out how many months they worked last year]

Table 13: Past Construction or Domestic Work, Years of Past Work and Reasons for Change

Past work Years of past occupation						
Reason cited by **construction workers**	less than one month	1 month< 1year	1year <4years	4-10 years	>10 years	Total
More income	0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)	1 (100%)
Work demands at home	0 (0%)	0 (0%)	1 (25%)	2 (50%)	1 (25%)	4 (100%)
Marriage	0 (0%)	0 (0%)	4 (44.44%)	4 (44.44%)	1 (11.11%)	9 (100%)
Health reasons	0 (0%)	2 (6.45%)	1 (3.23%)	9 (29.03%)	19 (61.29%)	31 (100%)
Sexual harassment	0 (0%)	0 (0%)	0 (0%)	1 (50%)	1 (50%)	2 (100%)
Childbirth	0 (0%)	0 (0%)	0 (0%)	1 (50%)	1 (50%)	2 (100%)
Any other	1 (25%)	0 (0%)	1 (25%)	1 (25%)	1 (25%)	4 (100%)
Total	1 (1.89%)	2 (3.77%)	8 (15.09%)	18 (33.96%)	24 (45.28%)	53 (100%)
Reason cited by **domestic workers**	less than one month	1 month< 1year	1year <4years	4-10 years	>10 years	Total
More income	0 (0%)	1 (9.09%)	3 (27.27%)	5 (45.45%)	2 (18.18%)	11 (100%)
Work demands at home	0 (0%)	0 (0%)	7 (63.64%)	2 (18.18%)	2 (18.18%)	11 (100%)
Marriage	0 (0%)	2 (13.33%)	6 (40%)	7 (46.67%)	0 (0%)	15 (100%)
Health reasons	0 (0%)	0 (0%)	0 (0%)	8 (61.54%)	5 (38.46%)	13 (100%)
Childbirth	0 (0%)	0 (0%)	0 (0%)	1 (100%)	0 (0%)	1 (100%)
Health of child or any family member	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (100%)	1 (100%)
Any other	0 (0%)	0 (0%)	3 (42.86%)	2 (28.57%)	2 (28.57%)	7 (100%)
Total	0 (0%)	3 (5.08%)	19 (32.20%)	25 (42.37%)	12 (20.34%)	59 (100%)

Compared to women domestic workers of whom 61 percent and 39 percent approximately left this work after 4 to 10 years of work and more than 10 years of work respectively for health reasons, 29 percent and 61 percent of women construction workers approximately left this work after 4 to 10 years of work and more than 10 years of work respectively (refer Table 13). Also 45 percent of all women construction workers had witnessed work changes after 10 years of work compared to 20 percent of the domestic workers who underwent the same. These findings tell that health and years of work of the respondent were connected, implying the strain of paid work over years and more so in case of construction work.

It was inferred that even if both faced these health issues, health issues had a greater impact on work of women construction workers. This was the preliminary understanding about health reason for work changes undergone by women construction and domestic workers. But how it had a greater impact was unknown. A common word ‘age’ was used by many women workers when they cited health reason and survey data on age of the respondent during work change corroborates it (refer Table 14). 96 percent of those who cited health reason were aged 35 years or above. Only 4 percent of them had cited health reason and were aged 25 years to less than 35 years (refer Table 14). This led to the understanding that with age there was a rise in incidence of health issues and work changes of women workers. Work demands at home was cited by 25 percent, 35 percent and 35 percent of women workers aged 25-less than 35 years, 35-less than 45 years and 45 or more than 45 years, respectively. It hints that work demands at home or unpaid work was a priority for women from all age groups. The possible reason that only 5 percent of women aged less than 25 years had cited work demands at home for work change could be that they never worked then for the very same reasons of unpaid work. So, there was no question of work change.

Table 14: Age of Respondent during Work Change and Reasons Cited

Reason cited for work change	Age of woman				Total
	Less than 25	25-less than 35	35-less than 45	45 or more than 45	
More income	0 (0%)	5 (21.74%)	10 (43.48%)	8 (34.78%)	23 (100%)
Work demands at home	1 (5%)	5 (25%)	7 (35%)	7 (35%)	20 (100%)
Marriage (relocation)	18 (29.03%)	21 (33.87%)	11 (17.74%)	12 (19.35%)	62 (100%)
Health reasons	0 (0%)	2 (3.77%)	15 (28.30%)	36 (67.92%)	53 (100%)
Problem of commuting	0 (0%)	0 (0%)	1 (100%)	0 (0%)	1 (100%)
Sexual harassment	0 (0%)	0 (0%)	0 (0%)	2 (100%)	2 (100%)
Closed	0 (0%)	2 (20%)	4 (40%)	4 (40%)	10 (100%)
Childbirth	1 (25%)	2 (50%)	1 (25%)	0 (0%)	4 (100%)
I don't feel like	0 (0%)	0 (0%)	1 (100%)	0 (0%)	1 (100%)
Son/s started working	0 (0%)	0 (0%)	0 (0%)	1 (100%)	1 (100%)
Health of child/any family member	0 (0%)	0 (0%)	1 (100%)	0 (0%)	1 (100%)
Any other	1 (5%)	4 (20%)	8 (40%)	7 (35%)	20 (100%)
Total work changes witnessed in the sample	21 (10.61%)	41 (20.71%)	59 (29.80%)	77 (38.89%)	198 (100%)
Total including NA in the sample	45	113	161	175	494

[Note: 4 values are missing since these respondents did not know their exact age, age when they shifted work and were in a hurry during the time of survey to tell any details from which age during work change could be estimated]

Overall, it was found that women below 25 years cited reasons of marriage, women aged 25-34 years aged cited reasons of family time and domestic chores and women aged 35 years and above cited both family time and domestic chores as well as health

reasons (refer Table 15). By the time women were in 35 years to less than 45 years, they started experiencing health issues and work reasons for the same. This survey finding hinted at gender, age and work influence (paid and unpaid work) on work changes due to health reasons.

Survey data on distribution of age group according to work hours per day shows that women working 4-8 hours or 8 hours and more every day had 68-79 percent of its women who belonged to 35-44 years age group or 45 years of age and above age group (refer Table 15). Data suggest that women aged above 35 years of age cited health as well as age reasons and this age group women also worked for longer hours than their younger counterparts (refer Tables 14 and 15). This hinted that there was something more than age, gender and work (paid, unpaid work) which was happening as age was found as hindering as well as facilitating paid work for this particular age group. And this was required to be known.

Table 15: Distribution of Age Groups According to Woman's Work Hours Per Day

Age (years)	Hours of work per day n (%)				Total N (%)
	< 4 n(%)	4–8 n(%)	> 8 n(%)	NA n(%)	
< 25	4 (5.56 %)	2 (1.54%)	4 (3.67%)	35 (19.23%)	45 (9.13%)
25–34	19 (26.39%)	25 (19.23%)	19 (17.43%)	46 (25.27%)	109 (22.11%)
35–44	25 (34.72%)	55 (42.31%)	44 (40.37%)	38 (20.88%)	162 (32.86%)
≥ 45	24 (33.33%)	48 (36.92%)	42 (38.53%)	63 (34.61%)	177 (35.90%)
Total	72 (100%)	130 (100%)	109 (100%)	182 (100%)	493 (100%)

[Note: 5 values are missing since these respondents did not know their exact age and were in a hurry during the time of survey to tell any details from which age during work change could be estimated. Also entries on work hours every day have been missed out while talking to respondents during the survey, the survey occurred in presence of family members, neighbours and these members also spoke in between the survey interviews while the respondent answered, for which these entries have been missed or the respondents did not specify work hours every day.]

Survey data on current age and paid working hours every day of women construction and domestic workers shows that of the domestic workers in the sample, 38 percent approximately were working up to 4 hours a day, 42 percent approximately were working more than 4 hours to 8 hours a day and 20 percent approximately worked for more than 8 hours a day (refer Table 16).

Table 16: Current age and Work Hours of Construction and Domestic Workers

	137 domestic workers n (%)			Total	94 construction workers n (%)			Total
	Hours of work per day				Hours of work per day			
	< 4	4–8	> 8		< 4	4–8	> 8	
	52 (37.96%)	58 (42.33%)	27 (19.71%)	137 (100%)	0 (0%)	32 (34.04%)	62 (65.96%)	94 (100%)
Age group	< 4 hours	4–8 hours	> 8 hours	Total	< 4 hours	4–8 hours	> 8 hours	Total
> 25	3 (60%)	2 (40%)	0 (0%)	5 (100%)	0 (0%)	0 (0%)	3 (100%)	3 (100%)
25–34	14 (46.67%)	12 (40%)	4 (13.33%)	30 (100%)	0 (0%)	9 (37.5%)	15 (62.5%)	24 (100%)
35–44	18 (29.03%)	30 (48.38%)	14 (22.58%)	62 (100%)	0 (0%)	15 (42.86%)	20 (57.14%)	35 (100%)
≥ 45	17 (42.50%)	14 (35.00%)	9 (22.50%)	40 (100%)	0 (0%)	8 (25.00%)	24 (75.00%)	32 (100%)

[Note: 2 values each for women domestic workers and construction workers are missing. These entries have been missed out while talking to respondents during the survey, the survey occurred in presence of family members, neighbours and these members also spoke in between the survey interviews while the respondent answered, for which these entries have been missed or the respondents also did not specify work hours every.]

Of the 27 women domestic workers who worked for more than 8 hours a day, 23 of them were above 35 years of age. This puts these women as those who had crossed the supposedly primetime required for household chores and care of young children at home. Majority of the women had children irrespective of whether they were married/widowed. It hints that elderly women domestic workers become free for more number of hours of work. Age gave them negotiating power with in family to allocate work hours. But how exactly it occurs, remains unknown. Possible explanation is gender norms and family structure along with increase in age mattered when it came to more work hours and work days (refer Table 16 & 17). In case of construction work, the data available for 94 women construction workers shows that, 66 percent approximately worked for more than 8 hours a day, and 34 percent approximately worked less than 8 hours a day (refer Table 16). There was hardly any scope for construction work less than 4 hours a day as none of them worked so. For women construction workers, the working hours remained fixed whereas number of work days in a month varied.

Of women construction workers those who worked more than 25 days a month were 11 percent approximately (refer Table 17). This 11 percent of women who worked more than 25 days a month was found to be more than 35 years of age. 29 percent approximately of women construction workers worked 16-25 days a month, again majority of this section was above 35 years of age. 47 percent approximately of them worked for 10-15 days a month and 13 percent worked for less than 10 days a month; both of these had a mixed age group of above and below 35 years of age (refer Table 17). 4 of 96 women construction workers who did not work last month for their own health reason or family issues were aged 35 years and above.

Table 17: Age Group and Work Days per Month of Construction Workers

	Work days of women construction workers per month 96 n (%)						
	30–31	26–29	16–25	10–15	< 10	Did not work last month	Total
< 25	0 (0%)	0 (0%)	0 (0%)	2 (66.67%)	1 (33.33%)	0 (0%)	3 (100%)
25–34	0 (0%)	3 (12.50%)	9 (37.50%)	9 (37.50%)	3 (12.50%)	0 (0%)	24 (100%)
35–44	1 (2.70%)	2 (5.40%)	13 (35.13%)	15 (40.54%)	4 (10.81%)	2 (5.40%)	37 (100%)
≥ 45	1 (3.12%)	3 (9.37%)	5 (15.62%)	17 (53.12%)	4 (12.5%)	2 (6.25%)	32 (100%)

[Note: 4 women construction workers were unable to a give an estimate of their age, these 4 values have not been considered here.]

There were women construction workers in all age groups who worked for 10-15 days a month or less and when it came to 16-25 work days and 26-29 work days women in only 25-34, 35-44 and 45 years and above age group and worked so. Women in 35-44 and 45 years and above age group alone were found working for 30-31 days (refer Table 17). This data supports the earlier inference (based on Table 16) that after 35 years of age women construction workers could take out more time for paid work than their younger counterparts who could not do so for gender based norms, family structure and double or triple burden. The reasons cited for the variation in work days by construction workers were seasonal availability of work and personal situation, this comprised of household responsibilities, financial needs or emergencies and individual health. The family role differed for different age groups of women workers. Women domestic workers had more agency than women construction workers while

choosing the hours of work in a day as they had some say or control when they fixed number of employer houses and work timings. Women construction workers had control over work days provided work was available as the woman opted to work or not work on a specific day.

The data on distribution of age group according to paid working hours per day for women workers showed that of majority of those who worked for 8 hours or more every day were aged 35 year or above. This could be so probably because my sample consisted of a greater proportion of older women. Thus, I compared the average number of work hours of women in each age group (refer Table 18).

Table 18: Specific Age Groups and Work Hours per Day

Age group	NA	Hours of work per day n (%)			Total (excluding NA)
		< 4	4–8	> 8	
< 25	35	4 (40%)	2 (20%)	4 (40%)	10 (100%)
25–34	46	19 (30.16%)	25 (39.68%)	19 (30.16%)	63 (100%)
35–44	38	25 (20.16%)	55 (44.35%)	44 (35.48%)	124 (100%)
≥ 45	63	24 (21.05%)	48 (42.10%)	42 (36.84%)	114 (100%)
Total	182	72 (23.15%)	130 (41.80%)	109 (35.04%)	311 (100%)

[Note: 5 values are missing since these respondents did not know their exact age and were in a hurry during the time of survey to tell any details from which age during work change could be estimated. Also entries on work hours every day have been missed out while talking to respondents during the survey, the survey occurred in presence of family members, neighbours and these members also spoke in between the survey interviews while the respondent answered, for which these entries have been missed or the respondents also did not specify work hours every day.]

Of the data available for 311 women workers, around 40 per cent, 30.16 per cent, 35.48 per cent and 36.84 per cent worked for more than 8 hours in the below-25, 25-to-34, 35-to-44 and over-45 age groups respectively and around 20 per cent, 39.68 per cent, 44.35 per cent and 42.10 per cent worked for 4-8 hours in the below-25, 25-to-34, 35-to-44 and over-45 age groups respectively. The data shows that when younger group decided to work, they had the maximum number of them who worked the most i.e., greater than 8 hours, but it was surpising to see the numbers fall for 4-8 hours and

then, increase sharply for less than 4 hours of work every day for this age group. Whereas the 35-44 age group and 45 years of age and above group made the most hours of work every day. The data if compared this way also shows that younger age group (less than 25 years, 25-34 years) had 40 percent and 30 percent of them respectively working for less than 4 hours and 35-44 and 45 years and above age groups had around 20 percent and 21 percent of them respectively working for less than 4 hours. This hints at the maximum decline of work hours in younger age groups, which is it corroborates what was earlier said, that they were unavailable for unpaid domestic and care work at home.

Survey on time and mode of commuting reveals most women workers refused to work outside the city in case of construction work. Those days were off days. In case of domestic work, they refused going to a potential employer's house beyond a certain walking distance. They took leave for sickness or family requirements. Such preferences for location of work implied that women saved their time and energy forgoing their earnings. Women domestic workers preferred employer's house in nearby locality and women construction workers preferred work within Cuttack city. Women who travelled outside Cuttack city to do construction work did not want to lose their earnings and women who did not want to travel outside Cuttack city, but wanted regular work throughout the month settled for less wages many times. And there were women who did not settle for low wages and faced irregular work availability.

Construction work conditions were different than domestic work. As narrated by women, construction work meant carrying bricks, cement, sand, and mixing it. Domestic work usually meant sweeping, mopping, cleaning utensils and cleaning clothes. At times or in certain cases, cleaning utensils and clothes meant lifting or carrying the utensils or clothes together to the balcony/roof/courtyard area and again bringing it back to the main house. How this figured in with age? How health issues emerged? More number of shifts or withdrawal from work had happened for women workers after age 35 and more work changes had happened for women construction workers. More number of shifts post 35 years of age and work changes for construction work was found associated with health reasons. While associations between intersectional identity of gender, caste, region of origin and class and

women's employment was found, intra categorical differences of age was also found in the categories of caste, region of origin and class when it came to their employment related changes.

This also reveals the manner in which women attempt to adjust their time between house work demands, work demands and economic necessity along with compulsions of heath problems. Construction workers worked for lesser days, more earnings and experienced heavier work while domestic workers worked on all days of month with low pay and tension of two shifts, multiple house timings.

This Chapter lays out the findings on interrelationships of intersection of gender, class, caste, region of origin and age and women's work, work change and health reasons. The following Chapter explores what these intersections imply when women undergo work changes for health reasons and what is the micro perspective of this phenomenon.

Chapter 5

Dynamics of Women's Lives, Health and Work Changes

The survey findings revealed about the present day women construction and domestic workers and the present work and life of those previously women construction and domestic workers, their socio-economic profile, the work they were engaged in or not, the reasons they cited to undergo work changes and the age at which they made these work changes. The survey informed of the way the present day construction and domestic workers managed their work, be it the work days or work hours or travel time and mode of travel to work, their family earnings, their husbands' occupation and earnings and the intersectional background the women came from. The situation of current women construction and domestic workers briefly portrayed the work and lives of erstwhile women construction and domestic workers, if not the exact one they would have had led. The survey provided insights into the possible work changes that could be expected at certain ages in these women workers' lives due to certain reasons. The trends of work changes differed relatively for women construction workers and domestic workers in relation to the age at which they made these work changes and the reasons they cited. Both the workers differed in the kind of their work days, work months and their earnings and how women domestic workers did not join any other work once they withdrew from work post 45 years of age, possibly since they did not have many work options available to shift. However, women construction workers joined domestic work or some other work available, if they could work. Work changes had occurred for 198 women in the sample. Of these, health was found associated with work changes for at least 50 cases. As a pattern, health was cited more as the reason responsible for work change in case of women construction workers, the women workers aged 35 years or above and those who had worked for 4-10 years and 10 years or more compared to their counterparts. As a corollary of these findings, it was inferred from the survey that health interacted with age, work years and work conditions to influence work changes. Health as a reason was directly associated with these three factors. Health issues were also found indirectly linked with intersectional identity of caste, region of origin and class since women construction workers who came from certain intersectional location had cited health reasons more than women domestic workers who belonged to a different intersection. The survey portrayed the

link between the past, present and the future, as women shifted to a new work or withdrew from work under certain circumstances at a certain age. According to the survey data, work changes were even associated with reasons such as marriage, work burden at home, pregnancy and child care. It was interpreted that underlying connotation of gender role and gender norms shaped work changes too. It raised questions about the other processes at work or family which were associated with health and work changes made, the similarities and differences between women construction and domestic workers who witnessed work changes, shifts and cited health reasons. Did they experience similar exposures and vulnerabilities or were there differences? What were the intersectional processes and what were the cross-cutting issues within? These questions were attempted to be answered by the case studies.

The theoretical framework of gender and social determinants of health (SDH) model by Sen & Ostlin (2007) wherein exposures and vulnerabilities to health ailments are determined by structural causes and succeeded by health and economic consequences has been adopted here to look at the interface between health and work changes of women construction and domestic workers. Whether the socio-economic factors and processes in the gender SDH framework are adequate in explaining and understanding the phenomenon of work changes of women workers due to health reasons? If gaps are there, in which ways these could be explained? How does gender as a SDH (underlying intersectionality) help in understanding the structural causes and the diversified consequences of health with possible policy implications for women workers?The 33 case studies based on in-depth interviews text data have been analysed. The processes through which women construction and domestic workers went through work changes, including the nature of exposures and vulnerabilities, the similarities and differences among the workers have been discussed here (Note 7).

I. Everyday Lives and Physical Health Exposures

It was found that besides everyday work, diet and living conditions, family conditions and access to health care were also critical in defining physical as well as mental health exposures of women workers. As each condition is looked at with the help of case studies, it is understood that worker and her intersectional location were the key

to how she reacted to these conditions and was affected by them similarly or differently.

To start with, the earnings were one of the determinants of these conditions in women's lives. Assessing earnings of women domestic workers reveals that it usually ranged from Rs.500 to Rs.1000 for one employer. Per day earnings (calculated from a monthly salary of Rs.500) was as low as Rs.17 per day for domestic workers. It did not exceed Rs.100-150 per day for any of them even when they worked in 2-3 houses with earnings up to Rs.3000 or Rs.4500, according to survey as well as case studies data. Maximum earnings meant more number of houses or work up to 8 hours in a single house. The case studies reveal that in some cases when food was provided, domestic workers even worked for Rs.500-600 per month. Provision of food by the employer, work hours, additional tasks such as washing clothes than the regular tasks of sweeping and mopping of the floor and cleaning of utensils, were considered while negotiating the monthly pay. Two work shifts every day in a single house was a common practice.

In comparison, an average per day wage for a woman construction worker was Rs.250 for 8 work hours, as found by survey as well as case studies. Sometimes in the month, they even worked at a lower wage of Rs.200 or Rs.220. These rates were compliant with the minimum wage under the Minimum Wages Act in 2014-15 in Odisha.[clxxi] Women workers were required to have a good rapport with a male mason for work. This rapport bordered between cordial relations to sexual harassment. In fact, there were two women in the survey who cited this as a reason for work change and even few case studies women shared the need to look good when the *meestri* wanted good looking women working around. Different women reacted to gender based norms of work differently, by not going for work or going to work with in a distance or, by adhering to some unspoken rules at work (women worked as helpers, men as masons) and as they did so, women's agency was subject to interpretation. One woman worker complained of the mason/*meestri*'s wife getting a share of the wage and paying lower wage to the workers (Note 8). She fought with her since she felt this was unfair, helping them get work does not entitle him/his wife to her wages. As a practice, women worked as helpers to male *meestris* in construction work and were positioned lower in the occupational hierarchy. For some women, wages were lower than

average wage rate in certain situations, such as when the worker was aged or not very strong and she worked with the help of other workers, such as lifting lesser number of bricks or *kadais* /iron containers full of sand or cement in a work day than the usual. They earned, albeit less despite her physical limitations. This worker who was anaemic post her delivery worked then on lesser wages than the market rate. Monthly earnings of a construction worker would be between Rs.3000 to Rs.5000 provided work was available for 15-20 days and she decided to engage in work.

As discussed in Chapter 4, Rs.6000 per month was a minimum requirement for a family of four to six, to afford at least have two meals a day and monthly house rent without any scope for savings. Survey and case studies inform that women domestic workers never earned so and women construction workers faced challenges in availing regular employment. In that case, it would require financial contribution of other family members to meet the minimum family expenses and ensure two meals. However, monthly family income was lower than Rs.6000 for 60 percent of the women as the survey tells. This was a crucial link between diet conditions, work conditions and family conditions and how this could potentially affect women's health. Her intersectional location set the ways how this interaction affected her and how she was similar or different from other workers. The ways how these conditions interacted to influence women's health and work changes have been looked at in the following sections.

Work Conditions

It was found that none of the domestic workers had injuries at work sites, whereas 4 women construction workers aged 45 years or above had met with injury. This injury was due to fall at work site in three cases. They narrated how they had slippery feet, felt dizzy and weak on the day when they had a fall or injury and how they did not take notice of their health issues till that date. Post injury they were either pushed out of work or were hesitant to work for the fear of recurrence of a fall and possible injury. In the fourth case, she continued construction work post injury in her back and ignored symptoms of swelling. A tiny gravel had pierced her back and there was a little swelling initially. She experienced impeding health effects of the same injury after 10-15 years when the swelling increased in its size. She shifted from construction work to sweeper work. Of the rest, Bhudei fell down at construction

work site when she was about 45 years of age. At that time, she was mentally distressed with her life and did not go for checkups even if, she was facing knee issues and fever. She had witnessed disturbing events, including deaths of her babies, asthmatic husband, and young son within 3-4 years, after 12 years and 18 years of her marriage respectively. She was struggling to discipline her adopted young son at home front when she met with this fall at work site post multiple deaths in family. The other two respondents who fell down at work site shared similar experiences. Pratima fell down at construction work site post her recovery from pneumonia when she had a fragile health and was nearing her 60s. Ishwaramma stopped construction work after she had a fall and fractured her hand at work site. She was around 50 years of age then and had lost her son and husband a few years before. Her fractured hand did not permit her to lift heavy things anymore which was a quintessential part of construction work. From these experiences, it could be inferred that as much as unsafe work conditions, worker was relevant too and cannot be ignored. Conceptually, the worker and her work condition were interactive and the worker reacted to work conditions given her situation which was defined by her intersectional location, her experience of processes of work demands (paid and unpaid), health issues, expenses, ageing, family deaths and illness in family at a physical and psycho-social level. Self-reported construction work conditions were climbing stairs, uneven surface at work site, carrying head load of sand, bricks, cement, gravel and excess heat in summers. Worker's plight under work conditions were different, such as the act of climbing stairs with headload was shared as difficult with age or lifting bricks was difficult post hand injury or going out of the city for work was difficult with domestic chores at home. In each of these situations, the woman worker took a step whether it was to go ahead and do or not to do or, negotiate work. Injury was found associated with unsafe work conditions, but also with worker's age and her pre-existing physical or mental health conditions, wherein the lens of interactive work conditions and worker as defined by intersectional location help in analysis. Pre-existing health conditions found before injury were, knee ache, weakness post recovery from an illness and mental disturbances with changes in family. Women stopped working after they fell down at work site and feared injuring themselves again when they did not have the strength to do such heavy work. The other reason cited was their younger counterparts were preferred at work place. And there were women construction workers who had not met with injuries, but their health issues were hampering work chances by mid-

40s and afterwards. Basanti and Radha left construction work when they were in their mid-40s, they said that they could not climb stairs with age and knee issues. Also, they lost out work to young competitiors which refers to biases of and discrimination by employer while recruiting. The unsafe work conditions acted as a deterrent.

Work hours combined with commuting time was usually longer for construction workers than domestic workers. They used shared autorickshaw or bus for commuting to work place regularly and spent out a part of their meagre earnings on fare. Women construction workers were found working and staying away from home for more than 8 hours. And coming back and attending to domestic chores at home late in the evenings. They had higher uncertainty of getting work especially during rains. From mid-June to August, there was very less chance of getting construction work as Cuttack city received good amount of rainfall. During the hot summers with temperatures soaring above 40 degree Celsius they risked their health to extreme heat and lost out work opportunities. It was found that they took frequent offs in a week during summers, even if it meant loss of earnings.

Self-reported work conditions by domestic workers were bending and half-sitting posture while sweeping and mopping, contact with water while mopping and washing clothes/utensils with bare hands. They also reported of the strain of walking twice a day to employer's house. At times, they washed floors by carrying buckets of water or carried buckets of cleaned utensils or clothes from one floor to another or from an open space to inside of the house. Manikamma, an erstwhile construction and domestic worker had frequent cold related health issues before quitting domestic work. Her eldest son was then a teenager and had started earning. Kalavati experienced severe asthma within a year of quitting domestic work. She attributes this to the pent up cold inside her body that had accumulated over years of working in water, walking in water logged roads during rains, eating gruel rice and sleeping on cold floor at night. It was a health consequence of the intermediary exposures at work and home along with the vulnerabilities of lack of rest, lack of checkup or treatment given respondents' predisposition to cold over time. She never had asthma before, yet after experiencing asthma so late in her life she regularly suffered from asthma attacks, the panic associated with it and had to inhale frequently. Notably, both experienced persistent cold when they had just reached their 40s. In these instances of

women domestic workers, even early 40s was indicative of health symptoms and this had a worrisome future course with intensive manifestation interfering with women's work capacity. At some point, women withdrew from work, when health symptoms surfaced and were not necessarily the only reason for work changes and when work changes have already been made and health symptoms intensified for changed work situation. Uma, a construction worker too experienced frequent cold and fever, but she had this issue when she had crossed her 50s. Washing utensils or clothes or floor at work or home meant regular contact with water. When domestic workers underwent constant cold, it was their work conditions of regular contact with water which interacted with their living conditions such as sleeping on damp floor and not bed, bathing in cold water throughout the year and walking in water logged roads during rains and poor diet conditions. Other health issues among domestic workers were hand ache, knee ache, and backache which was associated with work postures.

Conditions of Secondary Work

Conditions of secondary work were found crucial since women's main work was irregular or low paying. Women domestic workers did not have time to go for secondary work as the work days in a month were less flexible. But some managed to go for secondary work by asking a family member or neighbour to do the work in their employer's house in their absence like Ganga did. Relatively less women domestic workers (15 percent) went for marriage helper work than women construction workers (18 percent) as informed by survey findings. Of the 33 case studies, two women construction workers had suffered injuries at their place of secondary work. Kumari had a vehicle run over her on the road where she was a head load worker of decorative lights for a marriage procession at night. Kantamma had a fall from an inclined surface of a temple while fetching a plant pot where she was working as a helper for a marriage feast. Both did not receive any support from the employer for extensive medication and health checkups, diagnostic tests/surgical procedure required. Their financial condition did not permit them to do so either. Their employer only helped in immediate hospitalisation in an emergency ward, and observation for a few hours. Post discharge from the ward, they were left on their own. Post-accident and surgery Kumari could not walk again and post injury Kantamma could not do construction work. International Labour Organisation (ILO)

102 complying member countries are required to enforce the provisions for medical care in such situations[clxxii] (Note 8). India has not ratified this convention on social security of workers, neither do secondary workers come under any Workers Welfare Board in India. Their secondary work conditions of night hours and work on the road or hills and their state of prolonged engagement in paid work heightened the risk of injury, even if it helped them earn extra. There was no provision for compensation for the months or years of loss of work due to such injury for secondary work conditions. Such data helps understand health issues for exposures at work conditions in relation to the worker who juggles her main work, secondary work and unpaid work. Women combined work for insecurity of construction work, low pay of domestic work and need for extra earnings. Debt and expenses often pushed them into secondary work.

Women construction and domestic workers had different main work conditions, relatively different level of engagement in secondary work. However, they experienced health issues when vulnerable given the unique ways in which their main work conditions interacted with secondary work conditions, family conditions, living conditions, diet conditions and access of health care. Vulnerabilities were that of irregular and low pay work, ageing, pre-existing health issues and debt. The interaction of work conditions have been understood as everyday exposures which influence work changes.

Dietary Pattern

As women shared their family lives, daily routine activities, the way they managed home and work and their meal on that day, data emerged on not just about their food habits, meal timings, food affordability, food expense management, but the way they purchased grocery on a daily basis, prioritised other family members especially children when it came to food distribution (women looked after this in households), how buying food items was restrained when there was no or reduced earnings, the support networks of local grocery store who gave food on credit or the domestic worker's employer who gave food every day and the state support of subsidised ration supply to her family, provided she/her family had the BPL card. Be it the case of domestic or construction worker, her diet conditions were interwoven with work conditions (work strain, food provision at work place, etc.) and family conditions and

state support pointing towards the intersection of gender, class, family support and state support.

Most of the women domestic workers even if they ignored their breakfast meal at home, received tea and other food items at their employer's place in the morning and sometimes, in the afternoon. As already discussed in Chapter 4, at least 42 percent of them worked between 4-8 hours every day spread over two work shifts with a time interval of 3-4 hours and another 40 percent worked less than 4 hours every day. Since domestic work was usually in two shifts, they came home and had lunch. However, women construction workers' work hours affected their diet schedules. 66 percent of them worked for more than 8 hours and 34 percent of them worked 4-8 hours, which in real sense was about 8 hours of work for most. Construction workers had little time to eat breakfast in the morning. They had lunch at work site as their work hours were long and work site was far off most of the times, ruling out the possibility of coming home for lunch. Sanju, a construction worker shared that she had combined construction and rag picking work for so many years. During days of construction work, she did not always take cooked rice lunch from home and ate some snack meal from roadside vendor shops. She did not have food on time, a lunch at 3 or 4 in afternoon for her was regular, which was actually late. On days of rag picking work, she did not feel like eating rice after working day long to collect bottles and cans from piles of litter and filth. She lifted these from filth with her bare hands and did not feel like eating rice with the same hands near work site. She preferred eating some snack food which was less expensive than lunch. In other words, she missed one meal and the second meal was inadequate as she stayed away from home for long working and commuting hours. As a result, she had a recurring stomach ulcer after about 12 years. After this recurrence, she was diligent about her meals, she ensured that she had breakfast meal and had lunch by 2 o'clock. Her long work schedule resulted in health issues since it affected what, where, how much she ate and most importantly, her diet schedule. Dong (2005) found irregular timing and long work schedules which was more than 8 hours per day and more than 40 hours per week affected construction workers safety in United States and had high risk of work related injury.[clxxiii]

Two case studies bring forth that even when their situation was financially better than before, women construction and domestic workers regularly experienced hunger. Asha and Radha, both were around 50 years of age, had working husbands and grown up son/daughter who financially contributed to family regularly. Asking about what you had for breakfast today during the course of normal conversation was retorted back by both these respondents in somewhat similar terse manner: “what breakfast”, “what will we eat?” “gruel rice”. The use of “we” implied financial conditions of the family and gruel rice was not considered as good enough for breakfast. Women’s diet conditions was characterised by inadequate and absent meals on a daily basis for prolonged years with events like widowhood, desertion, illness and loss of or shift in work which compounded the deprivation. Asha, a domestic worker shared she would have her breakfast ‘somedays if the employer provides it’ and her husband and son will go to market and have some snack food (*idlis*, *vada*). She would give money to her husband for drinking. This was a conscious decision on her part to share some of the earnings for his requirements and make him happy, even though it affected overall food budget and particularly her meals. When it came to drinking or having breakfast at the market, men in the households had their say. Radha’s husband used to spend money on his drinking every day before he suffered from jaundice, was bed-ridden and was diagnosed with diabetes. For last five years he has not been drinking. He was forced to quit for health reasons; this saved Radha of the additional expenses, yet she suffered the additional medical expenses with debt. She could not herself do much to control her eldest son’s drinking with his group of friends from the slum. Instead, she got him married and send the couple off to a different state, Andhra Pradesh.

Gender, class and family support intersected when of the little earnings as low as Rs.30-50 per day or as high as Rs.200-250 per day usually from rickshaw pulling, a woman’s husband or son spent Rs.50-100 every day on alcohol. Even on days when men did not get work they continued spending that money on alcohol by taking the money from the respondents’ earnings. It was not necessarily his earnings, which he spent on alcohol. Manikamma, Sanju and Kalavati went through this experience, handled their alcoholic husband or son, struggled with food budget of the family on a daily basis (since they purchased food items on a daily basis) and bore the brunt of emotional scars from regular quarrels in the family. Alcoholism was a cause of both psycho-social stress and deprived diet conditions for the women respondents. Bang

(2010), a medical doctor by profession has found ill treatment by the husband and his family as an important cause of depression in women. She elaborates the causal pathway of illtreatment, stress and physical health issues by citing the case of Smita, one of her patients from a village in Gadchiroli district, Maharashtra. Smita came with the complaint of hopelessness post two years of separation from her husband who had remarried for a son. Her daughter was also kept by her husband and his second wife to do household chores. Smita was diagnosed with stress which was interlinked with her inability to eat properly and her physical health issue of anaemia and B complex deficiency.[clxxiv] In the present study, out of 33, 28 respondents had witnessed regular drinking of their husbands, irrespective of whether they were married, widowed or separate. Basu & Basu (2000) in their study in Delhi slums had found alcoholism of husbands as a reason of torture of wives.[clxxv] Of the 28, 3 respondents had said their husbands took money for drinking, but made sure she and her children got at least two meals every day. Rest experienced difficulties, at times abuse and quarrels. These women were at the risk of prolonged diet deprivation and stress for drinking habits of husbands, meagre earnings and family expenses. Women in comparison to men spent less on themselves. Some women spent money on chewing a mix of tobacco leaves, but it was Rs.1-2 every day, one-fiftieth of what men spent on themselves or less. Gender biases for male behaviour in family were there such as drinking or spending habits of men was expected by women. At times, some women had said, if the man of the household will not drink after a day of hard work what else he would do, he needs to relax and sleep well. The women did not see themselves or their daughters doing the same after a day of paid and unpaid work.

The third meal always carried a question mark in most of the households. Direct as well as indirect link between diet conditions, health status and employment changes was found. Sanju viewed her irregular diet timings, long work schedules, and skipping of breakfast meal as the direct cause of her ulcer and its recurrence after 10-12 years. Sita felt she had leprosy for the second time within a gap of 5 years as she could not even afford two meals a day out of her meagre earnings of domestic work. Both had experienced recurrence of their illness in a gap of 5-10 years with absence of one to two meals every day on a regular basis and this in turn, put a temporary stop at their work. Women such as Basanti, Bayamma and Ganga struggled for two meals a day when they were suddenly widowed without paid work or, when they managed

to get paid work, but had young children to care for and prioritised their meals. Even the food they received at employer's house, they brought it home for children to eat first. Gender and class mattered at the family level distribution of food.

Evidence for diet of older women shows that at structural level certain Government schemes could make a difference. Women could experience diet conditions differently based on the state support. There were differences in deprivation of meals based on support of their family members, their accessibility of Government run ration supply scheme and pension scheme, and any personal assets which was rare, such as gold, land or savings. These differences were visibly high for women aged around 45-50 years and above who witnessed reduced or zero earnings. Bhudei, a widow in her 60s who could not walk normally and experienced difficulty in getting up from the floor without steroid medication, was better off than Pedalamma, a widow in her 60s who had almost lost her vision in one eye and stayed in an under construction site (after being evicted by landlord for non-payment of rent) with her alcoholic son. Both worked as construction workers previously. Bhudei had the benefit of the Public Distribution System (PDS) based ration supply of 35 kgs of rice, 4 litres of kerosene and a widow pension of Rs.300 every month. Bhudei did not have any children staying with her who could be of some support. She managed with the widow pension as she received her cooked meals from her nephew or niece on a daily basis and in return, she gave her rice and kerosene to them. She pawned and sold whatever little gold (earrings and nose ring) she had to manage her medication costs. Pedalamma had her son staying in, but could not afford house rent or adequate meals. He managed to buy only one lunch meal for her every day and they did not have the benefit of PDS or pension scheme. She spent most of her awake time hungry and did not have a stove to cook either in her makeshift home. She could not visit a doctor for her eye checkup. Both lost work due to health reasons, one for knee issues and the other for poor vision almost ten years ago. Over time their health issue had escalated into full disability in a situation of loss of earnings, deprived diet conditions and difficulties in accessing health care. Both of them experienced difficulties in living conditions. Women workers were found differentiated on the basis of age, work schedules, earnings, debt or pawned items, husband's/son's drinking habit, family member's financial support, access to PDS, and pension schemes when it came to their access to adequate diet. The intersectional processes of gender, class, and family

support were earlier discussed, but the cross-cutting issues of state support and age rendered this process even more dynamic to influence women's diet conditions. Each of these had the potential to facilitate or render women vulnerable to health issues and thereafter, a series of interactive processes triggered by reduced or zero earnings.

Living Conditions

The World Health Organization (WHO) reinforces the importance of environment in health status as it states "but lack of health care is not the cause of the huge global burden of illness: water-borne diseases are not caused by lack of antibiotics but by dirty water, and by the political, social, and economic forces that fail to make clean water available to all."[clxxvi] Of the 33 case studies, 2 could not afford the house rent. One stayed in an under construction site and the other stayed with her elder sister's family. 2 women construction workers had constructed their own house by taking some debt, collecting bricks and sand from abandoned work sites at night and the skill they had learnt from construction work by working as labour. Women in Odiya Bazaar and Ranihat Sagadia sahi paid rent invariably whereas few households in Pattapol and Ranihat Das sahi had constructed their own house. The households in Ranihat Das sahi also shared their apprehension about the initiative under Government Housing Scheme which planned to relocate all the families there to a completely different area in the outskirts of the city and renovate that land for Government purposes. The houses here were all marked with RAY (Rajiv Awas Yojana) numbers which helped in locating them. The house rent was a priority along with debt interest payment when it came to managing monthly expenses. The house rent was below Rs.1000 per month in all 5 slum areas usually, except one case in Pattapol area. The rent found was as low as Rs.300 and as high as Rs.1500 per month. In many cases, there was electricity charge also. Some houses who watched television spent additional money. Living conditions of housing, sewage, water supply and toilet facility varied according to the slum area they lived in. In Chattra Bazaar and Ranihat Das sahi, hand pump was the only source of water supply. Women took bath in open near hand pump. During times of illness for getting drinking water from hand pump, for bathing or washing purpose there was no option, but to ask help from others. These slums had pay and use toilet, in one slum it was used by residents and in the other it was not used by residents for reasons of cost. Schenk (2001) in his study in

slums of Bangalore found that in two areas, Sulabh or public toilets for cost was a serious constraint for members of poor households in using this public facility.[clxxvii] In the present study, residents there used the ground near water canal for defecation. Open defecation in this slum was a source of discomfort for the physically disabled women who faced difficulty in going near canal. These women workers had become disabled due to severe work strain over time or some serious injury. Open defecation was also an issue of worry for young women workers, if they had to defecate at night or mid of the day for safety reasons. Very few people used pay and use toilet at a cost of Re.1-Rs.2 for each visit. If bathing was included, it was Rs.3 per visit. Acute illnesses such as brain malaria and filaria responsible for work changes was found in this slum with a possible cause being the littered and stagnant water canal in the months without rains. This was the canal used for bathing, washing clothes even then when water was less and dirty. Urination in some corner of the house or ground next to house was a common practice during evenings in both the slums. Women did so to avoid spending money and going to the toilet or they did not prefer to go the canal area in evening for safety reasons. Kumari was disabled from leg, and every day she dragged her lower part of the body on floor for almost 15-20 meters for attending to nature call near the water canal, a common place for defecation in her slum. She preferred to take bath in the dirty water canal and not near hand pump as she would be clean immediately after defecation and not have to ask anyone to pump out water from hand pump. At home, she received help from her husband mostly for getting water for cooking and drinking purpose. Bhudei who was unable to walk normally, found it tough attending to nature's call near the water canal. She had to request others for getting water from the hand pump on a regular basis as she could not exert pressure for pumping out water. Appiamma who was disabled for her knee issue and could not stand straight for more than five minutes stayed in a different slum. She had a toilet 4 meters away from her room and she was helped my some neighbor or family member to go to the toilet. Her surroundings were much cleaner than Kumari, even if she dragged her body or sat on floor it was not littered. In slums of Pattapol, Odiya Bazaar and Ranihat Sagadiasahi, women used common toilets either constructed by Government or by land owner free of cost. These toilets were shared by number of families (4-15) in the neighbourhood. Women could access water from a common tap source point and need not exert force unlike hand pump requirement. Water was supplied through taps thrice a day. They had to carry water for 4-10 meters of distance

for purpose of drinking and cooking. In mornings, water supply was usually for 3-4 hours. During lunch and evening time, the duration varied from 1-2 hours. Women ensured storage of water for the day based on when no water would be supplied and when water would be supplied, but they would be away from home for work. Mostly women had to carry used utensils for washing to the water source area, sit and wash the utensils. Such activities were difficult for the aged or, disabled or, sick women. These conditions made a difference in how during times of illness, respondents managed and recovered. Even a normal work day was stressed out as they had to adjust their work timings, cleaning and washing at home according to the water supply timings and others in neighbourhood who shared the water supply and place used for defecation and bathing. Neighbourhoods just did not form networks for work opportunities, but also support networks during illnesses while using common spaces. It was women's agency within constraints when they utilised these support structures. The way women responded to living conditions such as avoiding spending money on a public toilet or waiting in que for water were reflective of constraints of their intersectional location, class and gender which was different according to slum areas they were staying in, women's slum area of residence was an outcome of the caste and region of origin based social process. It also indicated the way as a slum based social group, their living conditions were prioritised, attended to or not by political parties in power.

Three cases of filarial fever, brain malaria and leprosy which were responsible for women's work changes had germinated from the living conditions and lack of proper health care (delayed, discontinued) and proper diet in spite of work strain. Living conditions were also a trigger of injuries, fractures with poor bone health such as Mamina who fell from a bed at a height less than 2 feet around dawn time and fractured her hand (she showed me the area below wrist where bangles stick on hand which was most affected and other parts of hand which was affected too). This happened in a nephew's house where she was supposed to sleep with their child since the child's mother (Mamina's daughter-in-law/nephew's wife) was away to attend to her mother admitted at the hospital. She fell down from the bed as her hand slipped from the bed when she was thinking it is time to get up, the day will start in a short while, she was sitting and about to get up ('the act while getting up'), before she fell down. Her hand probably slipped from the bed as she was not used to sleep on bed at

her home, she used to sleep on floor. Falling on a plain floor of the house from less than two feet height of a bed is different from falling on an underconstruction floor or stair etc. which is at a greater height because of the standing or bending position while working. Fall in a construction site is at a greater height and dangerous for the unsafe conditions at the construction site. Mamina's fall and fracture (hand and wrist) when she was just about 50 years of age points that her bones could not bear a minimum height fall and the bones were weak to cause a fracture. One of the reasons of poor bone health is poor diet, which in case of Mamina has been deprived over the years for reasons, including that of poverty. The necessity of a nutritional healthy diet especially when there were hormonal and physiological changes post menopause could also not be attended to since Mamina's earnings were reduced post work shift from construction to domestic work, she had lost her husband two years back, her eldest son who lived with her had become severely alcoholic in these two years, especially post separation from his wife and did not bother what she ate or how she managed meal expenses at home. A study in Norway on high-energy and low-energy distal radius fractures among patients aged 50 years or above found that "the increase in low-energy fracture with age may be explained by the increasing number of patients with osteoporosis, especially women. Low-energy fracture was defined as a result of falling from standing height or less, while high-energy fracture was defined as any other type of trauma (e.g. falling from height higher than standing height and motor vehicle accident)."[clxxviii] The access to basic health care of diagnosis and awareness of a healthy nutritious diet for women, more so when they are nearing or experiencing post menopause becomes an issue along with class, gender and age based differences in such cases of poor bone health. This deteriorated bone health condition is termed as osteoporosis medically after certified diagnostic tests. But it indicates the dynamism of health issues, such as bone health, which has the structural causes in class, gender and age.

Another respondent, Manju experienced work changes for care burden that was associated with her living conditions. The condition of their house was not a cause of worry till late at night just after the dinner, the wall broke off and fell on her three children who were sleeping. This was a wall of bricks and cement, probably old or of poor quality. In this accident, two of her children had small scratches, but the middle child sustained serious injuries on chest and thighs. She had to temporarily withdraw

from her paid work to take care of her son for about 6-7 months and then, rejoin work for health expenses and debt.

The kind of health issues associated with living conditions were diverse, whether it was in relation to basic facilities or illness/disability or risks associated and accompanying care burden or poor diet and bone health. Graham (2004: 111) says, "even though there is evidence of unequal distribution of 'living standards' and 'health behaviours', there are no models that capture it.[clxxix] One of the ways to capture these inequalities would be living conditions and women's responses towards these prior to illness in everyday life and post illness, especially during her recovery phase. Given the cases and their experiences, living conditions interacted with work and diet conditions, added to the daily stress and strain, shaped or aggravated her health issues, and hindered health recovery during illness.

II. Exposures of Psycho-Social Stress in Everyday Lives and Specific Times

Women workers were exposed to some amount of mental stress on a daily basis when they managed their work and family, handling the constraints of living conditions and diet. Construction workers lost their earnings or did secondary work when construction work was unavailable. During the survey, which was conducted in June-July or summer and rains, women construction workers shared the experience of working under extreme heat conditions, how they could not go for work for exhaustion out of heat and how they felt the need to save money for the lean period, such as rainy season when employers did not carry out work. While the worry of getting regular work and uncertainty of work location was expressed by women construction workers, the dissatisfaction with salary was conveyed by women domestic workers when they made statements such as 'worked for a monthly salary of Rs.500 for 10 years' or 'employer increased monthly salary to only Rs.800 or Rs.1000'. Helplessness in such job situations was expressed by women workers. According to WHO, "poor work quality may affect mental health almost as much as loss of work (Bartley, 2005; Muntaner et al., 1995; Strazdins et al., 2007)."[clxxx]

The construction workers got work through a known mason at times wherein good rapport with him was a prerequisite. Otherwise, there were common meeting points for construction workers wherein employers came and picked up number of workers

required for the day early morning. The process of getting work through common meeting point added to the work time required and there was always insecurity of getting work. Women construction workers cooked early in the morning and packed their lunches to work place. Construction workers started from home around 7.30 or 8 in the morning. Their work got over around or after 6.30 in summers and by 5.30 in winters in the evening. Rarely their work site would be nearer home which had repercussions on commuting cost, time and physical strain. They either cooked once again in the evening or had left over food for dinner after returning home. Women domestic workers cooked lunch in between their two work shifts, but it also meant walking twice a day to and from their work place. They walked to, worked in one to three employers' houses and managed time accordingly. For domestic workers, the employer could cut salary for the leave taken or ask her to leave if there was an altercation without any compensation. This was a source of some mental stress and varied according to the number of houses they were employed in and the temperament of the employer. In some cases, women workers had other family members to help them do domestic chores such as cooking, washing, cleaning, keeping water, buying grocery and vegetables. It was found daughters/daughter- in-law helped the respondents in the chores usually. This arrangement witnessed changes with marriage of daughter or paid work of daughter-in-law.

It was found that respondents had married within a year or two of attaining puberty, around 14-15 years of age. They had to manage their household at an early age. Early marriage and pregnancy and associated psycho-social exposures were rooted in traditions of community, based on caste, class and gender either in slum of residence or native village. Most of the respondents, whether women construction or domestic worker had an unhappy married life since their husbands were alcoholic and neglected their responsibilities towards family. Their sons too repeated the same. This was a constant source of mental strife for women workers from slums. In some cases, their neighbourhood witnessed on a day-to-day basis verbal abuse and quarrel over drinking expenses vis-à-vis food expenses which was embarrassing for the respondent. This respondent showed the marks on her body from domestic violence, another respondent shared that her life was hell like experience with constant troubles, especially with her drunkard husband.

For some death in family, be it of husband or children inflicted sorrow for a prolonged time. In these few cases, death brought forth a gloomy mental state that lasted for a year or more and affected their paid work. They experienced low mood, inactivity, confinement to home during that period and had less social interaction. These mental health symptoms were similar to depression. Mamina, a construction worker and Sadamma, a domestic worker left work for mental trauma experienced post death in their family, yet they did not access any health care. They were fortunate to have financial support from their children during this low phase. Mamina lost her husband to fever even before he could be taken to the hospital. Sadamma, a widow lost two of her sons when they were around 30 years of age. Her eldest son died of jaundice and one of the younger sons died suddenly of unknown illness. She had lost her husband to heavy drinking before these deaths. She quit working after the untimely death of her eldest son. This loss left her shaken from inside. Mamina was compelled to rejoin work after two years of her husband's death as her sons no longer financially supported her. After these two years of break, she did not have the strength to do construction work as before. So, she shifted to domestic work. Every time Bhudei lost her baby to malnutrition, her vulnerability and exposure was evident. Her baby died in womb as she ate little and went out for work every day without break. Her two babies died after birth within few months or a year when she went out for construction work leaving the baby at home with her ailing husband and the baby died without proper breastfeeding. She provided for her family and never had enough to eat and feed her baby. She deeply experienced the mental pain when she lost her only surviving young son at 17 years of age to unknown health issue. Recalling her son's death was emotionally difficult for her. Every such death was a socio-psychological exposure and how a woman responded to emerged from her intersectional location of class, gender, age and family support. These did/did not bring forth immediate work changes in respondents' life, but these pyscho-social exposures were never attended to and in course of time, accumulated and interacted with other conditions to affect work capacity.

Care burden at home exposed women to intense work load and mental agony and thereafter, illness in certain cases. Mani was not aware of her tumor till it became painful to do any work. Moving her hands during work resulted in friction with swelled tumour area near her breasts. She had to stop her construction and paper mill

work for this reason. She attributed her illness to mental turmoil she experienced during her husband's illness. She stayed away from work to care for her paralytic husband day and night for more than one and half years. In her words, she had become *'kala katha'* or a piece of burnt black wood during this phase for physical and mental strain. Her psycho-social exposures interacted with her physical health exposures with an outcome of illness.

Women experienced stress for heavy or continuous bleeding. Anaemia caused by heavy bleeding during delivery for Anu and menopause symptoms of continuous bleeding for Radha was a cause of distress along with fatigue and weakness. While heavy debt did not permit the anaemic construction worker to take rest and pushed her to resume work soon after, chances of engaging in additional work of helper in marriage functions and earning some money was hindered by menopause bleeding and weakness.

Women were apprehensive while consulting doctors for their own illness or accessing health care when a family member was sick. Such anxiety was characterised by how they would communicate their health issues to the doctor or practitioner, how they would commute to the health care centre particularly when sick or felt weak with age or had very little money and had to forgo earnings of the day. They were uncertain about long waits in the que and recovery or relief from pain. Such anxieties about accessing health care were shared by many including Kalyani, Mani, Sita, Sadamma, Kalavati, Ankamma, Amma, Bhudei, Chenamma, Kumari and Manju. These included women construction and domestic workers.

Such anxiety co-existed with apprehension about medical expenses such as how will they have enough funds to get the ill family member admitted to the hospital, how would they manage medical expenses of tests, surgery and medication and how would they repay their debt for medical expenses. State of mental anxiety was exacerbated when they had taken loans from a money lender. It was usually Rs.5 as interest for every Rs.100 taken per month (annually around Rs.60 as interest if principal amount of Rs.100 was unpaid). They pushed themselves to work even with health issues, such as Sanju worked to repay a house loan around Rs.60,000 and ignored her ulcer symptoms. Likewise, Anu worked in spite of anaemia and weakness post delivery. She had a debt for her husband's illness which was around Rs.40,000.

There was no mechanism to give loans to women at a minimal rate except one or two self-help groups which were also closed down due to financial issues. Even in past, when women were benefitted it was one time and was after participating/saving in the group for at least a year. Debt related stress was of limited duration till the debt was repaid. Day to day financial difficulties, family conflict with husband or son for their drinking habits and dissatisfaction at work became a chronic source of stress in their lives.

Physical health issues had a direct consequence on respondent's body, but had indirect repercussion on her mental health as she incurred reduction or loss of earnings with work changes, decreased spending on her food, increased spending on health and debt. Hypertension cases were seen when the respondent was reaching her 50s with mental worries such as unfulfilled expectations from her grown up sons or other illness and loss of earnings as found for Amma, Mamina, and Budhi. High blood pressure (BP) succeeded other health issues such as tumour, brain malaria or hand fracture, explained by such health conditions hindering regular earnings and loss of pay, which induced stress. It was also found in a worker in her 40s as her high BP was triggered by a huge debt.

III. The Challenges of Accessing Health Care

Post injuries and acute illness women sought health care, but there were delays and discontinuities in whatever health care they received. Women did not seek health care for mental health issues at all and chronic health issues were treated as a way of life. Besides the key issue of affordability, other issues for delayed and discontinued health care were the issue of the referred doctor, discomfort with allopathic medicine, loss of time from paid work and physical frailty to visit the hospital. Mani had difficulty in approaching the 'right' doctor initially. She had to threaten her husband of suicide for a health checkup since he was unwilling to take her to the hospital. After reaching the hospital, they realised that they did not have any clue whom to approach and went by what the registration counter person suggested. She was sent to an orthopaedic surgeon from the registration counter. After seeing her problem which was non-related to orthopaedics, the orthopaedic surgeon referred her to a private doctor who could actually diagnose her ailment, which was swelling near breasts. She went for consultation, diagnostic test and thereafter, a surgical procedure at the private doctor's

nursing home. She lost time in getting health care once she noticed it due to her husband's initial lack of cooperation and then, incorrect referral at the ticket/registation counter. She was uncomfortable with the hospital set up to approach a doctor on her own for checkup and she wanted her husband to accompany her. More so since she had swelling near breasts and was apprehensive of showing this to an unknown doctor, who could be male and not necessarily a female. Lack of counselling to share information on illness openly and right guidance at hospital ticket counter was a hindrance in timely access of health care for the poor illiterate women patients, with additional barriers for illness in parts considered difficult to talk about.

For a very few women workers, allopathic medicine was a source of discomfort and they preferred to stay away from it. Ishwaramma took homeopathic medicine for her acidity, knee issues, BP and diabetes. It worked for her because with allopathic medicine she developed nausea and loose motion. For Mamina, approaching a doctor for her hand fracture in the hospital was difficult. She was apprehensive of the x-ray, costs and even talking to the doctor. She decided to go for *'kalu pada sheka'* or heat therapy than regular plastering. She felt comfortable going to the traditional heat therapy centre even though it was at a greater distance from her home than the hospital and she felt the therapy healed her hand fracture. She spent on autorickshaw expenses and travelled to go the centre. She requested her therapist to charge minimally, around Rs.100 per bandage. Her bandage changed weekly for about 7-8 times. These are instances where accessible alternative medicine took away the fear and stress associated with allopathic medicine, diagnostic tests and talking to a doctor in the hospital.

Ankamma did not like spending hours at hospitals from paid work, spending money on different tests without any major relief. She went to two different doctors one at Government hospital and other at a private clinic for her knee issue. She discontinued her medication after few months and got only one or two tests done for Rs.200. She neither took full medication nor did the other tests required for her dissatisfaction with relief and cost of continuing health care. She told the other tests would have had cost her around Rs.900, which were blood tests prescribed by a private practitioner for knowing her knee condition. From this information, it is inferred that these tests were likely to be rheumatism and arthirits tests using blood as sample. She took painkillers

as and when required from the local pharmacist without going to the doctor, but her basic health issues remained unattended to. Sita, Kalyani and Bhudei shared how difficult it was to go to the hospital and wait in the que for a health checkup with discomfort in body. Kalyani and Bhudei were around 60 years of age, had difficulty with their knees and experienced physical weakness due to inadequate meals. It was difficult to go to the hospital alone without any family members' support, particularly Bhudei who could not walk properly. Bhudei had to spend on a cycle rickshaw and ask physical help from the rickshaw puller to go to the hospital. Kalyani depended on her daughter for checkup, she had got her cataract operation few months back with support of her daughter who was married and stayed in a different slum. Sita was only 40 years old. She shared how she had no strength to go to the hospital when she had leprosy and had barely anything to eat. Her husband was always drunk and did not bother about her. The medication was strong which made her feel weak with poor diet. The medication lasted for more than a year (her account while narrating the experience) was taken irregularly by her after one year and then, discontinued before the doctor had asked her to. In that whole phase of medication she had lost her work, which also affected her earnings and meals.

The women respondents ignored their health issues over family concerns. Anu preferred to go to doctors for her children, but not for herself. She continued ignoring a difficulty in her hand movement, this was her hand burnt of kerosene fire almost 12 years ago. This was gender and class based decision wherein gender norms were internalised by her. She took her husband for treatment before his death of jaundice and also children when they had fever, diarrhea for treatment, but ignored her own hand issue. Amma had ignored her swelling/tumour for almost 15 years and ultimately this swelling affected her capacity to work. She neglected her own health concerns to provide for her family of three children after losing her husband, then, get her daughters married and not bother her physically handicapped son. As time passed, different family concerns took priority leaving her health behind. She did not go for checkup even if her swelling increased in size. Mani went through a phase of neglecting her food and sleep while taking care of her paralysed and bed-ridden husband for almost two years. She stayed away from work to care for her husband and rejoined work after his recovery only to quit within a year after she was diagnosed with breast tumour. Putting family first, caring for children and husband was

internalised by most women respondents, which was one of the causes of ignoring health concerns. Also health checkup day was pitted against her paid work and women chose latter. Health expenses were deprioritised for family expenses. This internalisation of family first value and ignoring own health was gender and class based. It was not a fixed state, at some point women took notice of their health and even acted on it overcoming the constraints. Mani transitioned from one who neglected her health concerns to one who fought with her husband for a health checkup. She overcame the gender and class based constraints when she sold her share of land at village and went for her surgery. This also hints at how gender and class categories are fluid over time with power dynamics. She had lost her work, was taking longer than a year to recover with almost no savings. Their source of sustenance was her husband's odd days of earnings and subsidised ration supply of rice and kerosene. She expressed fears of recurrence of tumour, possible expenses and hardships when both of them were not in good health to work anymore.

Expenses were found to be a deterrent particularly for surgery or diagnostic tests. Affordability was one of the main hindrances in accessing health care. Amma did not go for an operation and carried the 6 inch diameter tumour on her back 24*7. The swelling increased in its size over the 15 years, an accumulation over the time without intervention. A surgery for its removal would cost her Rs.15,000. She also developed acidity, high BP and blood sugar over the years along with tumour. She took medicine every day by spending widow pension money and taking monetary help from her daughters. She could not get rid of her tumour as Rs.15,000 was a difficult sum for her, when she struggled with her meals and had a free lunch at the temple where she was a sweeper. She did not even go to a hospital for checkup and got a rough estimate of surgery expenses from a doctor who regularly visited the temple.

Except one erstwhile construction worker and another present day construction worker rest did not have a health card issued by Labour Department for construction workers. With her health card, Chenamma benefitted from a compensation of around Rs.15,000 out of the total cost of Rs.30,000 for her surgery. Manju was not given the benefits of labour card for her son and was asked to get her card renewed for benefits. None of the women domestic workers were given any such labour card.

Each of the cases of brain malaria, pneumonia, gastric ulcer, leg injury and tumour faced delay in health care for reasons of lack of affordability. When they had taken loans from a money lender, they pushed themselves to work in spite of health issues. Physical and psycho-social exposures were found interweaved in debt situation.

Very few cases did not incur debt while going for health care. They managed with their savings or by selling off any landed property or pawning gold. However, this was only one time and the continued utilisation of health care such as regular medication, checkups and tests over a year was difficult and witnessed discontinuities in the same cases. Budhi's husband spent his savings around Rs.70,000 on her hospitalisation and treatment for brain malaria. Post discharge, she but took her BP medication for one year. After that she stopped taking it as it was expensive. She started working after one year of discharge as a domestic worker. She continued working for three years, but she quit again for constant issues of shaking of limbs. Before her hospitalisation, she had worked as a construction worker for more than 20 years. Challenges of accessing health care acted as a direct cause of accumulation of health risks and escalation of health issues which affected employment chances.

IV. Work Changes Interceded by Intersecting Processes

Case studies of 33 women construction and domestic workers reveal that women by their 40s had started experiencing health issues and quit or shifted work for health reasons. Women in 20s or 30s cited reasons such as risks at construction work site during pregnancy and childcare, difficulty in managing child care along with construction and domestic work, lack of stamina to do construction work and unpaid work at home, change of slum of residence, higher earnings in construction work than domestic work and care burden of a sick family member. Women in their 40s cited reasons such as domestic chores, child care, husband/son's financial help/support, constant knee ache, constant backache, vehicle accident and disability, prolonged medication and altercation with employer. Women in 50s shared reasons such as health issues along with age related stamina issues and few of them had the reason of disability. Women construction and domestic workers in different age groups shared certain common experiences specific to their group in spite of the differences of incidence of health or other issues as a reason for work changes. When work changes were seen in relation to women's lives four intersecting processes emerged from the

metadata which formed larger background wherein different exposures and vulnerabilities influenced women's health. The four intersectional processes found were trade off between paid and unpaid work, changes in age and identity, changes in family and identity and health and ageing. These were complex and criss-crossing processes of intersectionality, exposures, vulnerabilities and accumulation which acted as the the cause of employment related changes and these complexities have been discussed here with the help of case studies.

1. Trading Off Paid and Unpaid Work

As discussed earlier in the section on work conditions and diet conditions, many women workers handed over domestic chores at home partially to another family member, a mother/mother-in-law or daughter/daughter-in-law, and then engaged in paid work or increased paid work days or hours. Family members's physical as well as financial support emerged as a determining factor for womens' work decisions (Note 9). Women chose paid work when they received family's physical support in attending to care work whereas they stayed off paid work when they did not get this help. On the contrary, women chose to stay off paid work when they had family member's financial help and instead attended to unpaid work at home. Interviews revealed that at times they handled all domestic chores at home while staying off paid work, usually just after marriage, also when ageing or, during demanding situations in the family. Women faced this dilemma of balancing paid and unpaid work where no paid work meant no earnings, particularly in situations of illness, pregnancy, childbirth and death in the family. In normal situations, women attempted a balancing act when they engaged in paid work. Most of the women construction workers preferred their work site to be within city limits in order to have time for unpaid work and leisure at home, even though some of them travelled outside the city for work at times. Within the city, they worked wherever the site was, irrespective of distance from their homes. For most domestic workers, their employers' houses were within 20-25 minutes walking distance and they all walked to work. Women domestic workers were found to have greater negotiating power than construction workers when work location was the concern. Women construction workers had to spend an additional one to three hours commuting besides work hours and far off work site

made them stay away from work on a regular basis or occasionally. The case of Asha illustrates this.

Asha quit construction work in her second month for a safe pregnancy and delivery. By then she had worked for 6-7 years as a construction worker and was in her mid-20s. This was her second pregnancy. Traumatised by her first miscarriage, she had waited eight years after her wedding for this baby. After her delivery, she stayed off paid work for four years as there was no one else to look after her baby, and shifted to paid domestic work once she decided to rejoin the workforce. She took this decision only when her child was around 4 years old, old enough to be carried to her workplace. Until that time she had decided to forego her earnings and managed household expenses with her husband's earnings and 'baaki' or credit at local grocery store. She did not have her in-laws or parents with whom she could entrust the care of her child at home (Note 10). In a different space and time, when she was close to her 50s and identified herself as ageing, she deliberately reduced her workload to two employers. She did so only after she repaid a loan of Rs.50,000 taken primarily for her son's education. Her son had begun contributing Rs.2500 out of his total income of Rs.5000 to family earnings every month. Her husband earned Rs.50-100 a day and spent regularly some money on his drinking habits and gave her the rest of the money. She earned Rs.1000 and Rs.1500 from two houses every month. Her paid work included sweeping and mopping floor, cleaning utensils and washing clothes. She walked one way 15-20 minutes of distance to her employers' houses. At home, she cooked two meals a day, cleaned used plates, utensils and clothes for three of them. She used a common source of tap water supply at about 10 metres distance from her house for washing and cleaning. She shared this water supply with around 15 neighbourhood families. She used a common toilet which was used by more than 15 families. The water supply was for specific duration in a day and she carried about 40 litres of water every day from this common source to her home for purposes of cooking and drinking. She ate her breakfast meal on days when her employer provided for it, rest of the days she missed it or had gruel rice. She had started planning for her son's marriage and expenses and was not sure whether she would increase her paid work once her daughter-in-law started staying with them.

Compromising paid work for a safe pregnancy had two different connotations simultaneously. One was a reassertion of gender norms, with a woman being brought up to internalise the patriarchal norms and values attached to motherhood and her identity; and the other was allowing herself personal time and rest when there was a physical need for less work, with the support of her husband. Post childbirth family's care burden affected paid work. Credit or '*baaki*' was a way of survival in this trade off. Repaying the debt or loan eased off her paid workload. Financial help from her son was helpful, but reducing paid work did not necessarily mean rest for her as there was the unpaid workload of domestic chores at home.

2. Changes in Her Age and Identity

Age was found hindering and facilitating paid work. According to the survey findings on work hours and work days, women domestic workers became free to do more hours of work and women construction workers became free to work for more number of days in a month when they were in 35-44 age group. The case studies data provided insight into what happened in 35-44 age group. Women in this age group could be perceived as having crossed the age threshold at which work related to household chores and care of young children at home peaks. With age women identified themselves relieved of care burden and domestic responsibilities as children were grown up and shared domestic chores with her. Women had a choice of earning more by allocating extra hours of work, but at the cost of their leisure time and rest. This decision was taken amidst diverse needs, such as women wanted more income to run the family, had a less demanding role in the family with increasing age, but also wanted rest for themselves. Going for paid work was marked by when her eldest child was around 5 years of age and could look after younger children. This was seen in women construction and domestic workers including Ramalamma, Chandramma, Ganga, Asha, Kalyani and Ankamma. These women while going for paid work were in the 25-34 age group. The case of Ankamma throws light on changes in age and her identity.

Ankamma started working after her youngest daughter was born and when her eldest daughter could take care of the younger two children. She was compelled to work since her husband deserted her, but at the same time her care burden was shared by her eldest daughter as she stepped out for construction work. It was then that she

could work and run her family. In her mid-40s she experienced knee issues which gradually became painful and led her to shift work. She said that she could not stay off paid work completely even when she was nearing her 50s and suffered from chronic knee ache. She had quit construction work when she was around 45 years old and earned a wage of Rs.150 per day. This happened in her life when she married off two of her daughters and her youngest daughter's education was taken care of by her father. She had deliberately reduced her paid work time for health reasons, but it coincided with other life events that signified reduction in her family responsibilities. However, in spite of health issues, she did not rest completely. She said she did not have a son or husband to give her money. She combined her paid work of selling bananas in the local market with unpaid work at her married daughter's place, where she ate her meals on a daily basis. She earned Rs.30-50 per day by her business. She did not have a 'chulha'or stove in her house for cooking. The unpaid work at her daughter's place included tasks such as buying groceries and taking care of grandchildren. In such situations, support from children or other family members facilitated staying off paid work, but not always from unpaid work. Even when health was cited as a reason for giving up paid work, there was some compromise and respondents attended to unpaid work, especially when old.

Age and change in identity was common to women construction and domestic worker's lives as women identified themselves as mother of grown up children or aged with reduced stamina.

It implied the effects of reduction in the double burden in women's lives with age, sharing domestic chores with family members, giving up their reproductive function, and so on. In other words, age gave the respondents the negotiating power to allocate more work hours or days to work as her identity within the family changed, which is discussed in the following section in greater detail.

3. Changes in Her Family and Her Identity

Changes in family implied changes in physical and financial aspects of family support, family demands and change in her identity, from being secondary earner to provider of the family, from being married to a widow, mother of a newborn, from being mother of young children to mother of working children, and mother of a

daughter who had attained puberty. Care burden, domestic chores and financial expenses were different types of demands made by the family. Respondents said they were uneasy about paying interest and principal, or *'sudha'* and *'mula'*, for a long time and it was stressful (Note 11). A loan was usually taken during festivals, daughters' puberty and in situations of birth, marriage, death and illness in the family. Any debt meant unpredictability with age and fluctuating family support. Family's financial support was not always adequate, particularly when the husband spent on drinking or children were not working. As found, desertion and widowhood both resulted in women taking similar work decisions in similar circumstances.

Region of origin, caste, class and gender based identity was expressed in an explicit or implicit manner by respondents as they entered certain occupation, stayed in certain slum, got their children married in certain community and observed specific festivals. Her identity in relation to family was asserted often explicity. Metadata suggests change in family occurred evidently in times of death, birth, marriage, separation, desertion or illness and occurred subtly in situations when husband became an alcoholic or sick and did not contribute towards family earnings, son started working but did not financially help, son became an alcoholic, daughter attained puberty, working daughter who contributed to family earnings got married, or children began working and contributed financially. Changes in family intersected with changes in her age and identity and had gender and class based implications such as who provided for the family, who bore the health expenses, who took the care burden, who repaid a debt, and who did or shared the domestic chores. Women adapted to these changes and implications by taking work decisions to shift, withdraw, join or resume work.

Such an understanding that emerged by looking at processes of change associated with woman's age, family and her identity helped in clarifying the inferences drawn from crosstabulation of work days/hours, age and specific work (Chapter 4, Tables 16 & 17). In 35-44 years of age group women were relatively less occupied with work demands at home and could devote more time for paid work and in 45 years and above age group health and stamina issues added the element of uncertainty to how much time they could give for paid work. This variation was seen in case of women

construction workers in 45 years and above age group. The case of Anu illustrates this dynamics of family and identity.

Anu, around 40 years old, was an agricultural labourer at her village. She shifted to the city after her eldest son was born. She started working as a domestic worker at a monthly salary of Rs.250. Her daughter was born within two years of coming to the city. Her eldest sister came to the city then and helped her care for the baby. She did not work during her first pregnancy, while she worked during her third and fourth pregnancy rigorously. Even though she worked during her second pregnancy, it was less strenuous with leave and flexible timings. She had her 8-year-old son, her oldest, look after her young baby girl so that she could do paid domestic work after her third delivery. Her second daughter was around 6 years old then. Occasionally she went for construction work to earn more money at a wage of Rs.80 per day. Her husband provided for the family by pulling trolley rickshaw. Her husband did not work for a year before his death, he used to drink a lot and physically abuse her. He had taken a loan of Rs.30,000. When she conceived for the fourth time, her husband had jaundice, other health issues related to his excessive drinking habit and became bed-ridden. Her eldest daughter helped in care work and other unpaid work at home. Her eldest son started working then for Rs.2000 per month. She said she had been compelled to take up construction work to meet her sick husband's health expenses, rent expenses, food expenses and loan interest. She initially combined paid domestic work and construction work, but later took up full-time construction work with a wage of Rs.120 per day. Her husband died about six months before her fourth child was born. She gave birth to a boy at a Government hospital and was given a blood transfusion during her delivery as she was severely anaemic. For her delivery, she was again pushed to take a loan. Within six months, her outstanding loan money increased to Rs.40,000. There was no rest and she continued construction work post child birth. After she became a widow, her older sister had offered her family free shelter in the same slum. This arrangement saved around Rs.600, a house rent she used to pay before. Her and her son's earnings was used for repaying loan. Her eldest daughter had started working for Rs.1000 per month then. A year and half after her husband's death she quit construction work to take care of the baby and some rest. She also shared the issue of being paid Rs.120 against the usual wage of Rs.200 per day. This was a reason too for quitting construction work. After a year she started paid

domestic work and her younger daughter, 8, who did not go to school, took care of the baby boy most of the time. She earned Rs.1000 and Rs.800 from two houses as a domestic worker and received financial support of about Rs.4000 from her two working children. After 3 years of her husband's death she received widow pension of Rs.300 per month from the Government. She had taken an advance of Rs.2000 from her employer for giving a community feast at her village in South Odisha to celebrate her eldest daughter attaining puberty or 'gujira'at the time of interviews.

Changes in her family was signified by illness, birth, death, children entering workforce and support from extended kin in her life. Linked to her work decisions were intersecting processes amidst the change of place or relocation with husband, onset of illness, care burden, double burden, debt, death, widowhood, birth and increased intensity of health issue. She decided to shift work during birth and illness in family. First, she decided to shift from domestic work to construction work for managing health and loan expenses. Second, she took the decision to reduce her workload to rest and take out time for the younger children when there was family's financial support. When she decided to work in spite of her delicate health post child birth, the interaction of health issues and debt was complicated. It was difficult to gauge her next course of action.

4. Health and Ageing: Accumulation of Health Risks

Women construction workers spoke of the effect of age on their stamina, feeling of fatigue and their inability to work like younger days. Commuting to work became an issue with age. Few women domestic workers who were above 45 years of age categorically stated how far they walked to their employer's house, how the walk was tiring and difficult during the rains. These respondents experienced such difficulty in walking to and from employer's house twice a day with increase in age and health issues. Walking was difficult during the rains. Women's access of health care was also affected by issues of distance of health care facility as they aged.

Women lacked basic facilities of toilet, sewerage facility and water supply in kitchen. Washing clothes, cooking and cleaning utensils was tasking during times of illness such as fracture and post-surgery or during age related health issues such as chronic ache issues. They depended on support of family members or neighbours to carry out

these activities. State pension for widow respondents was a meagre amount of Rs.300 per month (Note 12). Pension of respondents' husbands was received provided her husband had a regular Government job, and this was found rare. State supply of subsidised rice of 25-35 kgs and kerosene of 4 litres per month for BPL and poorest of the poor or 'antodyaya' families was helpful (Note 13). Single women respondents who received 35 kgs of rice and 4 litres of kerosene under Antodyaya Scheme sold or bartered it to friends and relatives in exchange of money or food. Two meals a day was difficult to manage without pension money and PDS ration supply. Even affording a single cup of tea every day worth Rs.5 meant adjusting expenses on their meals. When women stayed with family, family debt or expenses were prioritised over their own health by most respondents, irrespective of age. There were women who had discontinued medicines after taking them for some time, or those who did not opt for any diagnosis, surgery or take the medication required for fear of expenses. Commuting to the hospital, standing in a queue, and losing pay for the day inhibited most of the respondents from going for a health check-up in the first place. This ordeal increased with age, and in the absence of the family's physical and financial support. Even a diagnosed illness meant discontinued treatment in most cases. Such conditions in which damage from illness and age impacted each other were found to mark a shift in as well as withdrawal from paid work. This interactive process was laced with exhausted savings, reduced or loss of earnings, fluctuations in family support, and challenges of debt, difficult living conditions and issues of treatment.

Women workers who suffered fracture of hand or, had ulcer partially recovered, but could not go back to work like earlier days for their health and age. They were in their 40s or 50s and had accessed some kind of health care and some amount of rest, both of which were not sufficient. Three of them faced difficulty in hand movement while doing normal activity post fracture or injury. Another respondent had stomach cramps post recovery from gastric ulcer. Some of the respondents who were in their 60s and had not accessed health care for long for multiple reasons or had access to ineffective low quality health care faced permanent impairment of mobility and vision with advanced age. These were cases of severe disability which affected completely daily normal activity and hindered any possibility of paid work. But it was seen that even in severe cases of disability such as of Appiama and Kumari, they continued cooking for their family. Both of them could not walk. There were also cases wherein a knee ache

or an injury gradually exacerbated into moderate disability accompanied by either anxiety, acidity, high BP or all of them together. Moderate disability affected daily activity and paid work to some extent. This initial manifestation of health issues usually started in early 40s or mid-40s and then, continued or multiplied over the years. Health and ageing as an interactive process was witnessed as an 'accumulation of health risks' over time (Note 14). Beginning of accumulation of health risks could be traced to when health issues first emerged in women's lives as women entered their 40s. Some women left working or shifted work as soon as they faced health issues in their 40s and some continued working. For those who did not undergo work changes, the health issue lingered on with new exposures and was manifest as an impeding health issue for paid work in 5-10 years period of time. It was in the form of ache issues, asthma, chronic acidity, gastric ulcer, leprosy, BP and diabetes. They made work changes in this time period. This accumulation and manifestation was at times shorter than 5 years as seen in the case of recurrence of leprosy which recurred within 5 years. For some this accumulation resulted in permanent disability and was spread over 15 years of time. This was not a simple process of ageing of a population of women construction and domestic worker since it was mediated via accumulation of health risks. This was related to the different ways same interactive exposure conditions were experienced by a normal woman, woman with injury, woman with chronic ache with moderate disability, woman with severe disability, etc. and implied health outcomes. These were 'risks' as women were in a disadvantaged position which emerged from their class, gender, caste, region of origin, age and family/state support intersectional position with difficult conditions of living, diet, family and work and challenges of accessing health care. With age, health issues increased in intensity without adequate health care, rest, social security and these exposure conditions which were felt at different level depending on the stage at which their health condition was. There have been discussions on how illness can be epistemically transformative and existentially transformative. Carel, Kidd & Pettigrew (2016) say, "reading accounts of illness can both edify and inform non-patients about the experience of illness, revealing what it is like to live 'at the will of body' as Arthur Frank puts it."[clxxxi] This would be epistemically transformative. And they put existentially transformative as experience of a patient which changes her identity with illness, such as people may speed up or slow down post illness, reconsider their career or spend more time with family. They put it as "around the time of diagnosis or

symptom appearance people experience a substantial reduction in wellbeing, but return to slightly below baseline levels within a year or two. This adaptation explains why what seems to the outside observer like a terrible catastrophe is manageable and, moreover, something to which the person with the illness adapts."[clxxxii] But this adaptation to normal life post illness in case of women construction and domestic workers was at the cost of their health in long term. Illness was existentially transformative for them not just psycho-socially or physically (experience of multiple spaces at home or work was changed for the ill), but their whole material existence was deeply affected by illness. Illness as transformative (with the way women viewed themselves) was experienced when it was the reason of withdrawal from work or shifts in work and thereby, loss of or reduced earnings post such change. Illness could be transformative experience or it could be experienced at different levels by a patient which need not be transformative. Conceptually, the same physical and psycho-social exposures would be felt with increased intensity with any issue of health, such as deprived diet conditions would be experienced differently by women if she was a leprosy patient, an ulcer patient, an ageing person with poor bone health or, a normal person. The daily task of collecting water for household purposes from a handpump or a water tap would be experienced differently by a normal person, a person with chronic ache and a person with disability. The denial of health care would be experienced differently depending on the health condition. Essentially, the intensity of health exposure effect would vary even if same exposure conditions acted since the vulnerability of respondents were differentiated based on health condition. So, over a period of time, there would be an accumulation of health risks which manifested as recurrence of disease, disability, etc. It is an important process which was found as influencing women's health. The study findings particularly on living conditions in case of Bhudei, Appiama, Kumari and Mamina who had either disabilities or had illness corroborates this. These cases have been earlier discussed in this Chapter. The case of Kantamma specifically points out the process of health and ageing.

Kantamma got her head, hands and knees injured, and her two teeth broken when she fell down an inclined surface in an accident at her work site outside Cuttack city. She was working that day as a helper at a function. She narrowly escaped an eye injury when she fell down facing the ground. This happened when she was over 50 years old. Construction work was her main source of income then, and working as a helper was

her secondary work. After the accident, she was hospitalised by her employer for one night and next day transported back to her home in Cuttack. She was given some money and clothes by the employer, but that was all. There was no monetary support for medicine or health check-ups. She spent out of her pocket on some injections and medicines later. For the next six months or so, she could not move her hand properly, and experienced pain and a constant giddiness, which made it difficult for her to move. She could not resume construction work, it was far from feasible for her to continue as before. Her son, who was separated from his wife and a drunkard, did not help her much, though her married daughter, who stayed nearby, helped her in small ways by washing her clothes and giving her meals during her recuperation. Her only respite was the widow's pension of Rs.2000 per month, her husband had a permanent municipality job. Even after a year after this accident, Kantamma was unable to do construction work and started doing her secondary work of that of a helper at marriage and other functions occasionally. She earned a wage of Rs.250-300 as a helper only when work was available. She had to take a loan of Rs.5000 to gift new clothes to her daughter and her children on 'makar sankranti', a harvest festival (Note 15). She used some of this loan money for whitewashing her one-room house. She did not go for regular health checkups and continued to experience dizziness, she described it as 'clouds inside the head feeling'. She did not know whether it was a blood pressure (BP) or a result of her head injury. The difficulty in her hand movements persisted.

Her work conditions were unsafe and employer was unaccountable. An injury in her case faced discontinuities in treatment and neglect of health issues for fear of expenses and difficulty in accessing health care with no financial support from family (son or daughter). This was interlaced with reduced earnings, incurrence of debt, family expenses, physical support from her daughter and difficult diet, living conditions. Her rest period was one year which did not help her much since it was without proper health care. She did not fully recover, her discontinued health check-ups combined with her ageing hindered recovery. These health risks accumulated in the interactive process of health and ageing. Her future was uncertain with debt, partial recovery and poor chances of getting helper work every week. Her husband's pension was a respite, the state support in the form of the pension and her daughters' physical help was crucial in her survival after the accident.

V. Implications for Health Issues

Interviews with women revealed five points of activity in the continuum of their work lives, which are woman's work force entry, temporary withdrawal from workforce, rejoining workforce after break, shifting work and permanent withdrawal from workforce. There were some exceptions wherein women never stopped working in spite of health or age issues as they kept doing work occasionally or at a low pay. The points of work activity were found in varying combinations in women's lives from which the major work change patterns which emerged are: (i) women stopped working temporarily and resumed the same work, afterwards stopped working completely (ii) women stopped working temporarily, resumed with a new work and afterwards stopped working completely, (iii) women changed work once or more without break and then, stopped working completely, (iv) women never changed occupation, worked for many years non-stop, afterwards stopped working completely, and (v) few women never stopped working completely, irrespective of the shifts to another work or reduced earnings, they continued doing some work regularly or occasionally with work breaks for financial needs, in spite of their health and age issues. Health issues were found associated with temporary or permanent withdrawal from work and shifts in work by the survey as well as case studies methods. Survey data had pointed out that 27 percent of the women who had witnessed work changes had cited health reasons and more so when they had crossed 35 years of age or were previously employed as construction workers. The case studies brought forth the fact that even in cases where women had cited reasons such as work demands at home, it was actually their health concern as well as work demands at home which they found difficult with work. Or in cases where women had cited health as a reason, there were other issues interweaved such as son was financially supporting the family or she had built her own house which reduced her rent expenses and she managed with less earnings. This was seen in case of chronic health issues of both women construction and domestic workers. There were however, cases where health issue was so debilitating that women could not do their daily activity and were forced to make work changes. This was seen in case of injuries, mental health issues and acute illnesses requiring hospitalisation. Health issues found associated with work changes were at different levels of seriousness based on how these affected daily activity of the respondent. If not attended to in time, the not so worrying or less serious illnesses

became a major source of hindrance in work, earnings and daily activity. Case studies revealed that women's health issues were a part of their lives, it was just not a reason of work change or a consequence confined to a particular time in their lives. Health was found to be a continuous process spread over women's lives, wherein understanding its causes and consequences required understanding of interconnected processes, which were preceding, succeeding and concurring. This defines the approach of the study, how it understands and treats health as a reason of work changes.

From the case studies, four main categories of health issues were found responsible for work changes. These health categories were interactive and mutually debilitating. Even when one category of health issue was prominent, the other categories of health issue were also present in the same case. These four categories were injuries, acute symptoms of an illness, chronic illness and mental health issues. Even though women cited 'age' as a reason for declining stamina and their decision to shift or withdraw from work, it is not treated as a separate category of illness. Ageing is identified with chronic health issue which is considered as a separate category. A common phrase used by many women during the interviews in Odiya was declining *"bala bayasa",* when women said so it indicated their increasing age and declining stamina. It was found that women construction workers and marriage function helpers had suffered from injuries at work sites than women domestic workers. Injury was a reason for work changes for women construction workers and not domestic workers. Rest of the health categories were found among both and acted as a reason for their work changes.

Irrespective of it being an injury, acute illness, mental health issue or chronic illness, the pathways post health issue were similar for women construction and domestic workers. Women's health issue interacted with variety of exposure conditions specific to gender, class, caste, region of origin, age, family support and state support which influenced their health even more. For instance, an injury interacted with the frequency of access and affordability of health care, rest period from work, lack of earnings, financial worries, debt incurred in a lean period, difficulty in physical mobility to buy vegetables or necessary items from shop, living conditions of the slum area which included water and toilet facility, family's physical and financial support

and state support in form of pension, ration supply, etc. These interconnected processes of health implied that health was constantly taking shape, maintaining or unbalancing itself, more so once it has resulted in work change. Taking the case of mental health issue, similar interactions were found which affected woman's health further. It interacted with the support of family members, lack of earnings, lack of social interaction at work place and in neighbourhood, daily routine activity, lack of access to mental health counselling and other physical health issues. It was found that most of the women faced hindrance in accessing the health care initially after experiencing a health issue and later on, if health care was required on a prolonged basis. One of the key reasons was lack of finances or financial support from family member or state to afford health care besides other issues as discussed in the earlier section on challenges of accessing health care. In such a situation for access of health care, trigger of any health condition meant multiple exposure conditions and greater probability of multiple ailments over time. The differences in post health issue scenario existed not only for the health care they received, but also for the other exposure conditions whose effect was minimised by the intersectional position of age, family support and state support. If present, widow pension of Rs.300 per month or pension from husband's work supported minimum expense requirements during illness. Ration supply from the state at subsidised rates or family support prevented women going into starvation in such a state of injury. When aged on the younger side, women overcame vulnerabilities to health issues in spite of repeated exposures.The women in their younger days worked day and night as shared during interviews and it was only post 30s, they experienced reduced stamina or exhaustion or disability. Their ability to cope up then was supported by their younger age. The respondent's vulnerability mattered for her recovery. In Chapter 2, this has been discussed that vulnerability is present when an individual cannot cope up with different exposures (Sen & Ostlin 2007). It is also dependent on context (Luna 2009). The respondents did not recover when they could not access and afford continuous quality health care, could not rest, could not eat well and lived in difficult conditions. These vulnerabilities involved were complex as it was found that health exposure conditions occurred at daily, episode and recovery levels and these interacted with each other.

Some of the vulnerabilities which signified daily level exposures were commuting issues, issues of work availability, issues of low pay, absence of one meal, prioritising

children and husband's meal over her meal, particularly breakfast, work conditions affecting meal timings, work conditions of constant contact with water and living conditions of damp floors, alcoholism among male family members, double burden or unpaid domestic work, care burden, cost of using toilet, open defecation, distance of water tap or handpump from home and bearing strain for even getting water from hand pump or storing water. The vulnerabilities to such daily exposures rose from the informal worker identity, lower class female worker identity and slum inhabitant identity primarily. Though these were not homogenous identities, there were differences of age, family and state support within which kept changing. Some of the vulnerabilities which signified episode level exposures were death in family, illness in family and care burden, family health expenses. The vulnerabilities rose from particular time, more so for her informal worker identity, lower class female worker identity and slum inhabitant identity. These vulnerabilities with respect to daily exposures could be called as moderate vulnerabilities since their impact on health was always visible in long term. The vulnerabilities in relation to time could be called vulnerable situations. Illness was one such vulnerable situation and the exposures during illnesses were critical. The identity of the informal worker, slum inhabitant, female worker was no longer simply that, it interacted with her identity of a sick person. Some of the vulnerabilities which signified recovery level exposures were unaffordable or denial of health care, delayed or discontinued health care, access to poor quality health care, issues of leave, loss of pay, lack of rest for recovery, lack of physical support of family/neighbours.These vulnerabilities could be called as severe vulnerabilities because they produce an impact on woman's health visibly within short span of time. Lack of toilet facilities, water source near house, lack of PDS ration supply, lack of pension or widow pension, absence of meals, and lack of access to minimal interest loan mattered at recovery level, but these were rooted as daily exposures levels. Vulnerabilities to such exposures which mattered at daily, episode and recovery level, symbolises the interaction of multiple exposures at different levels in relation to situation and these influenced women's health.

Health affected work changes and led to loss of or reduced earnings and again this affected chance of recovery from a health issue, multiple ailments and disability. This was not straight forward. Health issues occurred before as well as after shifts in and withdrawal from work for health reasons. It was found that when health factors were

cited as factor of employment shift or withdrawal, it was associated with preceding exposure conditions and subsequent interactions of exposure conditions of work, diet, living, family, access of health care and finances when the context was changing in terms of age, family structure, support and age. To recover from each level of exposures was difficult, especially when multiple exposures were occurring simultaneously and interactively. It was here that the intermediate process of accumulation of health risks was discovered with results of recurring illness, multiple ailments and disability (also refer to the sub-section of section IV on health and ageing: accumulation of health risks in this Chapter). Mental worries, debt, deprivation of meals, struggle with living conditions, and delay/discontinued health care were commonly found post health issues, irrespective of the health category. Exceptions were there, when financial support of son or pension from husband's job was enough to afford her food and medicine, the post health issue scenario was different. But this was rare. In other words, women without paid work, in debt, aged, without family and state support were found vulnerable who could not recover. Health issues emerged from and were decided by the interactive exposure conditions and vulnerabilities over time. Analysis of case studies puts forth how health was always in conjunction with two or more of the intersecting processes in women's lives such as health and ageing, changes in her age, identity and family and tradeoff between paid and unpaid work, where in the intersectional location of gender, class, age, family and state support mattered. The health conditions of respondents interacted with different conditions, bringing in a situation over time where in a single ailment became a history and possibility of recurrence of diseases lurked such as ulcers, filaria and leprosy and possibility of disability impended such as difficulty in normal walking, washing clothes, pumping out or storing water, visiting the toilet, vision loss, shaking of limbs and food intolerance (related to issues of constipation/loose motion depending on the case, this affected how they felt every day and activities). With age, women had health issues such as urinary incontinence and constipation. This established that exposures, vulnerabilities and accumulation as processes of health issues were spread over time and were part of women's lives.

The SDH Table below (refer Table 19) summarises the processes of exposures to health risks, vulnerabilities to health issues and accumulation of health risks and consequences, three of these processes were found associated with women's health

issues and their work changes and were inseparable over time. The underlying reasons of these processes laid in the structure or certain intersections and these processes then culminated in health and socio-economic consequences, which manifested as a health reason for work change, with deeper implications for understanding structural causes.

Table 19: Depiction of Interactive and Accumulative Processes in SDH Model

I.Exposures to Health Risks in Work Lives, Living Conditions and Consequences			
Structure – Intersection of Class, Gender, Caste, Region of Origin Influence Health via Work Conditions and Living Conditions	**Interactive Exposures of Health Risks and Vulnerabilities to Health Issues**	***Health Consequences for Construction & Domestic Workers***	**Economic Consequences for Construction & Domestic Workers**
	Exposures	***For Construction workers***	
	• unsafe conditions of construction work	• *hand fracture* • *head and back injury*	• temporary withdrawal from work • shift from one work to another • permanent withdrawal from work
	• strenous nature of construction work	• *knee ache* • *back ache* • *fatigue*	• permanent withdrawal from work in advance of 5-8 years • reduced or loss of earnings
	• long work days for unpaid work and paid work • missed/late meals for long work hours • missed breakfast meals	• *chronic acidity* • *ulcer*	• *baaki* for food expenses • loan or debt for health expenses and festivals
	Vulnerabilities		
	• issues of irregular work during summer and rains, due to unavailability of work • time and cost of commuting to worksites which are usually far	• *anxiety*	• loss of earnings • over the counter expenses on ache medication

	• no say in unsafe work conditions as a worker	• fractures • injuries	
		For Domestic workers	
	• constant contact with water in domestic work	• *cold* • *fever*	• withdrawal from work • shift to other work such as vegetable selling
	• constant contact with dirty water while cleaning utensils	• *itching of hands* • *typhoid*	• temporary withdrawal from work
	• time issues of multiple shifts of domestic work	• *stress*	• limiting work to two houses for managing time and need for money
	• work postures of bending, use of hands	• *back ache* • *hand ache*	• poor negotiation of pay with the employer when visible issues of bending or lifting things are present
	Vulnerabilities		
	• issues of leave, and rest for recovery	• *weak health condition such as head reeling and paid work along with commuting to work*	• pay cut • loss of paid work
	• commuting issues in rains due to water logging in slums and roads • strain of walking twice to employer's houses	• *cold* • *fever* • *body ache*	• over the counter expenses on cold medication
	• issues of poor negotiations, insecurity of work/termination of verbal contract	• *helplessness, a feeling about themselves*	• low earnings
	Vulnerabilities	***Common to construction and domestic workers***	
	• informal worker, few or less stringent work regulations, low pay or inadequate earnings for irregular work	• *stress*	• casual worker status
	• as a slum dweller, lack of access to water taps, cost of using public toilet • extra time and effort for water storage, attending to nature calls	• *anxiety* • *physical strain* • *fatigue* • *malaria* • *lack of proper rest* • *cold*	• reducing work days in a month, shifting to lighter work or early stopping of paid work

	• cramped space for rest from a day of hard work • poor condition of house, sudden collapse of walls, fear of heavy rains and damp floor	• *asthma*	
	• lack of time and money to access continued health care	• *BP* • *filarial fever*	• accumulation of health problems along with loss of earnings, shift to another work
	• unaffordable or denial of health care and diagnostic tests for an injury, ulcer, chronic ache	• *aggravated ailment*	loss of earnings
	Exposures	***For secondary workers***	
	• working for very long hours, sometimes whole night or from morning till midnight	• *ache issues* • *lack of sleep while on night duty*	• affected main earnings/main work • huge medical expenses and debt • dependence on family and state support of PDS
	• unsafe work conditions particularly for outstation work, for the night time and work on the roads • cleaning piles of dishes in a feast ceremony or lifting heavy items in marriage procession or the feast	• *head and eye injury* • *leg injury* • *hand sprain* • *disability* • *itching of hands*	
	Vulnerabilities		
	• employer does not take any responsibility of continued medication in case of injuries		• huge medical expenses and debt

II.Criticality of family and state support in event of changes in her age, family and identity

Structure-Intersection of Age, Family Support and State Support Influence Women's Lives and Health	**Interactive Exposures of Health Risks and Vulnerabilities to Health Issues**	***Health Consequences for Construction & Domestic Workers***	**Economic Consequences for Construction & Domestic Workers**

	Exposures		
	• new born baby, care burden and domestic chores	• *anaemia*	• temporary withdrawal from work
	• commuting, double and care burden, family health expenses and lack of financial support of family members	• *fatigue*	• reduced or loss of earnings
	• grown up children and some relief from care burden if support of family members in domestic chores is there, but additional food expenses		• shift from one work to another • taking extra days or hours of work
	• conflict in family over expenses on drinking alcohol	• *emotional scars, hypertension* • *food deprivation* • *anxiety for conflict in family over expenses on drinking alcohol*	• '*baaki*' for food expenses • managing food expenses by PDS
	• expenses for health and other events such as festivals, deaths or marriages, etc. in family	• *anxiety for debt* • *extra paid work and strain*	• loan or debt for expenses • taking up secondary or extra work for more earnings
	• family illness, care burden and expenses	• *mental worries and neglect of health & food* • *physical strain*	• temporary withdrawal from work
	• family deaths and lack of counselling	• *withdrawal from social interaction post death*	• managing expenses by widow pension money from the Government
	• lack of health care, unpaid work and paid work	• *chronic ache*	• reducing work load and thereby, decline in earnings
	• housing conditions, diet conditions and work conditions	• *asthma* • *lack of proper rest* • *chronic cold*	• medical expenses
	• missed meals, living condition, delayed health care, medication and discontinued thereafter	• *worrying for expenses of food as well as visits to health practitioner during physical illness and*	

		physical strain of accessing water source or toilet	
	Vulnerabilities		
	• not just woman worker, but being woman of a household with poor financial contribution of male members or being a widow who had to work very hard at work place and at home, with low family income below Rs.6000 per month, care burden and absence of or inadequate breakfast meals • lack of functioning *anganwadi* centers to keep, engage and feed small children	• *stress of managing multiple works, paid, care and domestic chores*	
	• lack of family health and mental health counselling at slums • drinking habits of male family members	• *emotional scars which are recalled with bitterness*	
	• post 45 years of age, vulnerability keeps increasing thereafter • lack of health care and deteriorating health issues with increase in age	• *unbearable knee ache, hand ache* • *bone health issues* • *menopause and fatigue* • *poor vision* • *stiff joints, knees and fingers*	• secondary work becoming main source of income and main work • taking less load of work by reducing work days or employer houses
	• in event of lack of PDS ration supply, pension or widow pension money and savings/bank deposit account, lack of access to minimal interest loan, lack of health reimbursement by the state or employer	• *anxiety*	• not enough money to cook a meal of rice, dal and a vegetable • rising debt for high interest rates
	• multiple challenges of health care which are for lack of health counselling and reasons of cost and lack of physical support of family/neighbours	• *aggravated ailment*	• family expenses are prioritised over health expenses

III.Process of Accumulation of Exposures to Health Risks & Consequences with Ageing			
Structure-Intersection of Class, Gender, Age, Family Support and State Support	**Accumulation of Exposures to Health Risks & Vulnerabilities to Health Issues Over A Period of 5-15 Years**	***Accumulation of Health Consequences for Construction & Domestic Workers***	**Economic Consequences for Construction & Domestic Workers**
	• years of difficult work conditions and living conditions	• *chronic ache, chronic stress*	• shifts to other work
	• prolonged diet deprivation & difficult family conditions	• *ulcer, chronic acidity, poor bone health, worries*	
	• poor living conditions	• *filarial fever, leprosy*	• medication and expenses
	• delayed, discontinued and denial of health care	• *enlargement of tumours* • *deterioration of BP into Parkinson's disease* • *recurrence of illness*	• permanent or temporary withdrawal from work
	• Ageing	• *multiple ailments of BP, knee issue, diabetes, etc.* • *disabilities in doing daily activities for knee issues, either a case of swelling of joints or a case of stiff joints*	• early permanent withdrawal from work • zero savings • debt • loss of shelter
		• *early onset of disability, when in 60s difficulty in normal walking, washing clothes, pumping out water, and visiting the toilet*	• fluctuations in earnings, no/little scope for earnings by 50 years of age
		• *other issues of shaking of limbs, vision loss, food intolerance and constipation*	

This Chapter brings forth that conceptually, interactive processes occurred at the levels of exposure conditions and vulnerabilities and at the level of accumulative risks for health conditions, which had health and economic consequences as well as structural causes. The findings here also illustrate the larger intersectional processes which shape women's health reasons as well as her work changes. Thus, the survey and case study findings were well in sync with the theoretical frameworks adopted and allowed capturing the specificity of factors and processes influencing work changes through health issues. The final Chapter summarises and analyses the data further.

Chapter 6

Intersectionality, Accumulation of Health Risks and Agency: Methodological and Policy Implications

This study focused on employment shifts or withdrawal from work of women construction and domestic workers due to health reasons, its structural causes, intermediate processes and consequences.

I. Reviewing Methodology and Research Findings

The survey as well as case studies looked back at history of work changes and life events along with contemporary day to day events. Comparison of survey data of construction and domestic workers gave insights about their work options, intersectional location, health reasons (accompanying field notes) and the hypothesis that women from specific intersectional location join specific work or withdraw from it or shift to another work for various reasons including health. Extending the examination to change in work by domestic workers besides construction workers allowed to compare and understand the causal pathways, differences, similarities of health reasons and work changes and women's agency within constraints. While looking back at history of events, it used the method of retrospection for case studies. By using the method of comparison, it was found that health issues responsible for work changes had similarities as well as differences between women construction workers and domestic workers. While construction work was physically more strenuous, it paid better. Women here had the option to take off days of work, but they experienced the inflexible and longer work hours. Women domestic workers could not take much rest when they worked 26-29 or 30-31 days a month. Neither could they earn Rs. 250 per day even if they aspired to. However, they had the agency to negotiate their work timings and had to strictly adhere to time management to ensure their paid work in 2 or more houses for better earnings along with their share of unpaid work at home. They experienced the stress of going from one house to another and going twice a day for work.

Work exposure conditions were found to be different for construction and domestic workers, since work sites were of different nature, and their work hours, pay and

leave differed. But other conditions of living, diet, family and challenges of health care were largely similar. The difference between domestic and construction workers was more in terms of nature of illness, with injuries at construction sites being an intermediate in the pathway before work changes. For both, presence of support structures made a difference in their vulnerability, be it family or state support or community networks at slum or supportive employer and even a landlord. For instance, hunger and weakness was more imminent in absence of state support in form of ration supply than absence of family support. This was the case since family members were employed in insecure or low pay conditions of informal work or their earnings were hardly enough. A supportive landlord meant possibility of provision for a common toilet and a supportive employer meant better payment or few days of paid leave in a month. As found, degrees of vulnerability existed where in gender, class, caste and region of origin identity of the respondent gave rise to the fundamental vulnerability to repeated intersecting exposure conditions and her age and family/state support aggravated or minimised the effect of exposures. This has been explained in detail in Chapter 5.

The vulnerabilities were located in difficult work and living conditions, diet, family situation and challenges of accessing health care. The vulnerabilities involved were complex as exposure conditions inducing health issues occurred on a daily, episodic and recovery level with interlinked material, physical and psychosocial pathways. Daily exposures were embedded in day-to-day experiences at work, family and slum. Episode exposures signified the impact of sudden occurence of an event which upset their daily routine activity such as accidents or acute illnesses requiring hospitalisation and family deaths. In other words, it was an episode that affected/ had the potential to affect women's physical and mental health. Recovery level exposures implied exposures during the time when the woman was recovering from her health issue. To recover from each exposure condition was difficult, especially when multiple exposure conditions were occurring simultaneously and interactively. The complex of multilevel factors and processes appears to be critical, if the links of health and women's economic activity are to be understood. In other words, the processes through which exposures and vulnerabilities occurred were multiple, interconnected and in relation to time.

Health issues and work changes coincided either with health and ageing or changes in age, identity and family with variations in support structures and trade off between paid and unpaid work. In these situations, trade off between paid and unpaid work was always an underlying arrangement for the woman worker. These larger intersectional processes in women's lives were interceded by other social processes of settlement in slums, seeking work via neighbourhood networks, finding acceptable paid work by caste norms, getting married and pregnant at an early age by community norms, playing gender based roles at work and home, adhering to gender norms of mobility, having gender biases in male behaviour at work and family, accepting age biases at work place, forming community networks of lending and borrowing and experiencing challenges of accessing health care for being located at certain intersectional position. The structural causes or sources of these processes were located in class, gender, caste, region of origin, age, family support and state support of the respondent. The context of women's work changes due to health reasons was understood better, only when it was seen in relation to the processes of exposures and vulnerabilities to health ailments, process of accumulation of health risks, consequences, the notion of time and space as these processes occurred in women's lives. It is by this approach to understand health not only in terms of structural causes, intermediary processes and consequences, but health over the years in women's lives that led to a deeper understanding of health as a reason of work changes for women construction and domestic workers. Conceptually, exposures to risk conditions, vulnerabilities to health issues and accumulation of risks as well as effects were conjoint and inseparable in the analysis and formed the basis of constructing different categories of women workers based on these whose experiences differed. The sequence of causal pathways leading to health issues and work changes were interactive, and any understanding of causal pathways of health issues was incomplete without looking at past, present and possible future in women's lives.

Grounded Theory Approaches

In the study, Strauss and Corbin's grounded theory approach was used as an analytical framework initially. Critical reflection (methodological awareness and, reflexivity)[clxxxiii] even before going for collecting data kept the researcher aware of her state, which was not an empty mind; there was some degree of awareness about

public health and the links of health and work changes. The approach was to discover themes from the data items generated out of the case study interviews and then, discover the theory embedded. Strauss & Corbin (1998) state that "at the heart of theorising lies the interplay of making inductions (deriving concepts, their properties, and dimensions from data) and deductions (hypothesising about the relationships between concepts, the relationships also are derived from data, but data that have been abstracted by the analyst from the raw data)."[clxxxiv] This implies both induction and deduction from the data as a step towards theorising.

The unique intersectional positions, processes as well as causal pathways of health and work change were expected to emerge from the data. Doing so would explain the health issues, work changes and the interconnected processes. The data items such as *baaki* (credit from grocers every month), *sudha* (loan interest of Rs.5 for every Rs.100 per month), *bala and bayasa*, (stamina issues with age), *babu ghara* (employer for domestic work), *dhalei kama* (work of roof plastering and compulsory climbing of stairs), *muliya kama* (wage worker lifting bricks, sand, climbing stairs, etc.), *paani kama* (water work associated with domestic work), damp floor, daily purchase of grocery items, ignoring breakfast meal or a particular health checkup or diagnostic tests, discontinued medicine in case of BP or chronic ache, drinking habits of male members, followed by jaundice and deaths, zero savings, pawning small gold earrings or nose ring, widow pension, ration supply and labour card were few of the many data, which emerged from the data collected. These items facilitated the understanding of dynamics at different levels underlying women's health issues and work changes. Health issues were found preceded by the psycho-social and physical exposures and women were susceptible given they were in a specific vulnerable situation. Both these categories of exposures were embedded in living, diet, work and family conditions or in access to health care, and how women coped or not with these exposures, led to unravelling the structural causes, and the intermediate processes of health issues responsible for work changes. The causal pathways were interactive, such as long work hours, inadequate and irregular diet conditions together influenced the incidence of ulcer in a respondent and thereafter, work, diet conditions and discontinued health care resulted in recurrence of her ulcer. Or the work conditions of constant contact with water, and living conditions of use of floor for sleeping instead of a bed, damp floors/housing were found associated with causal explanations of the

respondent's asthma and work decisions. Or the unsafe work conditions of climbing stairs with head load at construction work, pre-existing disease and stamina issues with age triggered a fall and injury at the work site. Such injuries reduced physical capacity to work and such accidents had effects of generating fear and low self-confidence in women to resume the same work with age. Or death in the family and disposition of the individual woman triggered her mental health issues, which aggravated with lack of access to counselling and health care as she confined herself to her home and withdrew from work as well as from social interactions in the neighbourhood. Or discontinued BP medication by a woman with a history of brain malaria after one year of medication that resulted in her uneasiness, low self-confidence and other symptoms of shaking of limbs and then, resulted in her permanent withdrawal from work. These were some of the various causal pathways through which exposures of health risks (daily and episode) occurred for women construction and domestic workers and the vulnerabilities made them more susceptible to health issues. As mentioned earlier, the structural causes of health exposures were gender, caste, region of origin and class based. Age, family support and state support were the basis of vulnerabilities of women to health issues as women were exposed to difficult work, living, diet, family conditions and challenges of accessing health care. These processes of exposures and to some extent, processes of vulnerabilities associated with health issues and work changes were found by Strauss and Corbin's approach. It also helped in categorising the health issues responsible for women's work changes as injuries, chronic illnesses, acute illnesses and mental health issues. The causal pathway of health issues was interactive with presence of difficult work, living, diet, family conditions and challenges of accessing health care even if in each specific case, two or more conditions took a primary determinant role in this pathway. In case of injuries, the work conditions and access to health care took a primary determinant role, but these determinants were not enough for explaining the causal pathway since health issues were invariably found as outcomes of intricately interlinked multiple conditions. The details of how injuries occurred with age, pre-existing disease and unsafe work conditions has been discussed in Chapter 5. In the causal pathway of mental health issues, family conditions and then, access to health care were the primary determinants since events of death in family triggered this. But a history of psycho-social exposures such as deprived diet conditions, stress of debt repayment, irregular work and low paying

work cannot be ignored in this pathway. In case of chronic illnesses and acute illnesses, the causal pathways were formed of interactive work, diet, living, family conditions and access to health care. It was difficult to differentiate primary determinants in these cases, though access to health care played a critical role.

To put it broadly, the vulnerable women were differentiated from each other based on who recovered from health issues and who did not, both being exposed to these difficult conditions. Leatherman (2005) defines a "space of vulnerability" within a broader political-ecology perspective for the purpose of analysis in terms of patterns of health issues and who was at risk to problems of illness, what types of problems were prevalent, how socially and behaviourally disruptive they were to work and other aspects of everyday life, coping responses to illness, both in terms of negotiating the identification and treatment of health problems and in dealing with disruption of the work associated with daily activities and critical production tasks, the consequences of illness on household production and other income generating activities and what this meant for daily and longer term reproduction of the household.[clxxxv] The unit of analysis is both individual and household, as illness and work issues were analysed by Leatherman. Precisely, three key aspects of 'who were at risk', 'who coped' and 'at what cost or consequence' formed what Leatherman calls the space of vulnerability for analysis. In the present study, it was found that poor women workers, informal workers, slum inhabitants and amongst the poor women informal workers, the aged and those lacking family as well as state support were at risk of illness and work change in normal times, vulnerable times and in the long run. The situation of being young and with support structures helped women cope and recover from setbacks of illness and loss of work in spite of being poor woman informal worker. The consequences were often in terms of varied patterns of work changes and illness, and it was rather each being the cause of the other than a linear relationship where illness was the cause of work change. This is a broader way of understanding vulnerability of women workers, but within identities of specific workers, women were vulnerable for certain work conditions. Such as women construction workers were vulnerable to injuries and chronic ache for the heavy work conditions and stress for irregular availability of work. Women domestic workers were more vulnerable to cold and chronic ache for water related work and work postures and stress for issues with managing time to work in different employer

houses. Within households, women gave other members such as husband and children greater share of food, or choice of food or number of meals. Women were vulnerable to poor diet conditions within households. It has been earlier discussed in Chapter 5 how women skipped breakfast meals, but in the same household men did what they liked, such as eating a breakfast meal from a vendor shop and drinking in the evenings. Uraguchi (2010) in her study in Bangladesh and Ethiopia on food price hike, food security and gender equality post 2007-08 food price hike found that "women in both male- and female-headed households gave priorities in consuming food to their husbands and children."[clxxxvi] Within households, women gave preference to children for seeking health care services when it came to illness, they rather preferred to ignore their own health issues and not go for checkups.

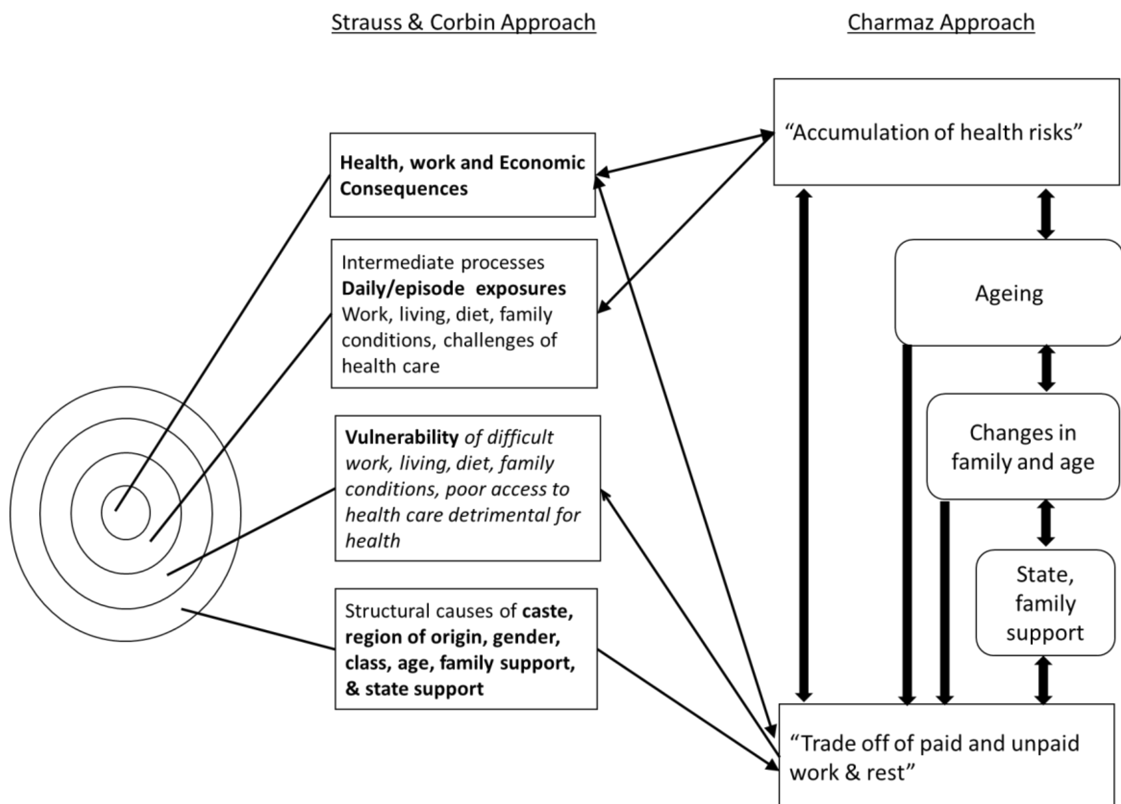
Among poor households, those who had taken debt were exposed to considerable amount of psycho-social stress, deprived diet conditions and possible physical health consequences for striving to earn and taking up extra paid work beyond body limits, debt made women vulnerable to health issues. This respondent who had a loan of about one lakh rupees at a high interest rate for her son’s marriage suffered from hypertension when she lost her husband post son’s marriage and the debt repayment became her responsibility. She experienced hypertension associated symptoms of heaviness in head, nausea and did not go for medication either after checkup and diagnosis. Illness was a vulnerability, among women the ones with health issues were vulnerable. But health issues were dynamic and changed over time.

Strauss and Corbin’s approach did not extend this understanding to the larger context of intersectional processes which also occurred in women’s lives. There was a gap in getting these interconnections of processes till Charmaz’s approach was adopted. Charmaz (2016) defines constructivist grounded theory approach as ‘bringing in doubt into analytic process systematically’ and coming up with ‘methodological strategies’ to discover what is later discovered. Herein, it was hypothesised that there existed something more besides causal pathways of interactive conditions responsible for health issues and work changes. Saldana (2009) says, “information seems to emerge during coding, that is, when no new properties, dimensions, conditions, actions/interactions, or consequences are seen in the data” (Strauss & Corbin, 1998, p. 136).[clxxxvii] However, after discovering new concepts, dimensions and processes,

during analysis reflecting on the data helped see new interlinkages through Charmaz's approach which were earlier invisible to analysis done by Strauss & Corbin's approach. Apart from health issues caused, health issues and women's situations changed and there were vulnerabilities and health issues over time, which were discovered through Charmaz's approach. Relooking at the data using Charmaz's grounded theory approach of constructivism brought in the very notion of time and foregrounded the intersectional processes, how these processes spanned over time in women's lives. The constructivist approach brought forth the dynamics wherein the intersectional processes in women's lives coincided, preceded, shaped or aggravated women's health issues along with exposures and vulnerabilities. It brought forth layers of vulnerabilities of women, such as with age when state support and family support was absent and its implications for women's work in relation to time (births, deaths, illnesses, etc. in family). This enriched what was previously understood as a vulnerable situation. By using the Charmaz' approach, it emerged that support structures were interwoven with the processes of tradeoff between paid and unpaid work, changes in age, family and identity, and health and ageing, wherein vulnerability came out not just by absence of support structures, but also over time and particularly during vulnerable times of death, illness in family and her own illness. While Strauss Corbin's approach aided figuring out multiple exposures and related vulnerabilities of health, Charmaz's approach brought clarity in understanding the repeated exposures over time or exposures particularly during the recovery phase of an illness and how it was crucial to interpret health issues related to work changes. In fact, the kind of exposures to risks that occurred during recovery from an illness or, in other words, the accumulation of health risks and consequences as a theme emerged through Charmaz's approach. It was discovered that accumulation of health risks, consequences intermediated along with exposures and vulnerabilities in a complex dynamics that affected health as well as work change. This was evident only when women's work changes due to health reasons was seen in relation to their lives using A constructivist approach rather than just as work changes due to health issues with intermediate processes of exposures and vulnerabilities, its structural causes and consequences. The very notion of time was better realised by using Charmaz's approach. The exposures during recovery phase from her illness resulted in aggravated ailment, recurrence and sometimes disability. Cases of knee ache, tumour and ulcer witnessed accumulation of health consequences in a time frame of 5-15

years. For instance, recovery exposures in case of a chronic knee ache/ailment were continuous rigorous construction work without required diagnostic tests, discontinued medication and ageing. The respondent was required to get her rheumatism and arthirits tests done which she could not afford and took prescribed medication for just two months. She never went back to the doctor who had asked her to get her diagnostic tests done, she stopped medication before the prescribed duration, and her diet conditions remained poor, constantly irregular and inadequate; these did not help her condition recover either. By age of 45 she had to leave construction work for her chronic health issue. Leatherman (2005) in his study of three communities with differences of land base, economic structure and range of production activities affected differently by agrarian reforms and capitalist relations in Peru found that "levels of illness symptoms and work lost also increased with age, because the elderly had longer to accumulate a life of hard work and debilitating conditions, and less resilience to work through daily health problems."[clxxxviii]

Figure 11: Application of Two Grounded Theory Approaches to Understand The Structures and Processes Relating Health and Work Change



By using Charmaz's Approach, it was realised that health issues never existed in isolation, even primary determinants in the causal pathways were interactive with other conditions of exposures over time. The interaction and accumulation in this process was crucial along with intersectional processes. The intersectional processes of trade off between paid and unpaid work, changes in age, family and identity and health and ageing were situated in the backdrop of the exposures to health risks and vulnerabilities that shaped actively women's health issues. Figure 11 depicts both the grounded theory approaches and the study findings using these.

Links with/Contributing to Epidemiology

This finding resonates with what Harenstam (2009) calls as 'contextual factors' of causes of health in epidemiology. She says, "traditional epidemiological methods identify specific exposures that are hazardous to health. With such an approach, there is still a long way to go towards identifying contexts in which these risk factors are the most prevalent."[clxxxix] She emphasises the need for adopting a holistic perspective in epidemiology where in social, psychological, physical conditions in work and non-work could be integrated in the same unit of analysis. In other words, these intersectional processes were the contextual factors of health issues going by the terminology used in the field of epidemiology. The health issues had causal pathways of exposures, vulnerabilities, contextual factors and also accumulation of health risk and consequences. The qualitative approach towards understanding health issues responsible for work changes contributes to the understanding gained through the quantitative approach, that of the incidence of health reason for work change was associated with specific work, work years and respondent's age. It is realised post data analysis of this study that the study findings on health issues and work changes contributes to the way diseases are studied in epidemiology. This is where social sciences come closer to epidemiology. The study had used retrospective method as one of the ways of collecting data.

Bartley and Blane (2009) cite Byod Orr's study which first used epidemiological archaeology and established links between poverty, poor diet and ill-health by looking at childhood dietary conditions from a dataset collected in the late 1930s and then, by looking at the data collected retrospectively of a subset about the interviewee's life between 1930s and 1990s, including anthropometric and physiological measurements.

Bartley & Blane (2009) put forth that 'epidemiological archaeology' refers to "the discovery and investigation of historical records and surveys, often ones that have been long forgotten. It involves unearthing social surveys, particularly those which collected biomedical measurements, and tracing the study participants to their present day locations in order to resurvey those who are willing to volunteer."[cxc] The present study though does not look at biomedical measurements, but takes into account injuries and acute illness (akin to biomedical episodes) and other health issues responsible for work changes and goes into unearthing the history of events surrounding health and work change in the past. This retrospective aspect is similar to epidemiological archaeology.

Beaglehole and Bonita (1993) bring forth the relevance of social factors in consequences of disease and how measurements should not be confined to 'occurence of disease, as with incidence and morbidity rates, but also the persistence of the consequences of disease: impairments, disabilities and handicaps' in epidemiology.[cxci] They acknowledge, "measurement of the prevalence of disability presents formidable problems and even more than for morbidity, is affected by extraneous social factors."[cxcii] This is indeed the study finding that health is not just an incidence, but a process with health consequences. Mehrotra (1987) puts forth the constant need for going back to the ways diseases are assessed as epidemiology 'deals with dynamic processes and therefore has to keep a constant track of changes in disease patterns, in health status and in the various factors influencing them.'[cxciii] These admissions in the field of epidemiology whether that of the challenge of measuring disability and consequence of diseases or, the dynamic processes of disease patterns, imply the complexity of health in terms of causes as well as consequences. In the present study, the multiple processes found associated with health and work change reiterate that health was not just determined by causal pathways located in a particular context, but health was determining further health consequences through accumulation of health risks, consequences and work changes. The present study helps in specifying some of the 'accumulated health consequences' as experienced by women construction and domestic workers in this process of work change, which were recurrence of an illness (leprosy, ulcer, filaria), multiple ailments (chronic ache, acidity, high/low BP), physical disability (injury induced disability, chronic ache induced disability such as difficulty in standing, walking and using hands for reasons of pain, stiffness in knee

joints and finger joints, reduced mobility due to shaking of limbs undiagnosed, but usually associated with parkinson's disease and poor vision due to poor quality of lens inserted in the cataract surgery), age related illnesses (urinary incontinence, fatigue due to continuous bleeding associated with menopause, stamina issues due to age, poor vision) and mental health issues intricately woven with physical illness, particularly low feelings about being poor, ill and aged. These low feelings were interpreted as women shared the pressure of meeting everyday food expenses, their reduced stamina with age which did not allow them to earn as before, their inability to go for follow-up checkups and required diagnostic tests or afford required continued medication, of being clueless about health care settings in government as well as privately run hospitals/nursing homes, their apprehension of medical expenses and inability to get satisfactory health care services after checkups, including surgeries in few cases. Women felt bad when their husbands resorted to heavy drinking and his financial contribution to family was whimsical, but these feelings were more of mental agony, humiliation in event of quarrel, abuse in neighbourhood and anger against the husband. Patel, Kirkwood, Weiss, Pednekar, Fernandes, Pereira, et.al (2005) had found that mental health factors had the strongest associations with chronic fatigue.[cxciv] McGibbon and McPherson (2010) say that "the psychological and spiritual stress of chronic worrying about basic necessities such as food and shelter happen concurrently with all the associated bodily stresses. These bodily stresses are the embodiment of poverty across the lifespan."[cxcv] In the present study, poor mental health was experienced in different ways, some of these were financial worries, worries of finding cure of the ailment and uncertainty of future employability and earnings with the onset of physical illness and reduced stamina.

Wrigley-Asante (2013) finds that women have reported 'constantly worrying or thinking' as contributory factors affecting their health. "But these expressions of women usually do not feature in discussions of the burden of disease in the developing world."[cxcvi] Such psychosocial issues are often sidelined in discourses of policies.

It was realised by using the Charmaz's approach that age, family support and state support were not just differentiators of more vulnerable women from the rest among construction and domestic workers, but these were interwoven in the intersectional

processes of women's lives over time as they shaped women's health issues and work decisions.

The understanding which emerged using both the grounded theory approaches was indispensable to explain the process of work changes and health reasons. Charmaz's constructivism complemented Strauss and Corbin's approach in explaining health reasons of work changes and the associated processes. This complementarity was important since particularly, women's age, earnings, family support and state support kept changing and situations of birth, marriage, illness and death were integral to women's lives. Family's financial support implied scope for the respondent to take a decision towards reducing her workload or taking the physical rest required given a health issue or simply stopping paid work. Family's physical support accelerated her engagement in paid work. Family support was found to be a more crucial component of the respondent's intersectional position and employment change than family demands as it had the ability to overcome the effects of family demands and influence work decisions. Family demands such as debt, influenced the decision of entering the workforce whereas care burden had the reverse effect. Absence of the family's physical support when required necessarily meant that women withdrew from or reduced paid work. Those with family support in the event of illness or loss of work were found to be better off in financial terms than those without it. The presence of very young and grown-up or working children made a difference in defining family demand or support. Parents, in-laws or working children and their financial support reduced women's urgency to join the workforce in situations of death or separation from husband. Parents, in-laws or grown-up children also provided valuable support in taking on unpaid work at home, which impacted the adjustment between paid and unpaid work. Unpaid work was unavoidable in women's lives since there was always a trade-off between paid and unpaid work. Pani & Singh (2012) in their study on women garment workers found that the non-economic factors of 'responsibilities at home' (unpaid work) forced women to change jobs.[cxcvii] There was a strong underlying identification of a woman with her family as it was found that she took on the provider's role in the absence of a husband or his financial support, and her identity of wife or mother was given priority by her over her individual health. The same was not true for many men who became alcoholic. Some women supported their

families even if their husbands were alive due to their inadequate financial contributions.

Age mattered for work decisions. Age is reported as a reason for work changes earlier by Dalmia (2012) and (Coelho, Venkat & Chandrika 2013). Women older than 35 years devoted more work hours or days as they experienced changes in their identity and family roles. Age enabled paid work in 35-44 age group, but was constraining too as interactive processes of ageing and health interfered with full recovery, resulting in multiple ailments over time and hindering paid work as women entered 45 years and above age group. Younger women or the ones below 35 years of age overcame health issues in spite of repeated exposures. Whether it was unpaid work vis-à-vis paid work, family demands vis-à-vis family support, loss of earnings vis-à-vis debt, family expenses vis-à-vis health expenses, health issues (care burden, own illness) vis-à-vis financial necessities (debt, loss of earnings), women experienced work changes through all of these dilemmas as they aged, saw changes in their family and identity, and faced demanding situations. These intersectional processes as findings of the study which were interwoven with health processes added to the understanding of identities being fluid and not stable (Hankivisky 2012; Dhamoon 2011).

Employment outcomes differed based on these dynamics, even when a health issue was present. Work decisions included those of entering the workforce, withdrawing from the workforce temporarily or permanently, and shifting from one type of work to another. Underlying intersectional processes, there were certain patterns of work decisions. But this predictability of work decisions was limited. Debt and illness had unpredictable work outcomes with a contrast of push and pull factor for being in the workforce. Conceptualising these four micro-level processes as criss-crossing over a woman's life span in terms of defining situations and everyday interaction brings forth the complexity, predictability and unpredictability of work changes. These variations give rise to the scope of interpreting woman's agency in how multiple dilemmas were tackled, compulsions were overcome or surrendered to as she made employment decisions. Lingam (2006) says that "though poverty and the need to survive in the context of adverse economic conditions are often given as reasons for women's participation in the workforce, close examination of trend patterns in women's work participation reveals factors such as household type and composition,

life cycle, women's age, marital status, and support structures as determinants of women's work."[cxcviii] The four intersectional processes underscore the centrality of gender, class and age in defining women worker's life experiences where dividing issues were of family support and state support. What is important to take into account is that most women faced lifelong poverty and their role models in the neighbourhood reinforced prescriptive gender norms and roles in family and work which are historically located in societies.

Methodologically, by using a mixed model framework and complementing Strauss and Corbin's grounded theory approach with Charmaz's constructivism, the present study brings forth rich insights into health reasons responsible for employment shifts and withdrawal from work of women construction and domestic workers and how time spanned out through demanding situations, changes in identity, exposure conditions, accumulation of health risks and work changes and health consequences.

Mixed Methods

Mixed methods were used to develop the understanding from one method to another, particularly from intersectional position to intersectional processes and processes associated with health reasons of women's work change. The principle of mixed method was used to develop understanding from survey methods on intersectional location of construction and domestic workers, their work changes, the differences, and similarities and enrich it with the understanding of the processes of intersectionality, exposures and vulnerabilities of health issues by case studies method. The processes of health which were explored through grounded theory approaches have been discussed in the above section. Here, I discuss how the mixed methods helped in developing the understanding of intersectionality and its processes.

Hancock (2007) says that intersectionality changes the relationship between the categories of investigation from one that is determined apriori to one of empirical investigation.[cxcix] It implies the unique ways in which multiple categories could intersect to produce different experiences, outcomes. In other words, even if you took intersectional categories of gender, caste, age, etc., before conducting the study, one does not know how these categories will intersect to produce different experiences and outcomes. The study had a similar approach, the survey method collected data on

certain well-known categories, that of gender, caste, region of origin, age, income, and then, looked at the intersections associated with work, past work, work changes and health reasons. It was followed by case studies to examine the different ways in which these intersections influenced the women's lives and work changes. This had an intrinsic constructivist approach towards the study of empirical phenomenon by use of categories and differences with in them, the intracategorical approach (McCall 2005).

Survey findings informed that intersectionality of gender, class, caste, region of origin and age was associated with present work, past work, work changes and slum of residence of women construction and domestic workers. This has been discussed in detail in Chapter 4. Here, I discuss briefly the salient points. Of the trends on work and intersectional position, particularly significant was the association of work and intersection of caste and region of origin. For instance, most of the upper caste Telugu women preferred construction work and majority of the lower caste Telugu women worked as domestic workers. Caste based inhibition to do paid domestic work was strongest among Telugu upper caste women, 10 percent approximately worked so. And caste inhibition to not go out of homes for paid work was strongest among Odiya upper caste women since 45 percent of them did not work. However, when Odiya upper caste women went out for paid work, they did not hesitate to work as domestic workers, 44 percent of them approximately worked as domestic workers. Telugu backward caste women preferred construction work (43 percent) over domestic work (34 percent). The trend was reverse for Odiya backward caste women. Greater number of backward caste Odiya women worked as domestic workers (48 percent) than as construction workers (28 percent). Finally, majority of Telugu lower castes (65 percent) worked as domestic workers than as construction workers (7 percent). Odiya lower castes worked as both construction (38 percent) and domestic workers (25 percent). Going by this survey data, certain social processes associated with intersectional location or position were inferred. There was greater internalisation of gender norms by certain groups (Odiya upper caste women). There was greater internalisation of caste norms by certain groups (Telugu upper caste women). Raju (2013) states that "it is well known that in India, women from the higher castes face a more restricted socially encrypted regime in terms of their participation in the public domain (Rani and Unni 2009).[cc] Such restrictions are more closely observed in rural

settings than the urban. In the present study, upper caste women from poor migrant communities were found adhering to caste norms who viewed themselves in relation to the others, lower caste women from their poor migrant communities in the same city. In contrast, there was greater identification with slum inhabitant identity than caste norms by women of certain groups (Odiya backward caste and upper caste women), they went beyond caste restrictions.Neighbourhood networks based on class, caste, region of origin and gender explained current employment, past employment and slum of residence. The details on intersectional position of women residents in each slum area have been discussed in Chapter 4.

The distribution of intersectional position of slum residents and of paid work in the survey data shows that slums were associated with particular communities and construction or domestic work was associated with same particular communities. Past work of women workers varied with geographical area such as if women were based in rural areas earlier, they worked as agricultural workers (16-36 percent). These women stayed in villages before migrating to the city. The reasons cited for work change showed how these previously agricultural workers relocated to the city with their husbands either immediately or few years after their marriage. If women were based in urban areas, they predominantly worked as construction and domestic workers since 54-70 percent of the women in these 5 slum areas worked so previously. The survey found that health was associated with age (96 percent were aged 35 years or above), work years (92 percent had worked at least 4-10 years or 10 years and more) and specific work (58 percent construction workers than 22 percent of domestic workers) when respondents reported of these, health reasons and work changes together. Health issues were found indirectly linked with intersectional identity of caste, region of origin, age and class since women construction workers who came from certain intersectional location had cited health reasons more than women domestic workers.Women construction workers cited more health reasons indicative of work strain on body and women domestic workers cited more of work demands at home as a reason (18 percent cited so), which implied stress of managing time. Construction workers worked for lesser days since only 11 percent of them worked for 26 days or more in a month, this also suggests of the strain on body and capacity to work, besides work availability. They had more earnings with an average earnings of Rs.250 on a work day, but experienced heavier work, longer work hours

of about 8 hours or more a day and faced irregularity of work. Domestic workers worked on all days of month since at least 80 percent of them worked for 26 days or more in a month, with low pay of an average earnings of less than Rs.100 per day, less work hours ranging between less than 4 hours and 4-8 hours a day, and tension of two shifts, multiple house timings. Going for less work hours did not work in their favour since their pay accordingly reduced and going for more work hours for better pay increased their stress of managing work time. More women domestic workers stopped work (52 percent) vis-à-vis construction workers who stopped work (38 percent) which signified poor work opportunities in case of domestic workers. Women construction workers shifted to domestic work or some other work. Survey on time and mode of commuting reveals most women construction workers refused to work outside the city. Those days were off days. In case of domestic work, they refused going to a potential employer's house beyond a certain walking distance (15-25 minutes approx.). These were indicative of interlinked factors and processes which influenced women's work and work changes over time. Overall, women adjusted their time between house work demands, work demands and economic necessity along with compulsions of health problems as can be inferred from their reasons of work change, family income, their own earnings, work days, work hours, commuting time and work distance.

Gender norms and gender roles influenced how a woman negotiated her paid work, this was corroborated through case studies. Age gave her negotiating power with in family to allocate work hours. Women below 25 years cited reasons of marriage (86 percent) predominantly. Women aged 25-34 years cited reasons of marriage and relocation with husband (51 percent) and domestic chores (12 percent) in most cases. Women aged 35-44 years cited reasons of health (25 percent), relocation with husband (20 percent), work demands (11 percent) and more income (17 percent). Women aged 45 years and above cited health reasons the most (47 percent), then relocation with husband (15 percent) and work demands at home (9 percent). This trend implied women worked more post 35 years of age, if their health permitted since gender roles in family were less demanding. Studies such as Barriento et.al (2004) witnessed that child care responsibilities acted as single most important barrier to women's ability to participate in formal (waged) labour markets.[cci]

Mc Call (2005) finds methodologically, intersectionality has traditionally meant an emphasis on the importance of holistic research that examines the potentially cross-cutting roles of race, class, and gender in the lives of a particular population.[ccii] The case studies built on this understanding about intersectional position of women construction and domestic workers, the cross-cutting issues of age, family support and state support of their vulnerability, health issues and work changes. When it came to intersectional processes associated with employment and work change, the dividing issues were family support and state support. Gender, class and age based intersectional identities were central as women traded off paid and unpaid work all their lives, experienced changes in identity with change in age and within family and faced health issues with ageing.These four key intersectional processes discovered through the case studies have been discussed in Chapter 6 in detail. These existed along with other intersecting social processes of identification with caste and region of origin and fellow members in community, slum inhabitant identity, caste norms of work, gender norms and roles at work, age norms of work capacity, gender based norm of seeking health care for a poor household, etc.

When women prioritised family expenses over their own health issues and ignored it, this reflected her internalisation of gender norms particularly the care provider for all, at the cost of neglecting herself who was located at the intersection of gender and class. Identities based on intersectional position of gender, class, caste, region of origin and age were found reiterated by respondents when she spoke about herself. A woman‘s expressions of herself helped in interpreting her identity in the discursive text, some of these expressions were on how she went for a particular paid work and avoided another work for belonging to a certain community, how she chose to stay or not to stay in a particular slum for her identity, how she struggled hard to sustain her family and fulfil her duties towards her children when they were young and she had lost her husband or when he was hardly concerned, how she tried her best to stay with a drunkard husband being married to him and earned for her family, how she and her family experienced difficulty in affording three meals every day, how being a poor mother she went for paid work or more work hours/days when her children were a little grown up for greater earnings or, how she carried her toddler baby to her work place or left the toddler baby in care of the eldest child at home, how being a mother/daughter/daughter-in-law she managed to receive help from her daughter or

other members in getting the domestic chores done at home, how she received financial contribution from her children for repaying a debt, how her neighbourhood friends belonging to certain community helped in getting her the paid work, how she faced reduced stamina with age and could not work as before, how she became sick over the years, how she was never the same self after her illness setback, how she could not go for her continued medication or health checkups for reasons of cost and how she managed with subsidised ration supply in spite of loss of earnings.

Mixed method approach was used to look at intersectionality and its multiple dimensions from both the quantitative and qualitative research point of view. There were explicit and implicit assertion of identities which were either collective or individual in nature. McCall (2005) brings in the methodological issues of understanding the complexity of intersectionality for the multiple dimensions of social life and complexity of social life.[cciii]

In a social space, the dimensions which women are usually identified with are married, widowed, separated or a divorcee woman. This is how the survey method looked at this identity. But the case studies highlighted that more than being a widow or a married woman, the identity women identified was that of a wife/widow of a irresponsible &/abusive drunkard, wife/widow of a responsible drunkard, divorcee of a philandering husband and wife of a responsible good husband. Irresponsible husband was defined by them as one who never cared for her or her children and did not provide for their meals. In that sense, the difference between widow and married woman was not so much, if the husband was non-cooperative and this aspect kept changing over the years of marriage. Nuanced dimensions for gender and class based identities over time were expressed when she viewed herself in relation to husband, based on whether he was alcoholic and what he contributed to the family earnings to run a poor household. This understanding came through case study method. For instance, a respondent said, “my husband was not working regularly then, he got Rs.9 per day. I started working, started a shop when my youngest son was 5 years old. I used to make *chakuli pitha* (snack food similar to plain *dosa*), *chelli ku paluu thili* (used to rear goat). "I used to get up at 3 in the morning. Used to grind rice and make *laddus, chakuli, china badam bhaja* (sweet and snack items). I used to sell it before the school ground. I sent my eldest daughter to study (till std.X), could not afford her

tuition fees." She was referring to a time around 1999-2000 and her account reflects how she bore a larger responsibility of household expenses then. This changed when her sons became older, started working, her husband got a permanent work and salary. Another respondent said, "*aama gariba kula re sei madapani*." It means, in our poor households, alcoholism prevails. Her husband died of jaundice and heavy drinking. Her account also gives in to the male ways of drinking, her beliefs were shaped so and practices insides slums reaffirmed it

Dimensions of class as measured through survey were woman's earnings, family earnings and husband earnings. Whereas dimensions of class brought forth through case studies were in relation to situations than just earnings. These times were when her husband spent money on drinking which reduced his earnings and family earnings, when woman gave majority of her earnings as interest repayment to the money lender or credit repayment to the local grocer at the beginning of every month, spent more during specific festive months and family events of marriage, birth and death, yet managed additional expenses by engaging in secondary work at that point of time. These subjective dimensions of class implied how it stood in relation to time.

In the suvey, the dimension of age was the number specifying the respondent's age. Through case studies, age was more of assertion of age identity by the respondent such as of a mother of grown up children, particularly son who contributed to family earnings or of a mother who had married off her daughters or sons and was relieved of some of her family responsibilities or, of an ailing ageing woman who could not do much for gaining her treatment and had some respite for subsidised ration supply in absence of her earnings. Through case studies, the dimension of age extended to family members, their physical and financial support and the state support through its different outreach schemes.

Dhamoon says that "while a contextual examination of the processes of subject formation and systems of domination is not immune from an over determinative understanding of difference, it foregrounds issues of power in ways that the focus on identity and categories masks. Specifically, the study of processes and systems draws attention away from "different" identities and bodies per se to the specific processes and conditions in which representations of difference are socially organised."[cciv]

Family support, state support and age were crucial in understanding the power dynamics within category based on gender, class, caste and region of origin.

The present study is rooted in an intracategorical approach of studying intersectionality as it does not treat categories as given always and questions the boundary-setting of these categories with an eye for new categories within. McCall (2005) attributes to intracategorical approach as one that "acknowledges the stable and even durable relationships that social categories represent at any given point in time, though it also maintains a critical stance toward categories."[ccv] Inherently, it acknowledges the dynamics. The mixed methods of survey and case studies helped in looking at categories, multiple dimensions, dynamics of categories and delineating the embedded differences within (Hankivisky 2012). Reflecting on intersectionality reveals each of these intersectional locations or categories, intersectional identities, differences within categories or identities, intersectional processes and systems operating intersectionality through various norms, values and practices. Construction of these categories or identities fundamentally indicates purposes, interests or experiences vis-à-vis the other group(s). Hancock (2007) examines that "intersectionality emerges out of the earlier unitary and multiple approaches, joining with other constructivist efforts in asserting first and foremost that reality is historically and socially constructed."[ccvi]

Another prevalent dualism in identity theories is between ‘agency’ and ‘structure’. Benwell & Stokoe (2005) elaborate about this dualism as, "the issue here is to do with whether people are free to construct their identity in any way they wish (the ‘agency’ view, in which the individual has agency), or whether identity construction is constrained by forces of various kinds, from the unconscious psyche to institutionalised power structures."[ccvii]

II. Question of Women’s Agency

Women’s work decisions were found close knit with their intersectional position from the survey as well as the case studies. Work decisions were taken in particular contexts, situations. While Bourdieu through his practical theory spoke of the realm beyond object-subject (structure and agency) dualism in an ambiguous manner, others like Mahmood point towards weaknesses of such dualism in understanding reality.

Mahmood (2005) says, “feminist scholarship performed the worthy task of restoring the absent voice of women to analyses of Middle Eastern societies, portraying women as active agents whose lives are far richer and more complex than past narratives had suggested.[ccviii] She found through her work with women that binaries of ‘resistance’ and ‘subordination’ ignore the projects, discourses and desires of women. These discourses and desires lay somewhere in between rules and practices which reinforced or undermined structures and spoke of the possibilities for human agency beyond these binaries.[ccix]

In the study it was found that there were constraints in women’s lives when women’s work choices were limited to informal work based on their class location, women’s mobility was restricted by gender and caste norms, women’s engagement in paid work was bound by caste and region of origin based community definitions of non-taboo and taboo occupations, and when women’s paid work suffered with age and declining stamina. Nevertheless within these constraints, women’s agency or rather nuances within, was found to have been asserted in various ways; there was no one way of reality, that of just constraints or agency in women’s lives.

Reviewing the discussion in Chapter 5 on these different conditions in women’s lives, the understanding dawns on one that women’s agency was expressed in multiple ways such as women benefitted through neighbourhood networks of slums, by supportive husband or other family members, supportive employer providing better payment, food and credit without interest, and state support in the form of health care, work regulations, ration supply, housing, toilet facility, water supply, etc. Mahmood (2005) describes that "human agency primarily consists of acts that challenge social norms and not those that uphold them, and so on."[ccx] She differentiates between positive and negative freedom. Mahmood defines "positive freedom as the capacity for self-mastery and self-government, and negative freedom as the absence of restraints of various kinds on one’s ability to act as one wants."[ccxi] And she finds "the negative conception of freedom seems to prevail in studies of gender that explore those spaces in women’s lives that are independent of men’s influence, and possibly coercive presence, treating such spaces as pregnant with possibilities for women’s fulfilment or self-realisation."[ccxii]

In spite of multiple difficult conditions in women's lives, agency was interpreted in three of the scenarios that came up in this study, when women decided to work or continued working, when women decided not to work, and when women decided to shift from one work to another. Agency was seen in three dimensions in women's lives, its key actions being utilising, overcoming and negotiating with respect to structure; these variations intermediated between domination and freedom.

There were similar patterns of work or work changes viz., working till death, temporary withdrawal from work and permanent withdrawal from work for women construction and domestic workers over time and space. This implied they made similar work decisions given similar situation. Their agencies differed from each other on the basis of kind of work negotiations, ways of utilising support structures and overcoming stereotypes that were prevalent. Women construction and domestic workers bargained different kind of negotiations as they settled for pay, work timings, work distance, work conditions and unpaid work. Both construction and domestic workers' unpaid work at home, changes in age, family structure and health issues brought forth how support structures were found crucial for any of their work decision. It was women's ability to utilise these support structures of family and state that helped them in taking work decisions. Situations of birth, marriage, childbirth, death and illness signified changes in crucial push and pull components and how family's physical and financial support mattered for work decisions. Components of state support facilitating her agency were subsidised ration supply, *anganwadi centres*, hospitalisation expenses compensated through labour card registration and widow pension schemes. Other sources of support were neigbourhood friends and employer.

Women construction workers typically experienced fluctuations in work availability, be it for market, distance, age or health reasons, there was not much scope for negotiating work decisions. Women construction workers did not have much say in work timings or work distance. They had to compulsorily work for almost eight hours a day for the earlier mentioned pay. However, they refused working at sites outside the city, within the city they negotiated the worksite, if only multiple work was available. Domestic work was less paid in comparison to construction work. She did not have much say in getting a higher pay. However, women domestic workers

resorted to negotiations when they fixed number of employer houses, distance of work place and their work timings. The agency embedded here was woman workers's say in these difficult work conditions over small things governing her paid work wherein there was no written contract, arbitrariness of negotiation and poor status of worker.

Slum networks facilitated work opportunities, but these networks had limitations as few women construction workers complained of how masons wanted women workers to 'please them' for getting regular work. Likewise, few domestic and construction workers lost out their job to a neighbor or a relative when it came to work competition. Women survived in this constant struggle for getting paid work amidst competition, sustained their families when their husbands in most of the cases did not contribute enough to the family earnings or when she was widowed.

Women wielded agency through better support structures when they managed paid and unpaid work such as by gaining physical support from family members be it mother/ mother in-law/daughter/daughter-in-law as Ganga did or utilising the state support structures of *anganwadi* schools and leaving the child at the early childhood care centers of learning and going for her work shifts, as Rajani did. With better support structures, women just not managed their paid and unpaid work, they also recovered from health issues such as Mamina, a widow in her 50s with a divorced and alcoholic son staying in with her recovered from hand fracture with help of her therapist and the support of her neighbours, who volunteered to wash her clothes and provided her water from the handpump on a daily basis at different points of time. She received some monetary concession from the treatment provider which reduced her health expenses and she could manage without work for 6 months. Women showed their agency of providing for their families when their husbands had deceased or had deserted them, and they succeeded in raising the young children, later got them married off even if it meant taking loans, as was seen in case of many, including Bayamma.

Women's agency was expressed even when women experienced difficult work and family conditions, yet saved themselves from loss of earnings. Rajani recounted that when she was around six months pregnant, she went for *'ranga kaama'*/whitewashing, *'bali cementkaama'*/construction work. She worked so till her

son was one and half years. The water at the construction site did not suit her child. It was difficult for her to take one year old child in a transport vehicle, commute and then do construction work. When he was one and half years old, he would move at the site, get cement, and stones over himself. Since she was worried about safety at work site and her baby's health, she stopped construction work. She shifted to part-time domestic work. Initially she worked in two houses, but then she left one house to take out more time for her son. She shared that it was a matter of habit for her to never leave her son alone, she took him along, be it for work, bathing, washing or even attending nature calls. Rajani made use of the state support structures of *anganwadi* centres and left her son child for few hours while going for her morning work shift and in the evening work shift she took her son along. She managed earning for her financial necessity and attended to her son too.

Amidst gender constraints and class compulsions, it was exercise of women's agency when she provided for her family and managed domestic chores, particularly because women constantly allowed their lives to be defined by their family, unlike most of their male counterparts who resorted to drinking, shunned family responsibilities. These decisions also reflected of fluidity of intersectional categories.

Women's agency was interpreted when she combined main work with secondary work for greater earnings as was seen in case of Ganga, Anu, Kantamma and few others. The secondary was mostly helper work in marriages, which included lifting lights in marriage procession, sweeping ground in the feast area, lifting and cleaning utensils.

15 of 60 women who were previously domestic workers, shifted to construction work. This could be obviously read as for economic compulsions, but underneath these were manifestations of her agency to go and engage in better paying work for herself and her family. When women construction workers shifted to lower paying domestic work or any other work, in spite of economic necessities, it was her agency to go beyond the existing slum based networks of getting her employment, not completely stop working and finding some employment.

Every time a woman took a step towards managing her unpaid work at home and went for paid work she asserted her agency. Within these limitations, she asserted her

own identity when she worked, in whatever little ways it could be. Such as eating a breakfast meal which she could not have afforded otherwise or, would have just eaten some leftover from the previous night. Ankamma, one of the respondents who shifted out of construction work to a lower paying vending business due to her chronic ailment puts it as “the days of construction work were different”, she did not have to 'worry' since she was 'earning and spending', even if she was the sole provider of her children after her husband had left her. She no longer feels the same, her vending business days are irregular and lower paying and with increasing age, she becomes 'worried even when she spends Rs.5', because she feels 'how she would manage her household expenses' with certain anxiety in her mind about her precarious health and uncertain earnings.

When a woman decided not to work, she exercised her agency to find some rest time particularly when she had a nagging health issue, though time off paid work did not mean no unpaid work at home for her. She bargained for some rest as she settled for only unpaid work at home than also going out and doing rigorous work at work site as Uma did. She exercised her agency within these constraints of unpaid work at home, she could find some time for physical rest given her health compulsions with better support structures, her family’s financial support and state subsidised ration supply. In case of Bayamma, she also availed pension of her dead husband, Rs.2000 per month as he was a Government municipality sweeper along with her son’s financial support when she decided to stay off paid work.

Every time, a woman took a step towards getting health care for her ailment, she asserted her agency in ways that reflected not only attempts to overcome class barriers of accessing modern medicine, but also attempts by few to avoid the same modern medicine and utilise other forms of traditional health care. At the same time, these women managed class based financial constraints by resorting to *‘baaki’*, loan or support from a family member when they were away from paid work. It spoke of how women overcame class and gender barriers and stereotypes of seeking health care. For instance, Mani sought health care for her tumour near breasts in spite of her husband’s initial hesitation to take her to a doctor and her own inhibitions of showing her private parts to a male doctor. She finally got her tumour removed in spite of zero family savings at that moment in her life. Her husband’s paralysis immediately before had

been financially and mentally exhausting for them. In spite of these, she stood her ground for seeking health care for herself. She went to the extreme end that she could do to attain this, she sold her parental share of land at village, altered her tactics from simply telling or nagging her husband to threatening him of her suicide, if he did not take her to the doctor and overcame her own shyness before a male doctor and fear of a surgery. She managed to break class and gender associated stereotypes, when she went through her surgery.

Women such as Mamina and Iswaramma went for the kind of health care service they wanted, not just conventional allopathic medicine or a mental stereotype that defined popular health care. Iswaramma went for homeopathic medicine for her acidity, sugar, knee issues and blood pressure related health issues. Each liquid bottle was for one ailment and cost her Rs.20 and lasted around 10-15 days. She knowingly stayed away from allopathic medicine as she developed reactions to it. She sought medicine of her choice and purchased it from the nearby homeopathic doctor who practiced in the slum.

Mamina went for traditional heat therapy and not plastering for her hand fracture. She decided not to undergo x-rays and usual plastering that is cast for 2-3 months without any change in between. Rather she went to a traditional healer for her bandages which was changed every week for the same period. Changing her bandages and heat therapy was comforting for her and relieved her of discomfort of plastering, x-ray procedure and even speaking to a medical doctor in a hospital setting. She recovered through traditional therapy and resumed work within 6 months of her hand fracture. Shanti on the other hand had initially tried *'kabiraji'* or ayurvedic medicine for her filarial fever for few years, but later she shifted to allopathic medicine since *'kabiraji'* did not benefit her much. When she started taking her filarial allopathic medicine regularly, she did not have fevers, even though the swelling of her legs stayed on. She tried to take her medicines regularly with her earnings from construction work and later, from domestic work. And she tried to continue her allopathic medication.When a woman worker resorted to a loan to build an asset, construct her own house or get her son or daughter married off or for children's education and later, paid off the loan in monthly instalments by putting in extra days and hours of work, she broke different stereotypes. When Sanju took a loan to build a house, she overcame multiple barriers,

that of stereotypes of being a slum dweller, a poor woman with drunkard non-cooperative husband and of being a sick person who dared to work and take a loan. In spite of her health issue wherein she experienced severe stomach cramps frequently, she managed to find construction work, worked hard for her earnings, managed family expenses, work time and meal timings. She achieved what she wanted which was having her own house, for herself and her family. She received physical support from her daughter-in-law which relieved her of domestic chores at home. Her son's earnings were meagre and fluctuating which did not assure of much financial help.

Women's agency was seen when she negotiated for better living conditions within her class constraints of a slum residence, such as bargaining for a common toilet facility with her landlord or resorting to a loan without interest from the employer, this was a practice for many domestic workers.

As these intersectional processes of trade off between paid and unpaid work, changes in age, family and her identity and health and ageing unfolded in women's lives, women's agency within the constraints of their intersectional location were evident and these were seen notably, when women could leverage their support structures, be it taking work decisions, recovering from health issues, managing paid and unpaid work with physical or financial support from family members or, managing household expenses from by buying food items on credit from local grocer or taking off days of leave or arranging for her breakfast meal by negotiating with her employer or accessing the state based social support. Components of state support facilitating her agency were PDS based ration supply, Rashtriya Swasthya Bima Yojana (RSBY) based coverage for hospitalisation expenses, Government free housing schemes (IAY) which saved her rent money and minimum wage regulations, particularly in case of construction work. As an inference, agency had its roots in gender, class, age, family support and state support. Hence, was linked with intersectional location. The social determinants of health as embedded in different conditions of work, family, health care, diet and living were found incomplete without understanding how the woman worker acted in these conditions or showed her agency to utilise, overcome and negotiate. Actor's agency within the processes of social determinants of health and intersectionality enriched the understanding of women's work changes.The other

takeaway from this was that state support structures had a role in women's agency and different policies could ensure agency of women in many ways.

III. Implications for Policy to Facilitate Women's Agency

I am not going into a detailed policy analysis in this section, but I focus on some of the key issues of those policies that were found on the ground when the respondents shared their experiences such as Rashtriya Swasthya Bima Yojana (RSBY), Public Distribution System (PDS), Indira Awas Yojana (IAY), Indira Gandhi Disability Pension Scheme (IGDPS) and Indira Gandhi National Widow Pension Scheme (IGNWPS). Based on the study findings, I have shared some ideas here on how the existing policy could be more inclusive and better implemented. I suggest the areas where lack of policies was felt during the study and how new policies could be conceived.

The Unorganised Workers Social Security Act 2008, Act No.33 of 2008 defines "wage worker" as a person employed for remuneration in the unorganised sector, directly by an employer or through any contractor, irrespective of place of work, whether exclusively for one employer or for more than one employer, whether in cash or in kind, whether as a home-based worker, or as a temporary or casual worker, or as a migrant worker, or workers employed by households including domestic workers, with a monthly wage of an amount as may be notified by the Central Government and State Government, as the case may be.[ccxiii] Under this Act, there is a provision for registration of unorganised workers so that they can avail any social security benefits by the Central Government or State Government sponsored scheme. Registration of unorganised workers would mean coverage for wage workers also, which includes both construction as well as domestic workers. The Act in Chapter V, the section on Registration says that "(1) every unorganised worker shall be eligible for registration subject to he or she shall have completed fourteen years of age and a self-declaration by him or her confirming that he or she is an unorganised worker (2) every eligible unorganised worker shall make an application in the prescribed form to the District Administration for registration (3) every unorganised worker shall be registered and issued an identity card by the District Administration which shall be a smart card carrying a unique identification number and shall be portable."[ccxiv]

In the present study, none of the domestic workers were issued any such smart card, nor were they aware of such a provision. Of the construction workers, only few had such cards. Soundararajan (2013) points out that poor worker registration rate not only deprives of workers of their due benefits under social security schemes which utilise the worker data base from boards, but also invisibilises the extent of problems among construction workers, such as injuries and accidents.[ccxv] Soundarajan (2013) puts forth the NSS data from 2009-10 with only 8.5% of the construction workers in India belonged to any sort of welfare association, board or union, 82% reported that there are no associations or unions in their activity, and 4% were not aware if unions or associations that existed for their welfare which only confirms that issue of poor worker registration.[ccxvi] This issue of poor registration of both construction and domestic workers poses serious risks for their health in the long run. It is an issue of exclusion at the implementation level, not policy level.

In Schedule I, this Act of 2008 specifies few social security schemes for unorganised workers, the prominent ones which were also asserted by some of the respondents during the study were RSBY and Janani Suraksha Yojana. Though the Act specifies Indira Gandhi National Old Age Pension Scheme (IGNOAP), this was not shared by any of the respondents. Rather a social security scheme for poor widows, IGWPS at a rate of Rs.300 per month was shared by many respondents. The widow pension though meagre was of some help to women, particularly when they lost their earnings. And some of the respondents mentioned that they were aware of the pension scheme for disability, IGDPS a monthly pension of Rs.300 per month, but they had not received its benefits since they did not come under its purview. The Scheme says any person suffering from severe or multiple disabilities as defined by the Persons with Disabilities Act, 1995 (PWD 1995) should be eligible for the benefits. Of these categories, one type of disability which affects the physical movement has been defined as 'locomotor disability' in Section 2 of PWD Act 1995 and further characterised as 40 percent or 80 percent of such locomotor disability by a certified medical authority.[ccxvii] Such respondents in the present study suffered from disability in carrying out their daily activities for chronic health issues (which affected knee joints and finger joints), but were able to stand and gradually walk with some person’s support. This did not qualify for inclusion under the Scheme. Such definitions of disability and social security should be reviewed since they exclude certain groups

within the disabled at the policy level. Also at some level such exclusion implies that such worker becomes severely disabled over time due to a chronic ailment and loss of earnings without any social security and health coverage (lack of health coverage for chronic health issue under RSBY is discussed below). The accumulation of health risks and health consequences as a finding of the study particularly, how a chronic ailment exaggerated into disability has been discussed in Chapter 5. The health risks were embedded in exposure conditions, with a health issue the exposure conditions would not mean the same as it would mean to a normal person. The experiences would differ. With every step of deterioration in health condition, the exposure condition would imply a heightened intensity of getting affected. The risks would lie in such a state. And this accumulation was disadvantaged since the very work, living, diet, family conditions were difficult and multiple challenges to health care existed. In the long run, it resulted in accumulation of health consequences for the respondents.

"The Unorganised Workers Social Security Act (2008) enacted by the Central Government to provide for the social security and welfare of the unorganised workers in India recommends that the Central Government provide social security schemes, to mitigate risks due to disability, health shocks, maternity and old age. As a part of this, RSBY was launched in early 2008 and was initially designed to target only the BPL households, but has been expanded to cover other defined categories of unorganised workers, covering: (i) building and other construction workers registered with the Welfare Boards (ii) licensed railway porters (iii) Street Vendors (iv) Mahatma Gandhi National Rural Employment Guarantee Act workers who have worked for more than 15 days during the preceding financial year (v) *beedi* workers (vi) domestic workers (vii) sanitation workers (viii) mine workers (ix) rickshaw pullers (x) rag pickers (xi) auto/taxi Driver."[ccxviii] RSBY is supposed to provide labour identity cards to certain workers and the beneficiaries under the Scheme are entitled to hospitalisation coverage up to Rs. 30,000/- per annum on family floater basis, for most of the diseases that require hospitalisation.

In the present study, among the case studies, only one woman who had previously been a construction worker had received and benefitted partially from this card. She did not get the full coverage of Rs.30,000, but got around Rs.15,000. Rest of her operation expenses was met with her son-in-law's help. Another construction worker

had procured the card for herself and her family, but her son who underwent surgery for the injuries suffered on his chest and thigh was denied of health coverage on the grounds that her card was not renewed. She did not know whom to approach for getting the compensation she was supposed to receive. Of the case studies, almost all women domestic workers were not even aware of such labour card and its benefits. In spite of domestic workers being included in the list of workers for RSBY, they did not know about it. This required a greater communication on the part of the policy implementation mechanism as it did not reach the target groups.

As a Scheme, RSBY does not cover OPD expenses, or expenses in hospitals which do not lead to hospitalisation. The concept of health compensation covered specific diseases with hospitalisation does not mention mental health issues or chronic health issues at all. It was an approach wherein physical health issues were dissociated from mental health issues completely whereas in reality these two were entwined mutually affecting each other as is found from this study and by others (Doyal 1995; McGibbon & McPherson 2010). In fact, the present study found that process of accessing health care threw up numerous mental health issues in women's lives. So, even finding cure for her physical ailments embodied a path of mental turmoil with issues of access to health care, paid work vis-à-vis health checkup day and health expenses vis-à-vis family expenses. Accessing health care was not just an issue of affordability, and there were other issues related, including issues of apprehension and discomfort which required mental health counselling. This has been discussed in greater detail in Chapter 5.

RSBY gives attention to illnesses at hospitalisation level and does not consider the damaging effect chronic health issues had with age exaggerating to disability for women construction as well as domestic workers. The chronic health issues were embedded in daily exposures and these should be considered in the Scheme, particularly for women since they combine paid work and unpaid work at home. Even diagnostic tests were a deterrent financially which was then avoided by women particularly for chronic health issues, even if required. Women's lives and health were interwoven as a continuous and interactive process where in past, present and future were in a web and her unpaid and paid work were constant features of her life. Constant body ache, lack of rest for combining paid and unpaid work, financial

worries of ‘low pay’ ‘insecurity of work’, ‘household expenses’, ‘difficult living and work conditions’ and ‘absent meals’ were part of everyday way of life and the sources of daily accumulation of health risks for women construction as well as domestic workers along with multiple issues of accessing health care services.

The Building and Other Construction Workers’ Welfare Cess Act, 1996, Act no. 28 of 1996 extends to the whole of India. This Act specififes, "there shall be levied and collected a cess for the purposes of the Building and Other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996 (27 of 1996), at such rate not exceeding two per cent, but not less than one per cent of the cost of construction incurred by an employer, as the Central Government may, by notification in the Official Gazette, from time to time specify."[ccxix] This cess is collected by the Government from the employer in relation to 'a building or other construction work of a Government or of a public sector undertaking or advance collection for any such construction work’, and is deducted at source where the local authority approval is sought before such construction. According to the Press Information Bureau, GoI, "this fund has to be utilised for the welfare of such workers. Central Government is the implementing agency in the central sphere for the purpose of enforcement of various provisions of the Act, while States are the implementing authority under State sphere."[ccxx] Welfare of such workers implies regularising wages and work conditions and ensuring worker’s safety and health. But according to the then Union Minister of State for Labour and Employment, Late Bandaru Dattareya at the Inaugural Session of National Conference of Labour, September 2016, "out of 27, 886 crore rupees of the construction sector cess with the states, only 5800 crore (rupees) has been spent." Then Union Minister had said "in case of Odisha, though the state government has a deposit of 940 crore (rupees) from the construction sector cess, only 120 crore (rupees) has been spent."[ccxxi] At the Conference, the Odisha Chief Minister Naveen Patnaik said that "the state government has spent 200 crore (rupees) against 1000 crore (rupees) for welfare of construction workers."[ccxxii] The key issue from different accounts of Central Government or State Government is that Welfare Cess levied and collected is not spent on construction workers and their welfare. National Campaign Committee for Central Legislation on Construction Labour through numerous writ petitions in the Supreme Court of India has brought into public notice the violations of provisions under Building & Other Construction Worker (Regulations of Employment

& Conditions of Service) Act, 1996 (for short, 'the Act') and the Building and Other Construction Workers Welfare Cess Act, 1996.[ccxxiii] Also the Employee State Insurance Corporation (ESIC) from July 2015 covers construction workers for injuries, deaths, disabilities, etc.[ccxxiv] This order came into force after data for the present study was collected; for this reason there is no data with respect to its coverage on ground. But this does not include domestic workers. Lack of policies providing reimbursement of lost wages for minimum duration for such injuries for construction workers, minimum retirement age and availability of credit at minimum interest rate for both construction and domestic workers added to the web of interaction between different exposure conditions to health risks.

The policies determining living conditions or ration supply or health compensation or pension or health care facilities for the poor women workers had underlying political and economic factors such as how the Government treated the welfare of select social groups, be it from certain class (poorest of the poor-Antodyaya Yojana), caste (SCs-welfare schemes and job reservation in municipality), region of origin and caste (Odiya, Telugu, etc-housing for Telugu SCs under IAY), marital status (widows), gender (pregnant mother and girl child-Janani Suraksha Yojana) and physical status (monthly allowance of Rs.300 for physically disabled). It involved policy implementing decisions as to which schemes were cost friendly and popular over others for vote banks, the political priorities in faster implementation of differently funded schemes such as by the Centre alone or by the State or on a sharing basis.

Of the 33 case studies, 9 had permanently withdrawn from work when they were around 50 years of age for health reasons. 7 were around 50 years of age and were working for lesser remuneration than before. Given a choice, they would have wanted to take rest or more earnings for the current work. Such work change implied loss of or reduced earnings. At age 50 women construction and domestic workers were as a rule left with declining stamina, zero savings and uncertain earnings since they either left working or shifted work. These are the findings from the case studies. From the survey, the incidence of health as causal for work changes was found to be greater in case of women construction workers than domestic workers. At this level, it implied the role of strenuous and unsafe work conditions in causing health issues and work changes for construction workers. But the findings from case studies pointed towards

similarities of health issues and processes of work change between the two groups despite differences.

The vulnerability at the level of age, family support and state support was found a deciding factor of how women could cope with multiple exposures which were always present since the root source was never attended to and then, the work changes impacting earnings occurred. For instance, the subsidised ration supply (PDS) or pension schemes helped women in their vulnerable times such as during loss of or reduced earnings and advanced age. Or the house provided under IAY was helpful in reducing the monthly expenses.

Lack of retirement policy for women workers which would look at the issue of early work shifts or withdrawal from work conveys a sense of apathy about this situation and treating it normal that women construction and domestic workers could not work till age 58-60, a standard age norm for number of active earning years. A retirement policy with a specified age is required for women construction and domestic workers provisioning compensation of pay in event of work loss for health issues originating from work conditions. But this will not be enough, there is a need to address the detrimental impact of diet, living, work and family conditions together, where in health issues do not necessarily start from the single source of work conditions. After considering local food expenses in Cuttack as shared by respondents at the time of study, it was found that a minimum of Rs.6000 per month was required to afford two meals (consisting of rice, dal and vegetables) every day and the house rent every month. This minimum requirement of two square meals of one's earnings was not met and there was some compromise on food value such as vegetables or dal required for meals were not adequately purchased for the day. The current PDS system should take into account the age group and determine the subsidised ration supply rather than a flat subsidised supply of 25 kgs of rice for all poor families. By doing so, it will take into account the intersectional location of class (BPL) and age with an assumption that post 45 years of age women had reduced earnings and required greater state support. A minimum of one month of earnings at end of every year as savings was required to compensate for the loss of wages in case of health emergency situations and allow the worker to take some rest from paid work, if not unpaid work. The labour policy needs to look at it this aspect of creating a pool of savings with the ease

of transacting in a bank or savings group or reimburse such sum of amount through a health insurance scheme. The National Health Protection Scheme (NHPS) announced in Budget year 2018-19 promises coverage of hospitalisation expenses through insurance scheme, and will replace the present RSBY.[ccxxv] However, the same issues of neglecting non-hospitalisation care, chronic health issues and mental health issues remain. In addition, personal savings would have given a greater assurance to women workers than just an insurance model of NHPS for hospitalisation. It cannot address to the issue of financial worries which add on to the detriment of physical health. There is also a need to look at security of work along with minimum pay per day or per hour in the active years of workers so that there is greater scope of earnings and savings. As of now, minimum wages are set for construction workers on per day basis, but domestic workers do not have any such minimum pay. Minimum wages were complied to in case of construction work too. For domestic workers, per hour of minimum pay referring to the stipulated minimum wages is workable since they do not stay at employer's house and work mostly 1-3 hours in any house. There are other states who have notified a minimum wage for domestic workers, such as in Karnataka which issued in March 2013, with a notified range of Rs.20-139 wage per day for each task of washing utensils, clothes and cleaning house, which could be calculated on an hour basis.[ccxxvi]Sankaran (2013) finds the overall coverage under the Minimum Wage Act (MWA) has been low in India with just 2 million workers registered here, of which 23,000 workers had fought for minimum wage.[ccxxvii] In case of Karnatka, the notification gives flexibity of determining the rate of wages, which could be time or piece-rated, or a guaranteed time rate and an overtime rate. But, this notification raises questions as to how it would be implemented, for instance, a city like Bangalore vis-à-vis Raichur or Hubbali-Dharwad in Karnataka would be implementing it differently. There are other proposals of working out wages of women domestic workers based on tasks, this has been put forth by Neetha (2009).[ccxxviii] This can ensure them earnings at par with minimum wages for 8 hours of work. When years of work was lost in advance of supposed retirement age, zero or negligible savings was often the case. This state was an outcome of insecure work and low pay which were not enough for daily expenses, drinking habits of male family members which disallowed them to save anything and their lack of familiarity as well as the cumbersome process of dealing with banking system that inhibited most of them to save something for future. The women started working early in their lives, but for them neither savings nor the

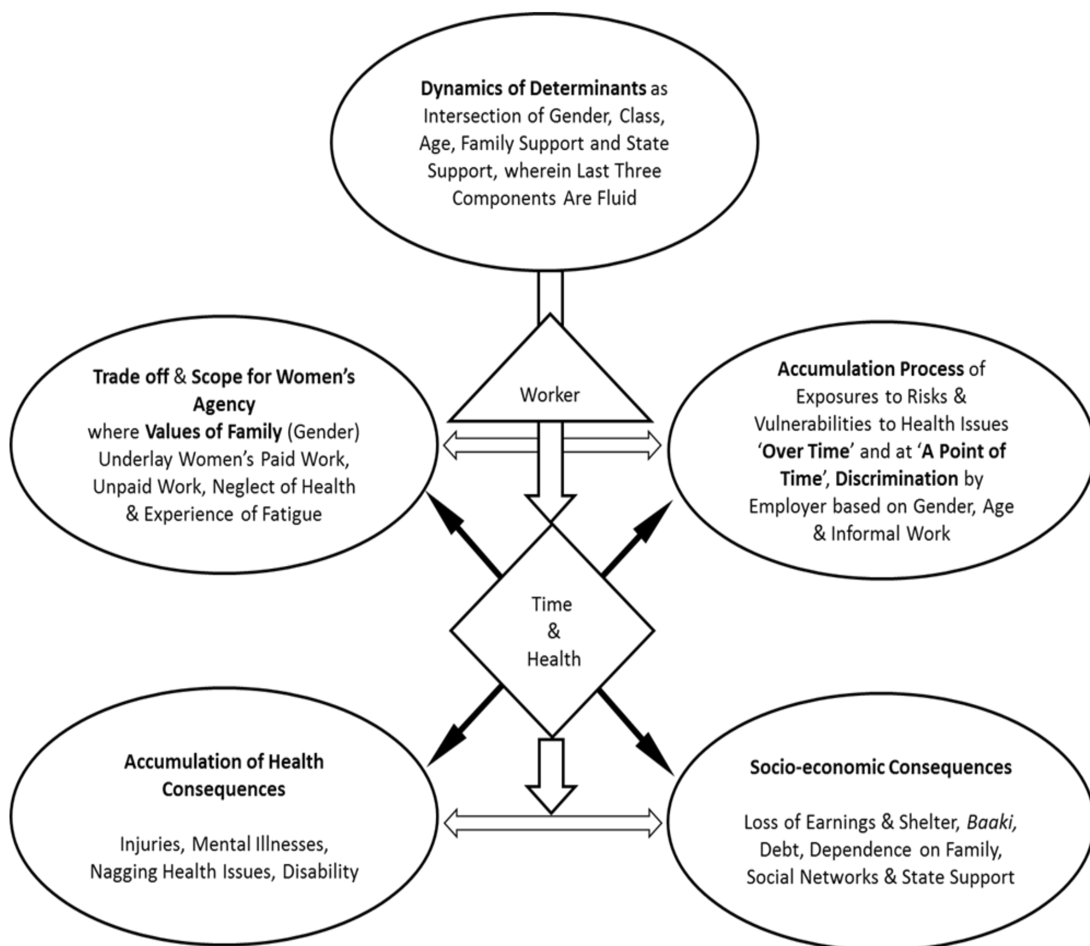
right to work till age 58-60 was guaranteed. Nor a life after work changes was good, in their own words, their prime working years were always better as they could spend money on food that they wanted to eat. After work change, they either earned less than before or did not earn at all. The only respite here was pension from husband's work or widow pension of Rs.300 per month, if it was the case. This supported part of rent or tea expenses every month. They quit or shifted work compromising on their financial earnings for reasons which stemmed from over strain of paid and unpaid work, ageing, work conditions and other conditions of poor diet, living, family and health care. Their shelter, food and medication needs remained in spite of loss of earnings and lack of savings, which often resulted frequent debt and this in return, made them compromise their food expenses. There was no policy that could ensure them debt at minimum interest rate and save them from a debt cycle then. The physically disabled women by chronic diseases with age did not get any allowance either, which was Rs.300 per month. And there was no health policy which looked at quality care for health issues for women post 40s when health symptoms started manifesting. Braveman (2010) finds that the human rights approach informs the health equity approach for measurement as well as analysis. She says, "the principle of the indivisibility, interdependence, and inter-relatedness of all human rights, as expressed in the International Bill of Rights has great relevance to both health equity and the link between social conditions and health. According to this principle, all human rights — civil, political, economic, social, and cultural — are interdependent and indivisible from one another."[ccxxix] This is something fundamental about how and when health issues are experienced by women workers, become the reason for work changes, wherein her loss of her earnings affects opportunities to live in a protected shelter, afford basic dietary requirements and deprives her of possibilities for a better health. Any health based social security policy (RSBY, NHPS) needs to take into account the relevance of inter-relatedness of rights, interactive social conditions and cumulative health conditions to positively affect health of women workers besides the provisioning for hospitalisation expenses.

IV. Linking Past, Present and Future

The following figure attempts to depict the three interactive processes of health, which are of exposure conditions of risk, vulnerabilities to health issues and

accumulation of health risks and consequences situated in the context of intersectional processes in poor women worker's lives. Gender, class, age, family and state support formed the complex of factors influencing intersectional processes. While gender, class, caste and region of origin explained the intersectional location of women construction and domestic workers, the various exposure conditions (the prominent ones being work and living conditions), age, family support and state support differentiated the experiences of more vulnerable women from the rest and explained these differences of diet, family and living conditions, access of health care and chances of recovery from illness setback. This schematic representation is based on the understanding gained by using mixed methods and the two grounded theory approaches in this study.

Figure 12: Schematic Representation of Health and Work Changes of Women Workers



[Note: SDH Model by Sen & Ostlin 2007 Adapted and Extended with the Study Findings]

Exposures to health risks were rooted in intersectionality and so was vulnerability of women workers. If women had not belonged to that particular intersectional location, they would not have been affected by the exposures, either in terms of health issues or work changes accompanied by reduced or nil earnings. This was the essence of their vulnerability when they could not get back to work or recover enough to earn the same. Signifying her state of vulnerability, along with gender, class, caste, region of origin and age was the state support in form of pension or subsidised ration supply schemes and her family's physical as well as financial support. While gender, class, caste and region of origin had every day implications for womens' vulnerability since this intersectionality determined their employment and other conditions of exposure that existed, gender, class, age, family and state support meant how women became vulnerable or more vulnerable at certain points in their lives or how one group of women was different from the others in terms of vulnerability. Intersectionality influenced manifestation or further deterioration or improvement of a women worker's health condition and the support systems available added to or detracted from the vulnerabilities. Physical and mental health issues of women workers pushed them to shift to other work or withdraw from employment. Just as a woman's health and work change were found to be interwoven, interacting with each other as consequences of interactive and accumulative exposures situated in her conditions of work, family, diet, living and challenges of accessing health care when she was vulnerable, a woman's life was found entangled with others, how she was placed in relation to others, at work, family, slum residence and even diet.

The SDH model

Accumulation of risk was critical along with interactive processes in understanding how illness became impeding and multiple in nature. The SDH model (Sen & Ostlin 2007) prioritises gender, considers other axes of social stratification, the associated norms, values, exposures and vulnerabilities, the health systems and research biases, but does not take into account accumulation of risk over the life course. Krieger (2003) mentioned cumulative economic deprivation wherein the process of deprivation occurred over time and was based on economic, political and social factors. SDH model's structural causes, interactive social, economic and political factors and processes of health exposures and vulnerabilities was inadequate in

understanding health of women workers since it did not take into account accumulation of health risks and the dynamics of health issues as one of the processes. Life course approach's 'accumulation of risk model' with predisposition and age at individual level and SDH model's explanation of interactive social, economic and political factors, structural causes, intermediate processes of exposures, vulnerabilities and consequences together were found to be helpful in understanding the illness of workers and work changes (Note 12). Others like Bartley & Blane (2009) have talked about the 'life course influences of health at older ages' which is indicative of accumulation of health risks over time. Bartley & Blane (2009) speak of three different health data and how the health issue of lung condition and deaths were outcomes of the long term disadvantage. First, they cite the study by Morris et.al (2007) which calculated the kind of expenses at basic level was required to support minimum dietary, living and other expenses of a retired couple in Britain and then, related it to the money available. The study found "at April 2007 prices per week, this conservative total (£208.00) exceeds the State Pension for acouple (£139.60) and their Pension Credit Guarantee (£181.70)" in other words, it referred to inadequate social security income.[ccxxx] Second, Bartley & Blane (2009) cite the study by Blane et.al (2000) on respiratory disease, winter mortality and housing quality in Britain. Prior to this study, excess winter mortality in Britain which was higher than its other European counterparts was attributed to cardio-respiratory diseases at old age. Whereas post study it was found that inverse housing law (mismatch between climate demand and housing quality) had an effect. The housing quality (physical characteristics and protection from cold and damp defined as 'stock quality') was associated with these deaths. The association between stock quality and lung function was strongest among those resident in the worst quarter of the climate distribution."[ccxxxi] Third, Bartley & Blane (2009) cite the deaths in Britain due to acute air pollution which were reported as many of the deaths in high air pollution days were those of elderly and sick.[ccxxxii]What was found common among three studies was a combined effect since "the same individuals are likely tohave less than the minimum income for healthy living, suffer from theinverse housing law and have a level of cardio-respiratory impairmentwhich makes them vulnerable to acute air pollution episodes. Further, these same individuals are likely to have had disadvantaged life trajectoriesprior to early old age (Berney et al., 2000)."[ccxxxiii] They describe these as the life-course and

contemporaneous processes which bring in the social class differences in the health of older people.

The present study found that the accumulation of health risks over a period of time particularly post 30s was crucial in shaping the women workers' health. The health risks had different implications depending on where the woman's health condition was at. For instance, a moderately disabled woman was exposed to health risks at a different intensity than a normal/healthy woman or, a severely disabled woman. These health risks could be any of the or, an interaction of the dificult living, diet, work, family conditions and challenges of accessing health care. It was found that health problems that had been ignored over 5-15 years escalated into an obstruction for respondent‘s daily activity and paid work and a single health issue turned into a complex of multiple ailments, wherein difficult work, living and diet conditions were experienced with heightened intensity as the health condition deteriorated. Some of the manifestations of these accumulated health consequences were whether a woman could work in supposedly working age (18-58/60 years), whether a woman could see properly when she was just around 50 years of age (issues of cataract than near or far sightedness) or, whether she could walk without support when she was around 60 years of age. This accumulative process was found co-existing with the interactive processes of health exposure conditions and vulnerabilities in women's lives, these three processes combinedly affected women's health and work. At the same time, it was found that women's lives unfolded through the intersectional processes of trade off between paid and unpaid work, changes in age, identity and family and health and ageing. Intersectional processes and three processes of of exposures, vulnerabilities and accumulation were juxtaposed in a dynamic fashion spread over time which brought forth how past, present and future were interlinked. All these processes then had health and work outcomes. Consequences of health and work changes were found influenced by these processes at the levels of intersectionality, exposures, vulnerabilities and accumulation. Amidst these processes, what came out as striking was by the age of 50, most of the women respondents could not earn at all or earned substantially less than before. And this occurred in most cases without any savings. One of the key reasons being health and this had varied implications for their earnings, recovery, multiple ailments and disability.

Health issues found responsible for employment shifts or withdrawal from work were broadly of four types based on its nature, viz., injuries, chronic diseases, acute illness and mental health issues. While the causal pathway of injuries was found mostly originating from work conditions and then, interacting with other conditions of exposure and accumulation, the causal pathway of mental health issues germinated from family conditions primarily and then, went through the cycle of interaction, accumulation and episodic outburst. For chronic illnesses and acute illnesses, the causal pathway was interactive right from the beginning, with equal influence of interactive work, diet and living conditions and this extended further along with the process of accumulation. By their 40s or mid-40s, both women domestic and construction workers' bodies started showing symptoms of chronic health issues, be it constant cold, knee ache, acidity, weakness of body which worsened with advanced age. Once health issues surfaced, they were initially ignored till they required urgent medical attention and after this stage, women experienced illness with delays and discontinuities in accessing health care. Women's health issues were found neglected and aggravated into multiple ailments with age, lack of earnings, difficult diet and living conditions and challenges of health care. In few cases, women became severely disabled and could not do daily normal activity.

In cases of injury or acute illnesses or mental health issues, health problems immediately hindered paid work. Chronic health problems hindered paid work intermittently since the women lived with the diseases and worked. This was the pathway by which health issues were determined and determining. Health status and problems embodied social processes rather than just being an incident. Health issues affected their paid work in advance of at least 5-8 years before the widely accepted retirement age norm of 58-60 years which implied reduced or loss of earnings. In some cases, retirement happened almost 10-12 years before than what is considered the 'normal' age of retirement, i.e. 60 years. Early onset of retirement or reduced earnings due to health issues for women workers was preventable, if their vulnerable times and conditions were understood and addressed in relation to interactive exposure conditions, accumulation and intersectional processes. The idea of health being a cause of work changes was not a linear path, it worked vice-versa too wherein work changes produced health consequences. Complicated health consequences resulted as has been discussed as accumulation of health consequences, illness as

transformative and implications for women's health in Chapter 5. Health was not just an incidence or reason of work change, but had a two way relationship/process with work change. The study findings corroborate what Leatherman (2005) and Braveman (2010) have spoken of about health and work relationship and what Marmot (2005) describes as stress (Rudas et.al study 1991, stress out of loss of job for workers) which affects physical health and psychological health.[ccxxxiv] This is what has been earlier discussed as a study finding when with women without work post illness, felt 'poor ill aged', and asserted this identity during interviews in explict manner.

Thus, this study enriches understanding of grounded theory's two popular approaches and their application. The key insights from its methodology help bring forth processes of women's health as well as intersectionality by the use of grounded theory approaches of Strauss & Corbin and Charmaz. The study disentangles the multiple dimensions that are attached to each of the categories of class, gender or age in intersectionality by use of mixed methods of survey and case studies. The theoretical frameworks adopted in the study help unravel the multiple interlinked processes which are responsible for women's health reasons and work changes. The study provides evidence to elaborate and extend the gender based SDH framework. Lastly, the understanding gained through this study helps look at how women worker's health or work issues could be addressed at a policy level by considering structures as well as the ways in which structural constraints are overcome or structural features are used to one's advantage and agency is negotiated.

End Notes

1. Formal and informal 'economy' is not the same as formal and informal 'sector' or 'work', the former is broader in its approach than the latter, however, both formal and informal economy/sector/work essentially portray a dualistic model (Mehrotra 2007)

2. NSSO definition of SNA, extended SNA and non SNA, conceptually is rooted in viewing domestic labour or care work in family as unpaid labour even if it recognises it as work or extended SNA.

3. By definition, LFPR reflects a person's willingness to work in the labour force.

4. WPR is defined as number of persons/person-days employed per 1000 persons/person-days.

5. Subsidiary status workers are non-workers or the unemployed persons engaged in an economic activity for part of the year.

6. Vertical segregation occurs when men and women in the same occupation hold different jobs in terms of rank and pay. In other words, women have fewer opportunities for advancement.

7. Pseudo names and not real names have been used to depict case studies for anonymity and confidentiality.

8. Mason were men and women worked as helpers at construction site. This was a norm.

9. Family's physical support implies sharing the unpaid work, that is, care burden and double burden, or domestic chores at home.

10. '*Baaki*' is a form of credit given by the grocery store owner wherein the shopkeeper kept a record of things purchased through credit in a month by the respondent. Every month some credited amount was repaid through salary or wage income by the respondent and some was carried over to next month. '*Baaki*' was a term used by respondents and was indispensable part of women's lives.

11. Loan referred to something that was taken from a moneylender at an interest, which was usually an interest/ '*sudha*' Rs.5 for Rs.100 every month till principal money/'*mula*' of Rs. 100 was repaid back.

12. The rates applicable for widow pension at that time have been referred to. under the Widow Pension Scheme.

13. Below poverty line (BPL) families and poorest of the poor families are targeted food subsidy schemes of the Government, wherein BPL card and Antodyaya Card was issued to beneficiaries. Rice and kerosene were given at a subsidised price, in Odisha then it was given at the rate of Rs.1 per kg of rice as against Rs.25-30 per kg in the local grocery store. Subsidised kerosene of 4 litres was given to Antodyaya families and not BPL families.

14. The "accumulation of risk" model suggests that factors that raise disease risk or promote good health may accumulate gradually over the life course, although there may be developmental periods when their effects have greater impact on later health than factors operating at other times.

15. 'Makar Sankranti' harvest festival celebrated among Hindus in January during which gifts for daughters is a cultural practice followed among the Telugu community.

References

[i] (Basu 2009), pp.232.

[ii] (Harris-Whyte 2004), pp.4.

[iii] (Harris-Whyte 2004), pp.6.

[iv] (Mehrotra & Biggeri 2007), pp.7.

[v] (Mehrotra & Biggeri 2007), pp.9.

[vi] (NSS 68th Round 2013), pp.18.

[vii] (NSS 66th round 2011), pp.87.

[viii] (Mehrotra & Biggeri 2007), pp.3.

[ix] (Harris 1989), pp.218.

[x] (Brenman 2013), pp.22-23.

[xi] (Herod 2003), pp.113-114.

[xii] (Herod 2003), pp.112-138.

[xiii] (NCEUS 2007), pp.75-77.

[xiv] (NCEUS 2007), pp.77.

[xv] (NSS 68th round, Report No.537 2011), pp.67.

[xvi] (Dalmia 2012), pp.252.

[xvii] (Dalmia 2012), pp.252.

[xviii] (Mehrotra 2010), pp.5-7.

[xix] (Mehrotra 2010), pp.20.

[xx] (Mehrotra 2000), pp.147-148.

[xxi] (Bauer 2014), pp.12.

[xxii] (Bauer 2014), pp.12.

[xxiii] (Baruah 2010), pp.37.

[xxiv] (Mohankumar & Singh 2011), pp. 70.

[xxv] (Mehrotra 2010), pp.11.

[xxvi] (Economic Survey 2012-13), pp.274.

[xxvii] (Chowdhury 2011), pp.23-26.

[xxviii] (NSSO 2013), pp.12.

[xxix] (NCEUS 2007), pp.85.

[xxx] ((Economic Survey 2012-13), pp.274.

[xxxi] (NCEUS 2007), pp.81.

[xxxii] (Sen & Ostlin 2007) pp.12-13.

[xxxiii] (NCEUS 2007), pp.83-84.

[xxxiv] (Wage Rates Rural India 2008), pp.9.

[xxxv] (Indian Labour Journal 2013), pp.185-192.

[xxxvi] (McGibbon & McPherson 2010), pp.66.

[xxxvii] (WCD, GoI Gender Development Report 2009), pp.5.

[xxxviii] (Chandrasekhar & Ghosh 2011), The business Line July 12, 2011.

[xxxix] (NCEUS 2007), pp.75-77.

[xl] (NCEUS 2007), pp.77.

[xli] (NSSO 2013), pp.A-2.

[xlii] (NCEUS 2007), pp.79.

[xliii] (NCEUS 2007), pp.79.

[xliv](Bisht 2004), pp.319.

[xlv] (Kantor 2002), pp.287.

[xlvi] (Kantor 2002), pp.287-289.

[xlvii] (Razavi & Miller 1995), pp.19.

[xlviii] (Chakravarti 1993), pp.582-584.

[xlix] (Chakravarti 1993), pp.583.

[l] (Sen & Ostlin 2007) pp.12-13.

[li] (Sen & Ostlin 2007) pp.12-13.

[lii] (Folbre 1994), pp.29

[liii] (Rege 2003), pp.69.

[liv] (Harris-Whyte 2003), pp.27.

[lv] (Mohanty 1984), pp.335.

[lvi] (Mehrotra 2010), pp.5-7.

[lvii] (Mehrotra 2000), pp.147-148.

[lviii] (Dalmia 2012), pp.252.

[lix] (Mohanty 2001), field notes

[lx] (Mohankumar and Singh, 2011), pp.69.

[lxi] (Gothoskar 2013), pp.67.

[lxii] (NCEUS 2007), pp.84.

[lxiii] (Baruah 2010), pp.36.

[lxiv] (Baruah 2010), pp.32.

[lxv] (Dalmia 2012), pp.252.

[lxvi] (Mohankumar & Singh 2011), pp.68.

[lxvii] (Basu & Thomas 2009), pp.239.

[lxviii] (Baruah 2010), pp.39.

[lxix] (Gothoskar 2013), pp.66.

[lxx] (Gothoskar 2013) pp.65-66.

[lxxi] (Mehrotra 2010), pp.16-17.

[lxxii] (Mehrotra 2010), pp.22.

[lxxiii] (Mehrotra 2010), pp.5-25.

[lxxiv] (Kaur 2010), pp.164.

[lxxv] (Lan 2003), pp.526.

[lxxvi] (NCEUS 2007), pp.86.

[lxxvii]Available at: http://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_INSTRUMENT_ID:2551460

[lxxviii] (Economic Times 2014), March 14.

[lxxix] (Hancock 2007), pp.67-68.

[lxxx] (Groenmeyer 2011), pp.260.

[lxxxi] (Alcoff 2006), pp.26.

[lxxxii] (Alcoff 2006), pp.27-28.

[lxxxiii] (Grabham, Cooper, Krishnadas & Herman 2009), pp.21-48

[lxxxiv] (McCall 2001), pp.3-175.

[lxxxv] (McCall 2005), pp.1773.

[lxxxvi] (McCall 2005), pp.1774.

[lxxxvii] (Smith 2004), pp.79.

[lxxxviii] (Dill & Zambrana 2009), pp.57.

[lxxxix] (Dhamoon 2011), pp.233.

[xc] (Bauer 2014), pp.12.

[xci] (Dill & Zambrana 2009), pp.56.

[xcii] (Krieger et al. 2010), pp.747-748.

[xciii] (Krieger 2001), pp. 697-98.

[xciv] (Krieger 2001), pp. 697-98.

[xcv] (Marmot, Friel, Bell, Houweling, & Taylor 2008), pp.1666-1667.

[xcvi] (Doyal 2000), pp.936.

[xcvii] (Doyal 1995), pp.35.

[xcviii] (Doyal, 1995), pp.13.

[xcix] (Graham 2009), pp.104.

[c] (Labonte & Schrecker 2007), pp.18.

[ci] (Sen & Ostlin 2007), pp.11.

[cii] (Doyal 1995), pp.155

[ciii] (Sen & Ostlin 2007), pp.44.

[civ] (Sen & Ostlin 2007), pp.44.

[cv] (Krieger, 2003), pp.654-55.

[cvi] (Sen & Ostlin 2007), pp.22-23.

[cvii] (Doyal 1995), pp. 24-29.

[cviii] (McGibbon & McPherson 2010), pp.66-72.

[cix] (Doyal 2000), pp.932-934.

[cx] (Sen & Ostlin 2007), pp.42-43.

[cxi] (Sen & Ostlin 2007), pp.32.

[cxii] (Kimberly, Arriola & Borba 2007), pp.4.

[cxiii] (Patel, Kirkwood, Weiss, Pednekar, Fernandes, Pereira, et.al 2005) pp.1191-1193.

[cxiv] (Baruah 2010), pp.37.

[cxv] (Mohankumar & Singh 2011)

[cxvi] (Mehrotra 2010), pp.11.

[cxvii] (Mehrotra 2010), pp.2.

[cxviii] (Gothoskar 2013), pp.72.

[cxix] (Hancock 2007), pp.71.

[cxx] (Bauer 2014), pp.12.

[cxxi] (Grabham, Cooper, Krishnadas & Herman 2009), pp.39.

[cxxii] Dhamoon 2011,

[cxxiii] (Ayyar 2013), pp.44-55.

[cxxiv] (Coelho, Venkat & Chandra 2013), pp.41-42.

[cxxv] (Mcgibbon et al. 2010), pp.61.

[cxxvi] (Mcgibbon et al. 2010), pp.71.

[cxxvii] (Mcgibbon et al. 2010), pp.71-72.

[cxxviii](Sen & Ostlin 2007), pp.11.

[cxxix] (Sewell, 1992), pp.6.

[cxxx] (Giddens, 1984), pp.25.

[cxxxi] (King, 2000), pp.428.

[cxxxii] (King 2000), pp.418.

[cxxxiii] (Sewell, 1992), pp.4.

[cxxxiv] (Sewell, 1992), pp.20.

[cxxxv] (Einspahr, 2010), pp.6.

[cxxxvi](Einspahr, 2010), pp.4.

[cxxxvii] (Ridgeway 2009), pp.146.

[cxxxviii] (Dhamoon, 2011), pp.241.

[cxxxix] (Hankivisky 2012), pp.1715.

[cxl] (Greene, Caracelli & Graham 1989), pp.258.

[cxli] (Cameron 2011), pp.96.

[cxlii] (Greene, Caracelli & Graham 1989), pp.260.

[cxliii] (Mohanty 2001), pp. 36.

[cxliv] (City Level Technical Cell 2012), pp.2.

[cxlv] (Cuttack Report, CRISIL 2013) pp.64.

[cxlvi] (Sahoo et.al, 2015), pp.84.

[cxlvii] (Mitra 2006), pp.2682.

[cxlviii] (NCEUS 2007), pp.241.

[cxlix] (Das, Das & Mohanty 2012), pp.63.

[cl](Bharat Jyoti 2011), Table 21, pp.20.

[cli] (NCW Gender Profile), pp.24-25. Available at:
http://ncw.nic.in/pdfReports/Gender_Profile_Orissa.pdf

[clii] (Kaiser 2010), pp.4.

[cliii] (Kaiser 2010), pp.4.

[cliv] (Sachs, Hougham, Sugarman, Agre, Broome, Geller, et.al 2003), pp.S5.

[clv] (Kaiser 2010), pp.8.

[clvi] (Jones & Alony 2011), pp.99.

[clvii] (Jones & Alony 2011), pp.99.

[clviii] (Ramalho, Adams, Huggard & Hoare 2015), pp.4.

[clix] (Hsiung 2008), pp.213.

[clx] (Charmaz 2016), pp.2.

[clxi] (Charmaz 2016), pp.2.

[clxii] (Charmaz 2016), pp.6.

[clxiii] (Kumar 2006), pp.64.

[clxiv] LIST of SCs for State of Andhra Pradesh, Ministry of Social Justice and Empowerment, GoI, Entry 35-Mala Available at: http://www.socialjustice.nic.in/writereaddata/UploadFile/Scan-0001.jpg

[clxv] LIST of SCs for State of Andhra Pradesh, Ministry of Social Justice and Empowerment, GoI, Entry 14-Chamar Available at: http://www.socialjustice.nic.in/writereaddata/UploadFile/Scan-0001.jpg

[clxvi] LIST of SCs for State of Andhra Pradesh, Ministry of Social Justice and Empowerment, GoI, Entry 4 & 6-Aray & Arwa Mala Available at: http://www.socialjustice.nic.in/writereaddata/UploadFile/Scan-0001.jpg

[clxvii] LIST of SCs for State of Odisha, Ministry of Social Justice and Empowerment, GoI, Entry 10-Bauri Available at: http://www.socialjustice.nic.in/writereaddata/UploadFile/RL-Odisha.jpg

[clxviii] CENTRAL LIST of OBCs for State of Odisha, Gouda Entry 43 Available at: http://www.stscodisha.gov.in/Pdf/OBC_list.pdf

[clxix] LIST of SCs for State of Odisha, Ministry of Social Justice and Empowerment, GoI, Entry 26-Dhoba Available at: http://www.socialjustice.nic.in/writereaddata/UploadFile/RL-Odisha.jpg

[clxx] CENTRAL LIST of OBCs for State of Odisha, Teli Entry 162 Available at: http://www.stscodisha.gov.in/Pdf/OBC_list.pdf

[clxxi] Available at: http://www.thehindu.com/news/national/other-states/odisha-govt-announces-raise-in-minimum-wages/article7161864.ece#!

[clxxii]ILO 102, refer Article 10, Social Security (Minimum Standards) Convention, 1952 (No.102) Convention concerning minimum standards of social security (entry into force: 27 April 1955) Adoption: Geneva, 35th ILC session (28 Jun 1952)

http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312247

[clxxiii] (Dong 2005), pp.330.

[clxxiv] (Bang 2010), pp.89-90.

[clxxv] (Basu & Basu 2000), pp.186.

[clxxvi] (CSDH WHO, 2008), pp.31.

[clxxvii] (Schenk 2001), pp.196.

[clxxviii](Diamantopoulos , A., Rohde, G., Johnsrud, I., Skoie, IM., Hochberg, M., & Haugeberg, G 2012), Available at: https://doi.org/10.1371/journal.pone.0043367

[clxxix](Graham 2004), pp.111.

[clxxx] (World Health Organization, 2008), pp.72.

[clxxxi] (Carel, Kidd & Pettigrew 2016), pp.1152.

[clxxxii] (Carel, Kidd & Pettigrew 2016), pp.1153.

[clxxxiii] (Hsiung 2008), pp.211-226.

[clxxxiv] Strauss & Corbin (1998), pp.21-22.

[clxxxv] (Leatherman 2005), pp.54.

[clxxxvi] (Uraguchi 2010), pp.497.

[clxxxvii] Saldana (2009), pp.159-161.

[clxxxviii] (Leatherman 2005), pp.59.

[clxxxix] (Harenstam 2009), pp.130.

[cxc](Bartley & Blane 2009), pp.58.

[cxci] (Beaglehole and Bonita, pp.26.

[cxcii] (Beaglehole and Bonita 1994), pp.26.

[cxciii](Mehrotra 1987), pp.2.

[cxciv] (Patel, Kirkwood, Weiss, Pednekar, Fernandes, Pereira, et.al 2005), pp.1192.

[cxcv] (McGibbon & McPherson 2012), pp.67.

[cxcvi] (Wrigley-Asante 2013), pp.534.

[cxcvii] (Pani & Singh 2012), pp.81.

[cxcviii] (Lingam 2004), pp.1992.

[cxcix] (Hancock 2007), pp.67.

[cc] (Raju 2013), pp.64.

[cci] (Sen et al. 2007), pp.18.

[ccii] (Hancock 2007), pp.74.

[cciii] (McCall 2005), pp.1772.

[cciv] (Dhamoon 2012), pp.235.

[ccv] (McCall 2005), pp.pp.1774.

[ccvi] (Hancock 2007), pp.74.

[ccvii] (Benwell & Stokoe 2005), pp.10.

[ccviii] (Mahmood 2005), pp.6.

[ccix] (Mahmood 2005), pp.15.

[ccx] (Mahmood 2005), pp.5.

[ccxi] (Mahmood 2005), pp.10-11.

[ccxii] (Mahmood 2005), pp.12.

[ccxiii] The Unorganised Workers Social Security Act 2008 Act No.33 of 2008, pp.2. Available at: http://lawmin.nic.in/ld/P-ACT/2008/The%20Unorganised%20Workers%E2%80%99%20Social%20Security%20Act,%202008.pdf

[ccxiv] The Unorganised Workers Social Security Act 2008 Act No.33 of 2008, pp.5. Available at: http://lawmin.nic.in/ld/P-ACT/2008/The%20Unorganised%20Workers%E2%80%99%20Social%20Security%20Act,%202008.pdf

[ccxv] Soundararajan, V. 2013. Construction Workers: Amending the Law for More Safety. Economic & Political Weekly June 8, Vol xlviII no 23, pp.21-25.

[ccxvi] (Soundararajan 2013), pp.22.

[ccxvii] Available at: http://mpsc.mp.nic.in/gacdn/SJ/PDFFiles/guidelinesonIGNDPS30sep09.pdf

[ccxviii] Available at: http://www.rsby.gov.in/about_rsby.aspx

[ccxix] The Building and Other Construction Workers' Welfare Cess Act, 1996 act no. 28 of 1996 [19*th August*, 1996.] Available at: http://lawmin.nic.in/ld/P-ACT/1996/The%20Building%20and%20Other%20Construction%20Worker's%20Welfare%20Cess%20Act,%201996.pdf

[ccxx] (Press Information Bureau Nov 1 2012) Government of India Cabinet

Available at: http://pib.nic.in/newsite/PrintRelease.aspx?relid=88755

[ccxxi] The Indian Express, September 20, 2016.

[ccxxii] The Indian Express, September 20, 2016.

[ccxxiii] Available at: http://www.hrln.org/hrln/labour-rights/pils-a-cases/878-national-campaign-committee-for-central-legislation-on-construction-labour-vs-union-of-india-a-ors.html.

[ccxxiv]http://www.esic.nic.in/press/PressRelease_Construction_workers%20(1).pdf

[ccxxv] The Times of India, Feb 2, 2018 Available at: https://timesofindia.indiatimes.com/india/national-health-protection-scheme-to-be-implemented-from-oct-2/articleshow/62757339.cms

[ccxxvi] (Sankaran 2013), pp.88.

[ccxxvii] (Sankaran 2013), pp.89.

[ccxxviii] (Neetha 2009), pp.505.

[ccxxix] (Braveman 2010), pp.37-38.

[ccxxx] (Graham 2009), pp.56.

[ccxxxi] (Graham 2009), pp.57.

[ccxxxii] (Graham 2009), pp.57-58.

[ccxxxiii] (Graham 2009), pp, 58.

[ccxxxiv] (Marmot 2005), pp.8.

Bibliography

1. Acharya, J. 2004. Methods and Materials on Marginal Workers'Experiences: Learning through Field Inquiry in Orissa. Economic and Political Weekly May 29, pp.2251-61.

2. Addlakha, R. 2001. Gender Blind or Gender Biased? Culture, Family and Patriarchy in Indian Psychiatry. Chapter X In Brigitte Sebastia (ed.) Restoring Mental Health in India: Pluralistic Therapies and Concepts. New Delhi: Oxford University Press, pp.253-284.

3. Alcoff, L., & Potter, E. 1993. Introduction: When Feminisms Intersect Epistemology. Chapter 1 in Linda Alcoff and Elizabeth Potter (ed.) Feminist Epistemologies. New York: Routledge, pp.1-14.

4. Alcoff, L A. 2006. Visible Identities: Race, Gender and The Self. New York: Oxford University Press, pp.1-290.

5. Anderson, B. 2001. Paying for Domestic Work. Gender and Development, 9(1), pp. 25–33.

6. Ayyar, V. 2013. Caste and Gender in A Mumbai Resettlement Site. Economic & Political Weekly (May 4) vol. xlviII no 18, pp.44-55.

7. Bambra, C. 2009. Changing the World? Reflections on The Interface between Social Science, Epidemiology and Public Health. Journal of Epidemiology and Community Health (1979), Vol. 63, No. 11 (November), Published by BMJ, pp. 867-868.

8. Bambra, C. 2011. Work, Worklessness and The Political Economy of Health. Conclusion Chapter. Published to Oxford Scholarship Online (January 2012), Access brought by Jawaharlal Nehru University, pp.1-8.

9. Bang, R., Khorgade, S., & Chinai, R. 2010. Putting Women First: Women and Health in a Rural Community. Kolkota: STREE, Chapters 1, 3 and 4, pp.3-27, 57-100.

10. Bartley, M., & Blane, D. 2009. Life-course Influences on Health at Older Ages. Chapter 1.2 in Hillary Graham (ed.) Understanding health inequalities. Berkshire: McGraw Hill Open University Press, pp.48-65.

11. Bartley, M., Sacker, A., & Schoon, I. 2002. Social and Economic Trajectories and Women's Health. Chapter in Diana Kuh and Rebecca Hardy (Ed.) A Life Course Approach to Women's Health. Published to Oxford Scholarship Online (September 2009) Access brought by Jawaharlal Nehru University, pp.1-19.

12. Basu, K., and Basu, S. 2000. Urban Poor Women: Coping with Poverty and Ill-health in Slums of Delhi. Social Change 30: 179.

13. Basu, R. & Thomas, M.D., 2009. Exploring Women's Daily Lives and Participation in The Informal Labour Market in Mumbai, India. Gender & Development, 17(2), pp.231–242.

14. Bartley, M., & Blane, D. 2009. Life-course Influences on Health at Older Ages. Chapter 1.2 in Hillary Graham (Ed.) Understanding Health Inequalities. Berkshire: McGraw Hill Open University Press, pp.48-65.

15. Bauer, G R. 2014. Incorporating Intersectionality Theory into Population Health Research Methodology: Challenges and The Potential to Advance Health Equity. Social Science & Medicine 110 10-17.

16. Benwell, B., & Stokoe, E. 2005. Discourse and Identity. Chapter I. Edinburgh: Edinburgh University Press Ltd., pp.17-47.

17. Bharat Jyoti. 2011. Report on Socio-economic Status of the Women Domestic Workers A Diagnostic Study in Five Major Townships: Cuttack, Bhubaneswar, Berhampur, Sambalpur and Rourkela of Orissa. Submitted to Ministry of Women and Child Development, GoI. [Online] Available at: http://www.esocialsciences.org/Download/repecDownload.aspx?fname=A20111018115544_20.pdf&fcategory=Articles&AId=4517&fref=repec

18. Bisht, R. 2004. Hill Women of Garhwal: A Study of Their Work and Health in The Context of Ecological Degradation and Male Out-migration. Unpublished Thesis Submitted to the Jawaharlal Nehru University (JNU) for the degree of Doctor of Philosophy. New Delhi: CSMCH, SSS, JNU, pp.316-324.

19. Bourdieu. 1977. Outline of A Theory of Practice. Cambridge Studies in Social and Cultural Anthropology, First Published in English translation, 1977, Chapter 2, pp.72-87.

20. Braveman, P., Egerter, S., & Williams, D R. 2011. The Social Determinants of Health: Coming of Age. Annual Review of Public Health, 32:381–98

21. Brenman, J. 2013. At Work in The Informal Economy of India. New Delhi: Oxford University Press. pp.26-43.

22. Browne, I., & Misra, J. 2003. The Intersection of Gender and Race in the Labor Market. Annual Review of Sociology, Vol. 29, pp. 487-513.

23. Cameron, R. 2011. Mixed Methods Research : The Five Ps Framework. Journal of Business Research Methods , 9(2), pp.96–108.

24. Census of India. 2011. [Online] Available at: http://censusindia.gov.in/

25. Chakravarti, U. 1993. Conceptualising Brahmanical Patriarchy in Early India: Gender, Caste, Class and State. Economic and Political Weekly, 28(14), pp.579–585.

26. Charmaz, K. 2016. Constructing Grounded Theory. London: Sage Publications, pp.1-183.

27. Chowdhury, S. 2011. Employment in India : What Does the Latest Data Show? Economic and Political Weekly, xlvi(32), pp.2009–2012.

28. Chen, M A., & Raveendran, G. 2012. Urban Employment in India: Recent Trends and Patterns. Margin: The Journal of Applied Economic Research 6:159.

29. Coelho, K., Venkat, T., & Chandrika, R. 2013. Housing, Homes and Domestic Work: A Study of Paid Domestic Workers from a Resettlement. Economic & Political Weekly (October 26) Vol. xlviiI No. 43, pp.39-46.

30. Crenshaw, K. 1991. Mapping the Margins: Intersectionality, Identity Politics and Violence Against Women of Colour. Stanford Law Review, 43(July), pp.1241–1299.

31. Committtee on Social Determinants of Health. 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: WHO. Chapters 3 & 7. [Online] Available at: http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf

32. Committee on Social Determinants of Health. 2007. A Conceptual Framework for Action on the Social Determinants of Health. Discussion paper for the Commission on Social Determinants of Health, DRAFT Last Version. Geneva: WHO. [Online] Available: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf (April, 2007)

33. Conaghan, J. 2009. Intersectionality and The Feminist Project in Law. Chapter 1 in Emily Grabham, Davina Cooper, Jane Krishnadas and Didi Herman (Ed.) Intersectionality and Beyond: Law, Power and The Politics of Location. New York: Routledge-Cavendish, pp.21-48

34. City Level Technical Cell, Cuttack. 2012 (February). Detailed Project Report on A Slum Free Cuttack Under Rajiv Awas Yojana. Implementing Agency, Cuttack Municipality Corporation. pp.1-19.

35. Dalmia, A. 2012. Strong Women, Weak Bodies, Muted Voices. Economic and Political Weekly, XLVII (26 & 27), pp.249–255.

36. Das, K., Das, K.B., & Mohanty, S. 2012. Social Security in Informal Sector: A Myth. Odisha Review September, pp.60-69.

37. Dhamoon, R K. 2011. Considerations on Mainstreaming Intersectionality. Political Research Quarterly, Vol. 64, No. 1, pp. 230-243.

38. Diamantopoulos, A., Rohde, G., Johnsrud, I., Skoie, IM., Hochberg, M., & Haugeberg, G. 2012. The Epidemiology of Low- and High-Energy Distal Radius Fracture in Middle-Aged and Elderly Men and Women in Southern Norway. PLOS One, August 24. [Online] Available at: https://doi.org/10.1371/journal.pone.0043367

39. Dong, X. 2005. Health, Long Workhours, Work Scheduling and Work-related Injuries Among Construction Workers in The United States. Scandinavian Journal of Work, Environment & Health, Vol. 31, No. 5 (October), pp. 329-335.

40. Doyal, L. 2000. Gender Equity in Health: Debates and Dilemmas. Social Science & Medicine (1982), 51(6), pp.931–9.

41. Doyal, L. 1995. What Makes Women Sick: Gender and The Political Economy of Health. New Jersey: Rutgers University Press. Chapters 1, 2 & 6. pp-1-57, 152-175.

42. Duffy, M. 2007. Doing The Dirty Work: Gender, Race, and Reproductive Labor in Historical Perspective. Gender and Society, Vol. 21, No. 3 (June), pp. 313-336.

43. Economic Survey, Government of India. 2012-13. [Online] Available at http://indiabudget.nic.in/survey.asp

44. Einspahr, J. 2010. Structural Domination and Structural Freedom: A Feminist Perspective. Feminist Review, 94(94), pp.1–19.

45. Flyvbjerg, B. 2006. Five Misunderstandings About Case-Study Research. Qualitative Inquiry, Vol. 12, No.2 (April), pp.219-245.

46. Folbre, N. 1994. Who Pays for The Kids? Gender and The Structures of Constraint, Chapter 1, pp.15-38.

47. Greene, J.C., Caracelli, V.J. & Graham, W.F. 1989. Toward a Conceptual Framework for Mixed-Method Evaluation Designs. Educational Evaluation and Policy Analysis, 11(3), pp.255–274.

48. Gibson, B., & Hartman, J. 2014. Rediscovering Grounded Theory. London: Sage Publications, Chapters 1-5 & 8-10, pp.1-99, 136-184.

49. Giddens, A. 1984. The Constitution of Society: Outline of The Theory of Structuration. University of California Press. Berkeley and Los Angeles, Chapter 1, pp.1-29.

50. Glaser, B. 2007. Constructivist Grounded Theory? Historical Social Research/ Historische Sozialforschung. Supplement No. 19, Grounded Theory Reader, pp. 93-105.

51. Glaser, B., & Strauss, A. 1967. The Discovery of Grounded Theory" Strategies for Qualitative Research. Chicago: Aldline Publishing, pp.1-160.

52. Gopal, M. 2006. Gender, Ageing and Social Security. Economic and Political Weekly, Vol.41, No.42 (Oct 21-27), pp.4477-86.

53. Government of Odisha. 2009. District Statistical Handbook Cuttack. Bhubaneswar: Directorate of Economics and Statistics, Odisha. pp.1-119.

54. Gothoskar, S. 2013. The Plight of Domestic Workers. Economic and Political Weekly, XLVIII (22) June1, pp.63–75.

55. Graham, H. 2004. Social Determinants and Their Unequal Distribution : Clarifying Policy Understandings. The Milbank Quarterly, 82(1), pp.101–24.

56. Groenmeyer, S. 2011. Intersectionality in Apartheid and Post-apartheid South Africa; Unpacking the Narratives of Two Working Women. Gender, Technology and Development 15(2), London: Asian Institute of Technology SAGE Publications, pp. 249–274.

57. Haan, A D., & Dubey, A. 2005. Poverty, Disparities, or the Development of Underdevelopment in Orissa. Economic and Political Weekly May 28-June 4, pp.2321-29.

58. Hancock, A. 2007. When Multiplication Doesn't Equal Quick Addition: Examining Intersectionality as a Research Paradigm. Perspectives on Politics, Vol. 5, No. 1 (March), pp. 63-79.

59. Hankivsky, O. 2012. Women’s Health, Men’s Health, and Gender and Health : Implications of Intersectionality. Social Science & Medicine, 74(11), pp.1712–20.

60. Haraway, D. 1988. Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. Feminist Studies, Vol. 14, No. 3 (Autumn), Published by Feminist Studies, pp. 575-99.

61. Harding, S. 1993. Rethinking Standpoint Epistemology: What Is "Strong Objectivity"? Chapter 3 in Linda Alcoff and Elizabeth Potter (ed.) Feminist Epistemologies. New York: Routledge, pp. 49-82.

62. Harris, J. 1989. Vulnerable Workers in The Indian Urban Labour Market. Chapter 10 in Gerry Rodgers (ed.) Urban Poverty and the Labour Market: Access to Jobs and Incomes in Asian and Latin American Cities. Geneva: International Labour Organisation, pp.217-263.

63. Harriss-White, B. 2004. India Working. New Delhi: Cambridge University Press. Chapters 1 and 2, pp.1-42.

64. Henderson, D., & Tickmayer, A. 2009. The Intersection of Poverty Discourses: Race, Class, Culture, and Gender. Chapter 3 in Bonnie Thornton Dill & Ruth Enid Zambrana (Ed.) Emerging Intersections: Race, Class and Gender In Theory, Policy and Practice. New Jersey: Rutgers University Press, pp.50-72.

65. Herod, A. 2003. Worker, Space and Labour Geography. International Labour and Working Class History, No.64, Fall 2003, pp.112-138.

66. Hsiung, PC. 2008. Teaching Reflexivity in Qualitative Interviewing. Teaching Sociology, Vol. 36, No. 3 (Jul., 2008), pp. 211-226.

67. Inhorn, M C. 2006. Defining Women's Health: A Dozen Messages from More than 150 Ethnographies. Medical Anthropology Quarterly, New Series, Vol. 20, No. 3, pp. 345-378.

68. Indian Labour Journal. 2013. Vol.54, No.2. Shimla: Labour Bureau, GoI.pp.121-25, 185-92.

69. Johnston, H B. 2009. Relationships of Exclusion and Cohesion with Health: The Case of Bangladesh. Journal of Health, Population and Nutrition, Vol. 27, No. 4, Special Issue: Social Exclusion: Inaugural Issue of the Gender Health and Human Rights Section (August), pp.426-440.

70. Jones, M., & Alony, I. 2011. Guiding the Use of Grounded Theory in Doctoral Studies – An Example from the Australian Film Industry. International Journal of Doctoral Studies, 6, pp.95–114.

71. Kabeer, N. (2016). Gender equality, economic growth, and women's agency: the "endless variety" and "monotonous similarity" of patriarchal constraints. Feminist Economics, Vol. 22, No. 1, 295–321.

72. Kachuk, B. 2003. Feminist Social Theories: Theme and Variations. Chapter 1 in Sharmila Rege (Ed.) Sociology of Gender: The Challenge of Feminist Sociological Knowledge. New Delhi: Sage Publications, pp. 53-85.

73. Kakad, K. 2002. Gender Discrimination in the Construction Industry: The Case of Two Cities in India. Gender Technology and Development, 6 (3): 355-72.

74. Kaiser, K. 2010. Protecting Respondent Confidentiality in Qualitative Research. National Institute of Health: Public Access Author Manuscript. Published in Qualitative Health Research. 2009 November 19(11), pp. 1632–41.

75. Kantor, P. 2002. A Sectoral Approach to the Study of Gender Constraints on Economic Opportunities in the Informal Sector in India. Gender & Society, Vol.16, No.3 (June), pp.285-302.

76. Karkal, M. 1999. Ageing and Women in India. Economic and Political Weekly, Vol. 34, No. 44 (Oct. 30 - Nov. 5), pp. WS54-WS56.

77. Kaur, A. 2010. Social Determinants of Health and Migrant Workers in South East Asia. Chapter in Sanjoy Bhattacharya, Sharon Messenger and Caroline Overy (Ed.) Social Determinants of Health: Accessing Theory, Policy and Practice (New perspectives in South Asian history). New Delhi: Orient Blackswan, pp.141-167.

78. Kaur, A. 2006. Indian Labour, Labour Standards, and Workers' Health in Burma and Malaya, 1900-1940. Modern Asian Studies, Vol. 40, No. 2 (May), pp. 425-475.

79. Kimberly, R., Arriola, J., Borba, P C., & Thompson, W W. 2007. The Health Status of Black Women. Black Women, Gender + Families, Vol. 1, No. 2 (Fall), pp. 1-23. Published by: University of Illinois Press

80. King, A. 2000. Thinking With Bourdieu Against Bourdieu: A 'Practical' Critique of the Habitus. Sociological Theory, Vol. 18, No. 3 (November), pp. 417-433.

81. Krieger, N. (2003). Gender, Sexes and Health: What Are The Connections and Why Does It Matter? International Journal of Epidemiology, 32 (4), 654-55.

82. Krieger, N., Alegría, M., Almeida-Filho, N., Barbosa da Silva, J., Barreto, ML., Beckfield, J., et.al . 2010. Who, and What, Causes Health Inequities? Reflections on Emerging Debates from An Exploratory Latin American/North American Workshop. Journal of Epidemiology and Community Health, 64(9), pp.747–749.

83. Kumar, N. 2006. The (No) Work and (No) Leisure World of Women in Assi, Banaras. Chapter 3 in Lina Fruzzetti & Sirpa Tenhumen (Ed.) Culture, Power and Agency. Kolkata: STREE, pp.52-89.

84. Kumar, R., Kumar, S., & Mitra, (2009) A. Social and Economic Inequalities: Contemporary Significance of Caste in India. Economic and Political Weekly, Vol. 44, No. 50 (December 12-18), pp. 55-63.

85. Kuh, D., & Hardy, R. 2002. A Life Course Approach to Women's Health: Linking The Past, Present, and Future. Published to Oxford Scholarship Online (September 2009), Access brought by Jawaharlal Nehru University, pp.1-20.

86. Labonte, R., & Schrecker, T. 2007. Towards Health-Equitable Globalisation: Rights, Regulation and Redistribution, Final Report to the Commission on Social Determinants of Health. Ottawa: Institute of Population Health. [Online] Available: http://www.who.int/social_determinants/resources/gkn_report_06_2007.pdf (June, 2007)

87. Lakhani, R. 2004. Occupational Health of Women Construction Workers in Unorganised Sector. Journal of Health Management. 6:187.

88. Lan, P. 2003. Negotiating Social Boundaries and Private Zones: The Micropolitics of Employing Migrant Domestic Workers. Social Problems, Vol. 50, No. 4 (November), pp. 525-549.

89. Laslett, B. 1990. Structure, Agency, and Gender: The Social Reproduction of A Discipline. Sociological Forum, Vol. 5, No. 1, pp. 135-41.

90. Leatherman, T. 2005. A Space of Vulnerability in Poverty and Health: Political-Ecology and Biocultural Analysis. Ethos, Vol. 33, No. 1, Special Issue: Building Biocultural Anthropology (Mar., 2005), pp.46-70.

91. Lingam, L. 1994. Women-Headed Households: Coping with Caste, Class and Gender Hierarchies. Economic and Political Weekly, Vol. 29, No. 12 (March19), pp. 699+701-704.

92. Lingam, L. 2006. Gender, Households and Poverty: Tracking Mediations of Macro Adjustment Programmes. Economic and Political Weekly, May 20, pp.1989-98.

93. Lingard, L., Albert, M., & Levinson, W. 2008. Qualitative Research: Grounded Theory, Mixed Methods, and Action Research. British Medical Journal, Vol. 337, No. 7667 (August 23), Published by BMJ, pp. 459-61.

94. Luna, F. 2009. Elucidating the Concept of Vulnerability: Layers Not Labels. International Journal of Feminist Approaches to Bioethics, Vol.2, No.1, Transnational Dialogues (Spring 2009), pp.121-39.

95. Mahmood, S. 2004. Women's Agency within Feminist Historiography. The Journal of Religion, Vol. 84, No. 4 (October), pp. 573-79.

96. Mahmood, S. 2005. Politics of Peity: The Islamic Revival and The Feminist Subject. Princeton: Princeton University Press, Chapters 1 & 5, pp.1-39, 153-88.

97. Marmot, M., Friel, S., Bell, R., Houweling, T. a J., & Taylor, S. 2008. Closing The Gap in A Generation: Health Equity Through Action on The Social Determinants of Health. Lancet, 372(9650), pp.1661–69. [Online] Available: http://doi.org/10.1016/S0140-6736(08)61690-6 (November 2008)

98. Marmot, M., and Wilkinson, R. 2005. Health and Labour Market Disadvantage: Unemployment, Non-employment, and Job Insecurity. Published to Oxford Scholarship Online (September 2009) Access brought by Jawaharlal Nehru University, pp.1-22.

99. McCall, L. 2001. Gender, Class and Race in the New Economy. New York: Routledge, pp. 3-202.

100. McCall, L. 2005. The Complexity of Intersectionality. Signs, Vol. 30, No. 3 (Spring), pp. 1771-1800.

101. McGibbon, E., Francis, S., & McPherson, C. 2010. Applying Intersectionality & Complexity Theory to Address the Social Determinants off Women's Health. Nova Scotia: St. Francis Xavier University, pp.59-86.

102. Mehrotra, S. 2010. Domestic Workers: Conditions, Rights and Responsibilities. New Delhi: Jagori. pp.1-58.

103. Mehrotra, S., & Biggeri, M. 2007. Asian Informal Workers Global Risks, Local Protection. London: Routledge Publications, pp.3-18.

104. Mehrotra, R. 2000. A Study of Illness, Disease and Well-being Among A Group of Construction Workers in their Sociological Ecological Context, Unpublished Thesis Submitted to the Jawaharlal Nehru University (JNU) for

the degree of Doctor of Philosophy. New Delhi: CSMCH, SSS, JNU, pp.147-58.

105. Messing, K., & Silverstein, B A. 2009. Health Gender and Occupational Health. Scandinavian Journal of Work, Environment & Health, Vol. 35, No. 2 (March), pp. 81-83.

106. Meyer, J. W., & Jepperson, R.L. (2000). The "Actors" of Modern Society: The Cultural Construction of Social Agency. Sociological Theory 18:1, pp.100-120.

107. Mitra, A. 2006. Labour Market Mobility of Low Income Households. Economic and Political Weekly, Vol. 41, No. 21 (May 27 - June 2), pp. 2123-30.

108. Mitra, A. 2006. Size of Informal Sector. Economic and Political Weekly, June 24, pp.2682-83.

109. Ministry of Labour & Employment, Government of India. 2010. Wage Rates in Rural India (2008-09). Shimla: Labour Bureau, pp.4-12.

110. Ministry of Labour & Employment, Government of India. 2009. Occupational Wage Survey Sixth Round. Shimla: Labour Bureau, GoI. pp.1-20.[Online] Available at: www.labourbureaunew.gov.in

111. Ministry of Law & Justice, GoI. 2008. The Unorganised Workers Social Security Act 2008 Act No.33 of 2008. New Delhi: Ministry of Law & Justice. pp.1-9. [Online] Available at: http://lawmin.nic.in/ld/P-

112. Ministry of Urban Development, Government of India. 2013. Rapid Baseline Assessment - Cuttack City Draft Report. CRISIL Risk and Infrastructure Solutions Ltd., pp.54-64.

113. Ministry of Women and Child Development, Government of India. 2009. Gendering Human Development Indices: Recasting the Gender Development Index and Gender Empowerment Measure for India. Summary Report, pp.1-16.

114. Mohankumar, S., & Singh, S. 2011. Impact of the Economic Crisis on Workers in the Unorganised Sector in Rajasthan. Economic & Political Weekly (May 28) vol xlvi no 22, pp.66-71.

115. Mohanty, T C. 1984. Under Western Eyes: Feminist Scholarship and Colonial Discourses. Boundary 2, 12(3), 333–59.

116. Mohanty, S. 2001. A Sociological Study of Lives of the Household Maids from Slums in Cuttack city, Unpublished Dissertation Submitted to the Jawaharlal Nehru University for the degree of Master of Philosophy. New Delhi: CSMCH, SSS, JNU, pp.32-43.

117. Mruck, K., & Breuer, F. Subjectivity and Reflexivity in Qualitative Research — A New FQS Issue. Historical Social Research / Historische Sozialforschung, Vol. 28, No. 3 (105), 189-212.

118. Nash, J C. 2008. Re-thinking Intersectionality. Feminist Review, No. 89, Published by Palgrave Macmillan Journals, pp. 1-15.

119. Navarro, V. 2009. What We Mean By Social Determinants of Health. International Journal of Health Services, Volume 39, Number 3. pp 423-41.

120. NCEUS. 2007. Report on Conditions of Work and Promotion of Livelihoods in the Unorganised Sector. Chapters 1, 2, 3 & 5. Appendix Tables. New Delhi: National Commission for Enterprises in the Unorganised Sector, GoI. Pp. 1-48, 75-92, 241. (Online) 2007. [Online] Available from: http://dcmsme.gov.in/Condition_of_workers_sep_2007.pdf

121. National Sample Survey Office. 2013. NSS 68th Round: Key Indicators of Employment and Unemployment in India (July 2011-June 2012). New Delhi: National Sample Survey Office, Ministry of Statistics and Programme Implemenation, GoI. (June), pp.1-104.

122. National Sample Survey Office. 2011. NSS 66th Round: Employment and Unemployment Situation in India (July 2009-June 2010). New Delhi: National Sample Survey Office, Ministry of Statistics and Programme Implemenation, GoI. (November), pp.67-97, 197-205.

123. National Sample Survey Office. 2011. State Sample Report of NSS 66th Round. (2009-10) on Employment and Unemployment Situation in Odisha. Bhubaneswar: Directorate of Economics and Statistics, Govt. of Odisha, pp.1-59.

124. National Sample Survey Organisation. 2001. Informal sector in India, 1999–2000: Salient features, NSS 55th round (1999–2000). Report no. 459(55/2.0/2), May. New Delhi: NSSO.

125. Neetha, N. 2006. 'Invisibility' Continues? Social Security and Unpaid Women Workers. Economic and Political Weekly, Vol. 41, No. 32 (Aug. 12-18), pp. 3497-99.

126. Patel, A M., & Hans, A. 2004. A Situational Analysis of Women and Girls in Orissa. New Delhi: National Commission for Women. [Online] Available at: http://ncw.nic.in/pdfReports/Gender_Profile_Orissa.pdf

127. Patel, V., Kirkwood, B., Weiss, H., Pednekar, S., Fernandes, J., Pereira, B., et.al. 2005. Chronic Fatigue In Developing Countries: Population Based Survey Of Women In India. British Medical Journal, Vol. 330, No. 7501 (May 21), pp. 1190-93.

128. Population Council. 2007. The World Health Organization on Health Inequality, Inequity and Social Determinants of Health. Population and Development Review, 33(4), pp.839–43.

129. Pani, N., & Singh, N. 2012. Women At The Threshold of Globalisation. New Delhi: Routledge, pp.16-60.

130. Papola, T S. 2013. Role of Labour Regulation and Reforms in India: Country Case Study on Labour Market Segmentation. Geneva: International Labour Office. Employment Working Paper No. 147, pp.1-22.

131. Paul, B., Bhirdikar, K., Shabnam, S., Mukherjee, P., Krishna. M., Bharadwaj, R, et.al. 2008. Indian Labour Market. Deonar: TISS & ADECCO Institute, pp.1-76.

132. Putnam, S., and Galea, S. 2008. Epidemiology and The Macrosocial Determinants of Health. Journal of Public Health Policy, Vol. 29, No. 3 (September), pp. 275-89.

133. Raju, S. 2013. The Material and The Symbolic Intersectionalities of Home-Based Work in India. Economic & Political Weekly (January 5) Vol xlviIi 60 No.1, pp.60-68.

134. Ramalho, R., Adams, P., Huggard, P., & Hoare, K. 2015. Literature Review and Constructivist Grounded Theory Methodology. Volume 16, No. 3, Art 19, September, pp.1-13.

135. Razavi, S., & Miller, C. 1995. From WID to GAD : Conceptual Shifts in the Women and Development Discourse. Geneva: United Nations Research Institute for Social Development, pp.1-44.

136. Rege, S., Devika, J., Kannabiran, K., John, M E., Swaminathan, P., & Sen, S. 2013. Intersections of Gender and Caste. Economic and Political Weekly Vol. XLVIII, No.18 (May 4), pp.35-36.

137. Ridgeway, C. 2009. Framed Before We Know It: How Gender Shapes Social Relations. Gender and Society, Vol.23, No.2, pp.145-160.

138. Roth, P. 1989. How Narratives Explain. Social Research, Vol.56, No.2, Explanation (Summer), Published by New School, pp.449-78.

139. Roth, WM. 2005. Ethics as Social Practice: Debating Ethics in Qualitative Research. Historical Social Research, Vol. 30, No. 1 (111), Qualitative Social Research, pp.157-67.

140. Sachs, GA., Hougham, GW., Sugarman, J., Agre, P., Broome, ME., Geller, G, et.al. 2003. Conducting Empirical Research on Informed Consent: Challenges and Questions. IRB: Ethics & Human Research, Vol. 25, No. 5, Supplement (Sep. - Oct.), pp. S4-S10.

141. Sahoo, K C., Hulland, K R S., Caruso, B A., Swain, R., Matthew C. Freeman, M C., et.al. 2015. Sanitation-related Psychosocial Stress: A Grounded Theory Study of Women Across The Life-course in Odisha, India. Social Science & Medicine 139, pp.80-89.

142. Saldaña, J. 2009. The Coding Manual for Qualitative Researchers. Sage Publications. New Delhi: Thousand Oaks. Chapters 1-5, Appendices A-C, pp.1-203

143. Savas, G. 2010. Social Inequality at Low-wage Work in Neo-liberal Economy: The Case of Women of Color Domestic Workers in The United States. Race, Gender & Class, Vol. 17, No. 3/4, Race, Gender & Class Conference (2010),pp. 314-26.

144. Sangster, J. 2006. Telling Our stories: Feminist Debates and The Use of Oral History. Women's History Review, Volume 3, Number 1, 1994. Published Online 20 Dec 2006. pp.5-28. Access brought by Azim Premji University.

145. Sankaran, K. 2013. Domestic Work, Unpaid Work and Wage Rates. Economic & Political Weekly October 26, vol xlviiI no 43, pp. 85-89.

146. Schenk, H. 2001. Living in India's Slums: A Case Study of Bangalore. New Delhi: IDPAD & Manohar Publications. Chapters 1 & 7, pp.17-37, 135-216.

147. Sen, G., Ostlin, P., George, A., Cook, R., Keleher, H., Dwyer, J., & Krantz, G. 2007. Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health : Why It Exists and How We Can Change It. Final Report to the WHO Commission on Social Determinants of Health. Bangalore & Stockholm: Indian Institute of Management & Karolinska Institutet. [Online] Available at: http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf (September, 2007)

148. Sewell, W H Jr. 1992. A Theory of Structure: Duality, Agency, and Transformation. American Journal of Sociology, Vol. 98, No. 1 (July), Published by The University of Chicago Press, pp. 1-29.

149. Shaw, J. 2007. Garment Workers in Sri Lanka's Export Processing Zones 'There is No Work in My Village': The Employment Decisions of Female Journal of Developing Societies, 23: 37.

150. Smith, D E. 2009. Categories Are Not Enough. Gender and Society, Vol. 23, No. 1 (February), pp. 76-80.

151. Soundararajan, V. 2013. Construction Workers: Amending the Law for More Safety. Economic & Political Weekly June 8, Vol xlviII no 23, pp.21-25.

152. Talpade, M. C. 1984. Under Western Eyes: Feminist Scholarship and Colonial Discourses. Boundary 2, 12(3), pp. 333–59.

153. Thukral, J. 2010. Race, Gender, and Immigration in The Informal Economy. Race/Ethnicity: Multidisciplinary Global Contexts, Vol. 4, No. 1, The Intersection of Race and Gender (Autumn 2010), pp. 65-71.

154. Timmermans & Tavory. 2012.Theory Construction in Qualitative Research: From Grounded Theory to Abductive Analysis, Sociological Theory 30(3) 167–186.

155. Vijay, D. 2013. Structure and Mobility in A Delhi Slum: 1988-2013. Social Change 43: 595.

156. Vlassoff, C. 2007. Gender Differences in Determinants and Consequences of Health and Illness. Journal of Health, Population and Nutrition, Vol. 25, No. 1 (March), pp. 47-61.

157. Walters, V and Charles, N. 1997. I Just Cope From Day to Day: Unpredictability and Anxiety in The Lives of Women. Social Science Medicine. Journal Vol. 45, No. 11, pp. 1729-39.

158. Wrigley-Asante, C. 2013. Unraveling The Health-related Challenges of Women in The Informal Economy: Accounts of Women in Cross-border Trading in Accra, Ghana. Geo Journal (2013) 78:525–37. Published online: 22 February 2012.

a. Government Schemes/Lists/Press Releases Online

159. Indira Gandhi National Old Age Pension Scheme & Indira Gandhi Disability Pension Scheme Under National Social Assistance Scheme. 2009. [Online] Available at: http://www.nsap.nic.in

160. ILO 102, refer Article 10, Social Security (Minimum Standards) Convention, 1952 (No.102) Convention concerning minimum standards of social security (entry into force: 27 April 1955) Adoption: Geneva, 35th ILC session (28 Jun 1952) http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312247

161. The Unorganised Workers Social Security Act 2008 Act No.33 of 2008, pp.2. Available at: http://lawmin.nic.in/ld/P-ACT/2008/The%20Unorganised%20Workers%E2%80%99%20Social%20Security%20Act,%202008.pdf

162. LIST of SCs for State of Andhra Pradesh, Ministry of Social Justice and Empowerment, GoI, Entry 35-Mala Available at: http://www.socialjustice.nic.in/writereaddata/UploadFile/Scan-0001.jpg

163. LIST of SCs for State of Andhra Pradesh, Ministry of Social Justice and Empowerment, GoI, Entry 14-Chamar, Entry 4 & 6-Aray & Arwa Mala Available at: http://www.socialjustice.nic.in/writereaddata/UploadFile/Scan-0001.jpg

164. LIST of SCs for State of Odisha, Ministry of Social Justice and Empowerment, GoI, Entry 10-Bauri, Entry 26-Dhoba Available at: http://www.socialjustice.nic.in/writereaddata/UploadFile/RL-Odisha.jpg

165. CENTRAL LIST of OBCs for State of Odisha, Gouda Entry 43 Available at: http://www.stscodisha.gov.in/Pdf/OBC_list.pdf

166. LIST of SCs for State of Odisha, Ministry of Social Justice and Empowerment, GoI, Entry 26-Dhoba Entry 162- Teli Available at: http://www.socialjustice.nic.in/writereaddata/UploadFile/RL-Odisha.jpg

167. Available at: http://www.thehindu.com/news/national/other-states/odisha-govt-announces-raise-in-minimum-wages/article7161864.ece#!

168. The Indian Express, September 20, 2016.

169. Available at: http://www.hrln.org/hrln/labour-rights/pils-a-cases/878-national-campaign-committee-for-central-legislation-on-construction-labour-vs-union-of-india-a-ors.html.

170. The Building and Other Construction Workers' Welfare Cess Act, 1996 act no. 28 of 1996 [19th August, 1996.] Available at: http://lawmin.nic.in/ld/P-ACT/1996/The%20Building%20and%20Other%20Construction%20Worker's%20Welfare%20Cess%20Act,%201996.pdf

171. (Press Information Bureau Nov 1 2012) Government of India Cabinet Available at: http://pib.nic.in/newsite/PrintRelease.aspx?relid=88755

172. Employee State Insurance Corporation Available at: http://www.esic.nic.in/press/PressRelease_Construction_workers%20(1).pdf

173. The Times of India, Feb 2, 2018 Available at: https://timesofindia.indiatimes.com/india/national-health-protection-scheme-to-be-implemented-from-oct-2/articleshow/62757339.cms

Appendix I: Table

Women's current work type and current work cross tabulation

	Salaried	Wage worker	Own business	Helps in family business	Domestic helper remuneration in kind	NA	Total
NA(non-worker)	0	0	0	12	0	170	182
Construction worker	0	96	0	0	0	0	96
Domestic worker	138	1	0	0	0	0	139
Marriage helper	0	4	0	0	0	0	4
Home based worker	0	4	0	0	0	0	4
Own business	0	0	28	2 (paid, not solo enterprise)	0	0	30
Municipality sweeper	5	0	0	0	0	0	5
Hospital sweeper	7	0	0	0	0	0	7
School or college helper	8	0	0	0	0	0	8
Cook	4	0	0	0	0	0	4
Rag picker	0	3	0	0	0	0	3
Godam helper	0	1	0	0	0	0	1
Masseur	1	2	1	0	0	0	4
Hotel helper	1	2	0	0	0	0	3
Tailor	0	0	3	0	0	0	3
Any other	4	0	0	0	1	0	5
Total	168	113	32	14	1	170	498

[Note: One domestic worker earned wages than salary since she worked occasionally as a substitute for a known friend cum domestic worker from the slum and earned some money on those days. She combined this with wage work of marriage helper in certain months of a year. 2 vending business women worked as helpers for their family businesses run by male members and earned some money for their personal expenses]

Appendix II: Survey Schedules

The close ended options particularly in case of questions on work and reasons for her work change were outnumbered by the varying responses that came during survey. The pilot survey modification could not anticipate these many responses for these questions. These were captured as a field note on the schedule sheet and there after, during data coding these responses were included in answer options for this particular question. Field notes on slum dwelling, which included water supply, toilet facility, bathing area, arrangement of houses, common area, etc. were taken during survey.

Slum Name
Cluster/lane or gully Name
Household No./Landmark

Name

Age (in years)

1) less than 25
2) 25-less than 35
3) 35-less than 45
4) more than 45

Odiya?

1) yes (2) no

Place of origin Odisha

1) Andhra Pradesh
2) Bihar
3) Others

Applicable for non-Odiya only,

1) Migrated person NA, for Odiyas
2) Yourself (marriage, employment)
3) Father

4) Grandfather/great grandfather

No. of years in this slum

1) <5
2) 5<10
3) 10<20
4) 20<30
5) >30

Caste status

1) General
2) OBC
3) SC-Harijan
4) ST-Adivasi

Religion status

1) Hindu
2) Muslim
3) Christian
4) any other

Marital status

1) married
2) widowed
3) separated/divorced
4) unmarried

Education status

1) did not go to school, illiterate
2) went to school, but cannot read or write
3) Std. I-V

4) Std. V-VIII

5) any other

Work status

1) yes (2) no

No. of working days last month

1) 30-31 days

2) 26-29 days

3) 16-25 days

4) 10-15 days

5) less than 10 days

6) NA

No. of working months last year

1) worked for 6 months or more

2) worked for less than 6 months

3) NA

Present occupation/s Main work

1) construction work

2) domestic work

3) light loading

4) home-based work

5) business

6) any other

7) NA

Specify the secondary work or, occupation

1) does not do secondary work

2) light loading

3) home-based work

4) any other

Years of present occupation

1) less than one month

2) 1 month <1 year

3) 1 year <4 years

4) 4-10 yrs

5) >10 yrs

6) NA

Present work type

1) salaried work

2) wage work

3) business

4) home-based work

5) NA

Woman's earnings per month (in Rupees)

1) <1000

2) 1000<2000

3) 2000<3000

4) 3000<4000

5) >4000

6) NA

Work timings

Morning shift------------------------

Afternoon shift------------------------

Main work location

(distance in minutes)

-------minutes

Mode of commuting

(1) walk (2) bus (3) rickshaw

(4) dual or multiple modes

Past occupation/s

1) NA
2) construction work
3) domestic work
4) light loading
5) home-based work
6) business
7) any other

Years of past occupation

1) NA
2) less than one month
3) 1 month <1 year
4) 1 year <4 years
5) 4-10 yrs
6) >10 yrs

Reasons for changing occupation

1) NA
2) more income
3) work demands at home
4) marriage

5) health reasons
6) problem of commuting or travelling to work place
7) any other

Age (years) at which changed occupation

1) NA
2) <25
3) 25<35
4) 35 or more

Husband's paid work status

1) NA, when separated, divorced or widowed
2) yes
3) no

Husband's work type

1) NA, when separated, divorced or widowed
2) wage labour
3) salaried work
4) business
5) any other

Husband's monthly income

1) NA
2) <1000
3) 1000<2000
4) 2000<3000
5) 3000<4000
6) >4000

No. of family members

Adults-

Children-

Average family income per month in last 6 months

1) 2000 or less
2) 2001-4000
3) 4001-6000
4) 6001-8000
5) >8000
6) Other

Appendix III: Case Study Interviews

General Guidelines

1. Starting off with self-intoduction and then declaration of the study purpose which is like: How are you? Iam so and so, doing this study for my Ph.d. We had last met during my earlier data collection for survey. Usually a counter question, yes you had spoken then, written down something. What else would you want to know? I explain that this is to know more about her life, work and health. Would you have some time to talk about it? If answered yes, then I ask, "When can I come, which time would be convenient for you? Will you be available here?"
2. Declaration of the study purpose was followed by seeking voluntary participation. Informed consent was taken verbally as well as in written, I had to tell what was written in Odiya in the consent letter since none of them knew how to read. Few signed their names as signature which they had learnt, but did not know how to read.
3. At the scheduled time the interview sittings took place or at times while on way to meet another respondent a little chit-chat happened and then, next appointment for interview was taken.
4. At least 3 sittings with duration ranging from 30-60 minutes.
5. Accompanying field notes as observation from field were taken.
6. General questions helped in making the respondent comfortable and usually, respondent spoke on their own to these questions. And thereafter specific questions were asked. Probe questions were used accordingly.
7. Recapitulation of previous interview was a followed practice before starting the next interview.
8. Cautious to keep the interview mostly free-flowing conversation manner

General Questions

Tell me about yourself, your life, your family, work.

Specific Questions

You had earlier said this about your present work/status, isn't it?-------------------------

For how long have you been working so?--

You had earlier said this about your past work, so, what really happened?--------------

When Required, Probe questions

- You said you were not well and then shited or left work? What happened?...You said you did it for work demands at home? What happened? ….
- Were you ever sick and hospitalised?....Where did you go?...How long?.....Why did you fall sick then?
- Tell me about your daily schedule, when do you get up, what all do yo do, when do you come back, go to sleep?....
- Who all are there in your family? So, who is the elder one?...When did you get married?...What does your husband do?.....How long in this house?....Rented or Own?…
- When will you have lunch?....And cooking?....Again cook for dinner?....Breakfast?...
- Did you take a loan ever? ….When?....Why?....How much interest?....
- How did you get this work? ...Oh…So, you still go there?...No, what happened?...
- What all work you do at work place?....How do you get paid?....

Further probe questions were related to specific responses by the respondents.

Recapitulative statements before subsequent interviews (sittings)

- You had in our previous meeting said that this happened and then, this happened and then, this happened? …..Hmmm….No, this was before or after?....Then, in between what happened? Why did you change work?