EMPLOYMENT AND HEALTH- A COMPARATIVE STUDY OF HOUSEWIVES AND WORKING WOMEN IN ANUSHAKTI NAGAR, MUMBAI

Dissertation Submitted to the Jawaharlal Nehru University in partial fulfillment of the requirements for the award of the degree of

MASTER OF PHILOSOPHY

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CERTIFICATE

This dissertation entitled "**Employment and Health- A Comparative Study of Housewives and Working Women in Anushakti Nagar, Mumbai**" is submitted in partial fulfillment of six credits for the award of the degree of **Master of Philosophy (M. Phil.)** of this University. This dissertation has not been submitted for the award of any other degree of this University or any other university and is my original work.

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We recommend that this dissertation be placed before the examiners for evaluation.

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Saman Afroz

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INTRODUCTION

The status of women has changed over time. Earlier women were confined to the four walls of the house and were expected to perform only the household chores. But now, a woman's role has extended beyond the domestic domains. Today's women are employed as wage earners in myriad occupations ranging from industry, medicine, research, computers, media and agriculture. But this doesn't free her from her traditional roles of looking after her family, cooking food and managing the household after coming back from work. As a result she is stuck in striking a balance between her family and work front and end up facing a **Role Strain** which is often due to the stress that she faces in balancing the multiple roles of a wife, mother, daughter, daughter-in-law and above all that of an employee. However, some women are effectively able to combine these different roles, in fact they are able to compensate the dissatisfaction that they get in coping up with one role with the satisfaction that they derive in performing the other role. This is called **Role Enhancement.** The present study thus, attempts to observe these phenomena of role stress and role enhancement among women belonging to different socio-economic groups and tries to see the effect of these two on the health of women. This has been done by comparing the health of housewives who has lesser number of roles to perform with that of a working woman who has to perform an additional role of an employee.

This dissertation tries to capture the result of the above mentioned study in terms of the experiences of these women and their endeavors in battling with the multiple roles, it also tries to examine the effect of these on their health. Besides it also attempts to suggest some measures in helping women cope up with the stress of handling the multiple roles and thus minimizing the negative impact of role stress on their health.

Chapterization

The study presented in this dissertation has been given in seven chapters.

The **first chapter** attempts to review relevant literature that introduces the problem and helps to understand it better. It also reviews some relevant international and national studies done on the theme and related themes.

The **second chapter** on methodology of the study, first conceptualizes the problem under study; it then talks about the aims, objectives, place of the study and the methods used in data collection and data analysis. It also talks about the limitations and problems faced during the study.

The **third chapter** gives a brief description of the socio-economic profile of the respondents which includes information about their age, education, income, occupation and familial backgrounds. It also tries to draw relation between variables, like education and income, education and family size which helps in better understanding of the socioeconomic background of the respondents. Besides, it tries to analyze the contribution of the working women to their family income. Information in the chapter has been presented in three sections namely: demographic details, education and income and work and employment.

The **fourth Chapter** brings about the overall difference in the health of working women and housewives. Health has been measured by self reported morbidity and self perceived health status. It then tries to explore the first level of explanation for the health and ill health of the women of these two groups by looking at their health seeking behavior, health related behavior, leisure time and activities, sleeping pattern etc.

The **fifth chapter** looks at the health differentials of working women and housewives belonging to different socio-economic backgrounds. This has been done by looking at the health status, health seeking behaviour and health related behaviour of women of the two categories belonging to the high, middle and low socio-economic backgrounds.

The **sixth chapter** further explores the reason for the differentials in the health of working women and housewives by looking at the phenomena of Role Stress and enhancement faced by the women of the two categories and the factors contributing the same. This has been done by looking at the association of different variables like age, education, income, family support, domestic maid, leisure time, health related behaviors, job satisfaction, travel time etc. with Role Stress and Role enhancement. Lastly, the chapter tries to see the effect of Role Stress and Role enhancement on the health of women. Some of the aspects covered in this chapter are also depicted by some interesting case studies of women battling with multiple roles and having poor health. Some case studies also depict the beneficial effects of multiple roles on a woman's health and well being.

Finally, the seventh chapter on **Conclusion and Suggestions** sums up the major findings of the study and discusses the reasons for the same. It also tries to suggest some solutions to mitigate the problem and brings forth issues which needs consideration for further research in the area.

CHAPTER I

REVIEW OF LITERATURE

The present chapter has been divided into two parts. The first part reviews various literature that helps in better understanding of the problem under study and the next section reviews some national and international studies done in the field and related field.

The Gender Division of Labour

Nature has defined the sexes. In spite of this fact, or rather because of it, woman is a human being and hence at the apex of the living species. As a human being there are more similarities than dissimilarities between man and woman, which fact is usually overlooked. The impact of dissimilarities has been too heavy on woman hood as it is mainly because of these dissimilarities that the gender division of labor is constructed (Hate A, 1969).According to this division of labor on the basis of sexes, the woman is primarily responsible for the reproductive task of giving birth to child, along with the associated tasks of child rearing, cooking, cleaning, child care, looking after the old and sick, running the household etc. and the men are primarily held responsible for productive tasks of being a wage earner (Moore H, 1988). While the productive tasks are carried in public sphere, reproductive tasks are carried in private sphere. Engel explained this division of labor as a pure and simple outgrowth of nature which existed only between the sexes. The men went to war, hunted, fished, provided raw material for food and the tools necessary for these pursuits. The women cared for the house, and prepared food and clothing, they cooked, weaved and sewed. Each was master in his or her own field of activity, the men in the forest, and the women in the house. Each owned the tools he or she made and used: the men, the weapons and the hunting and fishing tackle, the women the household goods and utensils (Engels, 1972).

In present times this gender division of labor has been altered to some extent with the women entering into the male's domain of productive tasks (These women will be hence forth referred as working women). However, her reproductive responsibilities still remains the same. It is mainly because of this that the working women of today are finding it very difficult to combine the productive and reproductive tasks, as several roles are associated with each of these tasks. Hence, the intact and rigid nature of the traditional roles of male and female is the major reason for the Double- burden

of work or Role strain which is being faced by most of the working women of today. Before, entering into this discussion it would be useful to understand the concept of Role.

Concept of Status & Role

The International Encyclopedia of Social Sciences defines **Role** as a, "*A set of norm (obligations or expectations) attached to an individual's social position, occupation, or relationship status. People are motivated to adhere to norms and perform roles in order to win approval, avoid social penalties and win self esteem*" Weber Ann, 2001:1135). Roles are indicators of a person's way of living as a member of the society. According to Ralph Linton 1936) an eminent anthropologist, *the term "role" refers to the behavioural prescription bearing one to one correspondence with social status. For e.g. The status of a wife demands a typical "role playing" from the status holder in accordance to the norms of the society. Hence, the term status and roles are very closely related.* He further explained this relationship between status and role by saying

"A status, as distinct from the individual who may occupy it, is simply a collection of rights and duties.. A role represents the dynamic aspect of status. The individual is socially assigned to a status and occupies it with relation to their statuses. When he puts the rights and duties which constitute the status into effect, he is performing a role. Roles and statuses are quite inseparable. There are no roles without statuses and no statuses without roles (Linton, 1936:113).

Linton went on to observe that each person in the society inevitably occupies multiple statuses and that for each of these statuses there is an associated role. In other words, all members of society has multiple role therefore the status of wife, mother, an employee all demand different roles attached to them. Merton, gives examples of such distinct statuses in which the individuals finds themselves and calls them multiple roles of an individual. These roles are carried out in the spaces allocated to people. Traditionally men occupy the public space and the women occupy the private space. But when the latter steps out of private space to public space, she can neither leave the private space completely nor can she exclusively confine herself to public space. As a result women working in the public space continue to be recognized only as mothers

and wives and bear the brunt of this public/private distinction as housewives, confined to private space and they are regarded as secondary earners. Hakim says, part time employment simply reduces the pressure on husbands wage without increasing wives influence over finances (Hakim C, 1996).

The relationship between status and roles is stated most simply by the International Encyclopedia of Social Sciences according to which, "*Status refers to an individual's position in a social structure, where as role refers to the behavior that is expected of someone who occupies a given status*". (Abbel H, 2001:1360).

The interdependent nature of status and role has also been expressed by Oppong, according to whom, *Status is not a unidimensional concept, but that women hold a configuration of statuses associated with roles that change over the course of their lives. Similarly, roles are not isolated phenomena but are associated with the social contexts and situations in which they are embedded* (Oppong C and A Katherine, 1998:2).

It's mainly because of this inseparable nature of status and roles, it is imperative to understand the status and position of women in the present society, in order to understand her present roles.

Status and Role of women in India- Past and Present

According to Thapar (1975) The role, status and position of women has been far from static, ranging from what is thought to have been a position of considerable authority and freedom to one of equally considerable subsistence (Thapar R, 1975).This variation in women's status occurs is mainly because of the wide variation of cultural milieu, family structure, class, caste, property rights and morals found in the Indian Subcontinent.

In order to have a better understanding of the present social structure and the position of women therein, it is imperative to know the operation of various historical, political, cultural and economic factors molding the society. It is crucial to look at the past society because some of the norms and values affecting women today have their roots in the past(Desai and Krishnaraj,2004).However, it's not been easy to review

women's status across historical phases. This has rightly been put by Professor Shrinivas according to whom *"The changing position of Indian women has many facets and generalization is well nigh impossible because of the existence of considerable variations among regions, between rural and urban areas, among classes, and finally among different religious, ethnic and caste groups. While in certain contexts the Indian subcontinent is a single cultural region, in many others it is heuristically more rewarding to look upon it as a congeneries of micro-regions, differences between which are crucial"*(Shrinivas M.N., 1978).

Historian Romila Thapar also refers to the same predicament when she remarks: "*Within the Indian sub-continent there have been infinite variations on the status of women diverging according to cultural milieu, family structure, class, caste, property rights and morals*" (Thapar R, 1975). Besides the difficulty of providing a monolithic picture of women's position at various phases of development, there is a serious of difficulty of locating authentic sources which can help construct a profile of Indian women. While on one hand historical documents that have been used by the mainstream scholars are elitist (Altekar, 1962;Kane, 1930; Upadhyaya ,1974) on the other hand , the historians who have attempted to build up the history from the very beginning have not paid enough attention to the women's question. Recently, some women historians and Sanskrit scholars have attempted different interpretations of the original brahminical text inorder to decipher the status of women. The description of status of women in different phases of history presented here is a result of their work.

Women's Position in Different Phases of History

With changing times women's position has also changed. During the Vedic Period when Civilization was simple, life was lived in agricultural communities and wealth consisted of crops and cattle. Woman was comparatively free and her place in the community was naturally determined by her ability to share the work of that community.

The Buddhist period saw the intellectual advancement of women. They occupied a very high place in the social scheme. Sanskrit literature and drama of that period are full of instances of educated Buddhist ladies. The available material shows that at this time and through out the period of classic Sanskrit literature women in India enjoyed

a status similar to the status of women in the classical periods of ancient Greece and Rome. The poet Kalhana in his master piece "The Rajatarangini" a history of Kashmir written in the middle of 12th century A.D. mirrors the political and social ideas of the Hindu India. One finds that at that period women had already emerged from the domestic into the political stage, were free, owned immovable property, managed their own estates and even fought at the head of their troops (Indra M.A., 1996).

In the post Vedic or the pre-British period particularly after the establishment of the class society and the rise of private property, women's position in the society started declining. Patriarchal values relating to sexuality and regulation of her movement, thus controlling her purity, got entrenched during this phase. This decline in the women's status dates back from the period of Manusmriti, i.e., 500 BC to 1800 AD. The deterioration in the position of women in this period is explained by historians as being a consequence of the establishment of the rigid hierarchical caste structure, through the Manav Code which stated that a woman should never be independent. As a daughter she is under the surveillance of her father, as a wife of her husband and as a widow, of her son. Hence the Manav Code gave way to patriarchy with the oldest male as the supreme head of the patrilineal kin group, and the subordinate status for the Shudras and Women. Some of the facts that shows the poor status of women in this period are the fact that the birth of a daughter, which was not a source of anxiety during the Vedic period, became a source of disaster for the father. Education of women which was an accepted norm during the Vedic period, slowly began to be neglected, and later on girls were totally denied of any access to education, there was a decline in the marriageable age of women. Some of these still exists in rural societies in some form. Hence, in the post Vedic period mainstream life for the upper caste women was confined to the four walls and restricted to serving the kin members.

The British period brought some improvements in the status of women. This was mainly due to the influence of English education which brought the values of liberty, equality, respect for individual, secularism etc. Besides the Social Reform Movements of the 19th Century and the Nationalsit Movement of the 20th Century also affected the status of women greatly. The social reformers hit the issues of sati, ill treatment of widows, the ban on widow marriage, polygamy, child marriage, denial of property rights and education to women and tried to eradicate them from the society by raising

consciousness. The nationalist movement not only drew a large number of women to political activity but it also generated the strength and confidence among women which helped them to organize and to fight for their own cause, rather than depend upon their benevolent men to fight for their cause. With regard to economic position though the women of the lower strata have been working for wages, the middle class women's entry into the world of work appeared more significantly after the Second World War. A few women did take up some professions like law, medicine, teaching etc, but their numbers were very limited. Hence, during this period one doesn't find many voices being raised regarding women's dual role or the burden of working women (Desai and Krishnaraj, 2004).

In Short, during this period prior to independence , an awareness of the need to remove social disabilities of women was created, the doors for education was opened for them , women's organizations emerged to represent the needs and cause of middle class urban women, political participation of women increased women's mobility. Finally through several legal enactments, women's unequal position was being rectified.

In the contemporary society again one homogenous picture of the status of women can't be presented as the condition is different among different sections. Middle class educated women, particularly in large urban agglomerations, who are working, moving freely, generate an impression that the status of women has substantially improved. However, the plight of women in the small towns and villages convey a different story. In these places women are still confined to home bound activities and involved in responsibilities and interests limited to only their kith and kin. However, this study caters to the problems of the women of the first group who have entered into the labor market and apparently looks empowered and represents the face of modern India. Besides it also tries to see the differentials across socio-economic groups by also looking at the problems of the working women belonging to the lower economic rung. Henceforth, only the women in this category would be referred. Before moving to the specific problems pertaining to the women of this group it would be useful to examine the entry of women in the labor market.

Women in the labor Force- General Trends, Pros and Cons

As mentioned above in the Pre-British and British period, only the women in the low economic ladder were employed and the women from the middle class families did not seek employment. It is the post globalization period that saw a significant increase in the women work force participation. Hence, the entry of educated, middle class, urban working women in the white collared jobs is a recent phenomenon. This happened mainly in the post globalization period. The inflation and the resulting increase in the cost of living forced more and more women to seek employment (Kapur and Sonpar, 2001).However; most of them are mostly employed in low paid jobs that are lower in hierarchies (Seth Mira, 2001).They are paid lesser wages in comparison to the men and also their numbers are much low than men in all sectors be it private, public, organized or unorganized (Census of India 2001). Hence, the plight of women in the labour market shows that besides the women's reproductive labor, her productive labour are also regulated by patriarchal norms and values. A greater understanding of the issue can be had from the section on feminist theories on work and family, in the later part of this chapter.

Women's entry into the workforce has its own benefits for empowering the women in society, reducing gender inequality and affecting changes in levels of fertility and child mortality (Nakkeeran N,2003).It has also brought a new sense of identity, financial security, sense of worth and relationship for women outside the domestic sphere (Kumar R, 1990).Approached from any discipline- demography, economics, sociology etc,-women's participation in paid employment and particularly participation outside the household domain has uniformly been given a positive connotation. In demography, for example, the seemingly high correlation between increase in female WPR(Work participation rate) and reduction in fertility rate has catapulted this statistical finding into a policy decision, where in growth in population in populous LDC's (Low development countries)is controlled through, among other things, larger participation of women in paid employment. In Economics, where the study of poverty is a major preoccupation, wage employment is central among the prescriptions for poverty reduction. Further, paid employment for women is also generally associated with greater economic independence resulting in better household nutritional status as well as better scope for education of girl children. Sociological studies of women's participation in wage employment stress

the enhanced status and autonomy that such work participation provide for women, which in turn confers on them greater decision making power (Swaminathan P, 2004).

While, female work participation brings several benefits to the society on the whole, it has some damaging repercussions as well. One major disadvantage of this is that it heavily increases the work burden of women. With the sexual division of labor rigidly in place (Kapur and Sonpar, 2001) it becomes extremely difficult for women to combine the dual tasks of production and reproduction and the multiple roles associated with these. An important consequence of combining the multiple role associated with these two tasks is that it has a serious impact on the women's well being (Swaminathan P,2004). According to Kapur and Sonpar (2001) *"Work would certainly affect a woman's well being if her working outside triggers conflict at their home, and also if their work burden has to stretch to include income generation in addition to their traditional tasks of household and family maintenance"* (Kapur and Sonpar, 2001).A greater look on the multiple roles of women and its effect on health and well being can be had from the section below:

Multiple Roles of women- Types and their implications on their Wellbeing

Women as it is perform multiple roles of that of a wife, mother, daughter, daughter-in- law etc. at home. Working women have to perform an additional role of that of an employee which creates additional demands on her time and energy. Before, understanding the effect of these roles on the health and well being of women, it would be useful to understand each of the roles performed by the women and their associated tasks and demands. Oppong (1998) has described the different roles of the women under seven categories. These roles along with the expected behaviors are as follows:

1. Parental Role: The woman's paternal or maternal role focuses attention on women's activities as bearers, nurses and socialisers of the next generation.

2. Occupational Role: The occupational role, as others, may be defined in three ways in terms of context, activities, and functions. The context is any place in which the woman carries out productive and income generating activities. Women's occupations vary very much according to their degree of formality

and the range of behaviors includes a wide variety of possible activities, from agricultural work to factory employment.

3. Conjugal Role: the Conjugal role is a positional role arising from a woman's position as a partner to a male for a multiplicity of purposes, which may include procreation, sexual satisfaction, domestic services, financial/material support, economic co-operation , companionship etc. the role relationship may involve the activities and related functions associated with some or all of these. Three important variable aspects of all these behaviors may be critical. The first is the extent to which spouses share rights, duties and associated tasks (the degree of joint ness of the conjugal relationship). The second is their mode of decision making which may be autonomous, or dominated by one spouse or subject of discussion and agreement (syncratic). The third is the extent to which each right, duty or task is delegated or shared with others including kin.

4. Domestic Role: The domestic role refers to all the behaviors related to a house, compound, a set of rooms, a home. The activities may include some of those associated in some instances with the roles of mother, wife, kinswoman and individual. They may also overlap with the occupational role in that income, goods and services may be produced for sale within the home.

5. Kin Role: The kin roles women play as sisters, daughters, grandmothers, nieces and so on are assumed to be basically important for their life courses in terms of resources opportunities and support available to them, as well as for many of the expectations and constraints governing their lives. The array of behaviors associated with kin roles is likely to be varied and to encompass activities ranging from participation in life crisis rituals such as namings, funerals and weddings to provision of resources and sharing of domestic tasks and responsibilities including chores, child-care etc.

6. Community Role: the role of community member is defined in terms of context where she happens to reside at a particular point of time. Salient aspects of the community role include participation in community

organizations such as religious congregations and related activities; political parties; communal welfare meetings and activities; women's voluntary organizations etc. in addition there may be annual seasonal and sporadic community and neighborhood activities, feasts, celebrations , campaigns, included here may also be behaviour in her role as citizen of her nation state in terms of participation in political activities, voting, payment, payment of taxes etc, rituals etc. in which she plays a part.

7. Individual Role: The individual role encompasses that aspect of a person's activities relating to personal development, self expression, a sense of individuality, use of leisure time and opportunities for privacy. The importance of the individual role varies enormously in different cultures, being most salient in wealthy "post-industrial" countries, and less so in poor communities where facilities and opportunities for enhancement of the individual role may be lacking or "individualism", privacy, friendship, play and leisure may be discouraged.

   It can be highly significant for the performance of other roles, since it may be in competition for time, energy and money (Oppong C and A Katherine,1998:8-10).

Very often women are not able to combine the demands of these multiple roles and end up facing a **Role Strain or Role Stress**. Role strain/stress arises when someone finds it difficult to fulfill the obligations associated with a role according to expectations (Oppong C and A Katherine, 1998:10).Role strain is often associated with the misallocation or overload of roles. Overload occurs when one person has too many roles to perform or when demands placed on a group, exceeds the group's resources and misallocation occurs when people disagree about who should perform which roles in a relationship (Weber A, 2001).

Role strain may be simply categorized according to the level observed. Three different kinds are distinguished.

a) Financial or Material strain in which a person finds it difficult to provide or to pay for the things needed to fulfill the obligations and expectations of that role.

b) Time Strain- This occurs when someone does not have enough time to do what she wants to do or thinks she ought to do with respect to a particular role. Time strain may be observed when activities associated with a particular role causes excessive fatigue, or haste and rushing to do things in too much of a hurry.

c) Interpersonal Role strain. This occurs when a person is suffering in her relationship with another e.g. husband, child, relative, colleague. This ill feeling may be expressed in frequent quarrels or silently borne feelings of resentment, jealousy etc. It may be minimized by conscious or unconscious avoidance (Oppong C and A Katherine,1998:10).

Working women most often are victimized by the second kind of role strain where they don't have enough time to combine the two roles of a homemaker and wage earner. In an attempt to perform both the roles successfully she usually has to compromise on her leisure and sleeping time which has damaging repercussions for her health and well being (Gothoskar S,1997).

Factors leading to Role Strain among Working women

As mentioned earlier in this chapter, the rigid gender division of labour is the primary reason which leads to role strain among women. While the job strain remains the same for both men and women, home has different connotations for them. For, men family connotes provision of comfort and support but for working women it means two sets of overlapping responsibilities (Sen and Pillai ,1998).If the house isn't tidy and food isn't on the table, many women feel it reflects on their abilities as an inadequate wife or mother. And if marital relations are strained or if the kids are not doing well, women tend to internalize these problems, feeling that they are due to their personal failures. Their high expectations for harmonious relations in all these roles often force them into shifting their own immediate needs, as well as long term dreams (Snodgrass M, 2003).

So, for working women, home acts as the second work front where she usually does an evening and an early morning shift. With this continuous back breaking work and without any rest it is obvious that they would feel Role Stress.

According to Pleck (1985)stress is felt particularly when the working women desires to carry out both her roles very efficiently and feels torn between her loyalty towards her profession or job and towards her home, even though she spends more time on family and household work than does her husband (Pleck J, 1985).

Another explanation for this Role stress among the working women as given by Swaminathan is as follows:

"*Occupational demands and expectations continue to be based on the assumption that the worker is an individual who is relatively free of domestic and family responsibilities. Further, an underlying dimension of modernization is the increasing centrality of individual goal attainment. This has important, and, more often, negative implications for women. For women to become modern or to compete with men on equal terms would imply that they are unburdened by household duties and child care. Otherwise they must make adjustments at a personal level, for example, by working part time or limiting the sizes of their families, if they wish to combine the two roles"* (Swaminathan P, 2004).

The first solution given by her is usually not possible as the primary role of a woman is still considered to be that of a homemaker. So, she is only left with the second choice, which again doesn't materialize in most of the cases. As a result they are constantly stressed out in an attempt to juggle work and family responsibilities, their spouse, children and childcare, and often aging parents.

However, this doesn't mean that the working women are the only troubled lot. Housewives have their own set of stressors. Since, housework is not industrialized or developed into a major enterprise and since it continues to be in the private domain where the division of labour is inequiatable, it is usually not included in the broad definition of 'gainful activity." And is both economically under valued and socially underrated. Its significant feature is that the continual and repetitive nature of its

tasks, performed mostly in isolation, results over a long period in physical and mental fatigue (Kumar R,1990). Feminist's literature is full of criticism for housework as it is neither considered work, nor an economic activity and hence are invisible, unrecognized and unpaid (Bhasin K,2000). It's an extreme depiction of the control of men over women, where women are reduced to slaves in the name of marriage. The problems of housewives can be very well depicted by the text below:

> *"The husband has the "the queen of the commodities" i.e. money, in his, in his pocket, but the wife is not paid for her work. The husband must give her only board and lodging, as he would also have to do for a slave. The housewife's working hours, conditions of work, holidays, leisure are not settled by contract; the marriage contract is comparable to an employment contract. There is no right to strike, no sisterly organization of housewives, they are instead, individualized and atomized. They enjoy no social security on the basis of their work as housewives, nor are they protected by law from the despotism and violence of their husbands. In the home nobody ensures the observance of human rights, hence they are a private affair, which allegedly do not concern the public even when there is no guarantee of physical safety. The wife must serve, and above all obey the husband; he can demand this in a court of law. In short, the housewife is an unpaid worker, at the disposal of her husband, round the clock, all her life. Even more, her whole person is at his disposal including her sexuality and childbearing capacity, her psyche and feelings, She is at same time slave and serf who is compelled to do all the work that her husband and children need, including demonstrating love even when she doesn't feel any. Here one works out of love and love becomes work. The situation is not always intolerable but it is impossible to predict that it will not become so."*
>
> *-Claudia Von Werlhof (op.cit.:175)*

Mainly because of the features described above, housewives develop a very low sense of worth, they don't have their individuality and their lives revolve around the same set of people of the family. She doesn't have much of an exposure to the outside world and doesn't have a life of her own. This can be very suffocating for her at

times. The question which now arises, is that which one of the two is happier: a working women who has to continuously battle between the multiple roles that she performs within the public and private sphere or a house wife who is confined to the private sphere, and who leads a boring and socially isolating life? This present study tries to seek an answer to this.

Before understanding the implications of multiple roles on the health and well being of women, it would be interesting to understand the feminist's perspectives on the issues that have been discussed so far.

Feminist views on Family, Housework, Employment and double burden of work

Subsequent to the women's entry into the labour force, several feminist have asserted that women's role as a wage earner –simultaneously with their role as home workers leads to the "double burden" (Hartmann, 1979; Eisentein,1979).

The four major feminist streams of thought have extensively talked about family, housework and paid employment. The section below attempts to capture the feminist views in these themes that are pertinent to the present study.

Liberal Feminists: Focusses on individual rights and choices, which are denied to women and ways in which the law and education could rectify this injustice.

Among the rights for which the liberal feminists fight for, the most important are those related to work. They believe that women are entitled to work outside the home whether or not they are married; that men and women doing the same work should receive the same wages, mothers of young children should be enabled or encouraged to enter into paid employment and that women should be better represented in legislative assemblies. These feminists see employment as a source of fulfillment and an escape from the drudgery of family life. Some critics of this theory believe that though liberal feminists have long demanded that women should be liberated from domesticity and should be enabled to work outside the home. Many women today who are working do not feel liberated but exhausted and exploited as they are expected to go out to work retaining their traditional family responsibilities. Some other critics of the theory feel that liberal feminists have never realized the importance

of family and have given all the importance to work. It has assumed that family is a part of personal sphere which has nothing to do with the public sphere. Thus, it has failed to see the extent and social importance of the work done by women within the home, or to consider the consequences if women are no longer available to do it, or for that matter the problem of dual burden of work which the women faces in combining the public (work) and private (home) spheres.

Although this stream, has tended to devalue women's family role, liberalism's individualistic approach suggests that the women's concentration into part-time employment is an easy solution for balancing work and family responsibilities. Socialist, Marxist and Black Critics have accused liberal feminists of holding narrow and class based assumptions and by saying that in reality many women are forced to choose between economic dependency within marriage and poverty outside it, or between a career and a family.

Liberal feminists critique housework because it is unpaid. This makes women dependents on men and devalued, since their work is outside the meaningful spheres of public economic production (Frieden B,1963).

Marxist Feminists: They see women's oppression as tied to forms of capitalist exploitation of labour, and thus women's paid and unpaid work is analyzed in relation to it's function with the capitalist economy.

The Marxist feminists assert that the class relations and economic exploitation of one class by another are the central features of social structure and these determine the nature of gender relations. Man's domination over women is a byproduct of capital's domination over labour.

The family is considered to benefit capital by providing the day to day care of workers, such as food and clean clothes, and for providing the next generation of workers. It is cheap because women as housewives do this for no wage, merely receiving maintenance from their husbands. Thus, capital benefits from the unequal sexual division of labour within homes.

Like the liberals, the Marxist feminist too have often ignored family and the division of labour within it, seeing these as either natural or as a by product of conditions of economic production. This approach seems to suggest that there is no need to address the inequalities within the family directly, and that feminist energies are more appropriately directed towards workplace organizations and campaigns for socialist change. However, recent developments in Marxist theory have attempted to understand the economic importance of women's domestic labor and the ways in which both capitalism and men may benefit from it. According to these theorists housework is part of a household feudal mode of production of goods for use that persists under capitalism and gives men feudal powers over women's work (Benston, 1969; Fox, 1980). Other Marxist feminists argue that women's housework is part of the social reproduction of capitalism (Federici, 1975, 2004; Malos 1975; Vogel 1995). That the necessary work of reproducing the working class is unpaid allows more profits to capitalists. It is the sexual division of labor in productive and reproductive work that makes woman unequal to men and allows capitalists to exploit women's unpaid labor. Some even make this analysis the basis for a demand for wages for housework (Dalla Costa, 1974; Federici, 1975). Finally, Marxists argue that since the human care involved in taking care of children and elders creates a public good, it should clearly be characterized as work, and those who are caretakers, primarily women, should be fairly compensated for it by society or the state (Fergusson and Folbre, 2000; Folbre, 2000). Such analyses suggest that the family is a part of the material basis of society, and that changes or challenges to the way household work is organized are as important as conditions of work outside the home.

Although Marxists have never advocated the individualistic pursuit of a career but they too felt that the entry of working class women into the paid labour force is progressive, as it represents a strengthening of the ranks of the working class in the forthcoming battle against capitalism.

Socialist Feminist: Though they are similar to Marxist feminists, their posture on women's exploitation considers women's oppression not only rooted in the modes of production but also goes further to focus on the gender. Several such commentators (Delphy,1984;Eisentein,1979)have insisted that apart from the class inequality under

capitalism family mode of production in which women's labour is exploited is central in defining women's position in contemporary society.

As mentioned earlier in the chapter, according to the traditional gender division of labour men are primarily responsible for productive tasks of wage earning carried out in public sphere and women for reproductive tasks of giving birth to child, child care and household maintenance which are conducted in private sphere. Today's women have stepped out of the private sphere to public. However, her roles in the public sphere haven't changed. This has been most often talked by socialist feminists who propounded the Dual system perspective according to which the private and public spheres are totally distinct from one another. Vogel a Marxist feminist supported this view and said that the possibility of dualism arises because women are both mothers and workers; reproducers and producers and the two aspects of their lives can be seen as analytically separate (Vogel L, 1995).However, feminists from various disciplines particularly anthropology (Moore H) critiqued this view and said that the productive and reproductive roles of women cant be separated out and analyzed in isolation from each other (Moore H, 1988). According to the first perspective women won't face stress while combining the two roles and hence won't experience the double burden of work. However, according to the second perspective women would feel stressed out while balancing the roles of the two spheres as they are inseparable from one another.

The Marxian analysis of the economic importance of domestic labour led some socialist feminists to demand "wages for housework". However, critics have said that this campaign would further make housework a domain of women and would further prevent men from participating into domestic work.

Like the other theorists, socialist feminists also think that women's employment is not only important in her struggle against capitalism but also against patriarchy. Alison Jaggar, for example says that "When women workers achieve a living wage, they are not just workers winning a concession from capitalism, they are also women winning economic independence from men"(JaggarA,1983).

Radical Feminist: They focus on male violence against women and men's control over of women's sexuality and reproduction, viewing men as a group responsible for women's oppression.

In contrast to other approaches, the family is the starting point of analysis for much radical feminist analysis. This insists that personal relationships within the home are not simply matters of individual choice, but both reflect and maintain men's patriarchal power. From this perspective, most men's continuing failure to accept their fair share of position of domestic responsibilities is not accidental, but a refusal to give up a position of privilege which, by restricting their employment prospects, helps maintain female women's financial dependency. Susan Moller Okin have used the ideas of the liberal theories John Rawls to argue that a just society is impossible until there is justice within the family, and that this requires a radical restructuring of domestic and caring responsibilities (Richarda J.,1982; Okin S ,1990).

There is a growing understanding among this school of thought, that the personal economic dependency and poverty experienced by many women within the marriage is incompatible with either equal citizenship or domestic partnership, and that women need to access their own financial resources if they are to escape or resist domestic abuse. Hence, these theorists talks about the empowering effect of work. Some radical feminist even believe that women's oppression can not end unless family as an institution is dissolved.

Although the radical feminist analysis points to the importance of financial independence for women, it does not see employment as an easy route to liberation, for it argues that patriarchal power is exercised in the workplace as well as in the home, and that it is exercised not only by employers but also by trade union movement. From this perspective, women's concentration in the low waged, low status jobs is not an accident, or the result of individual acts of discrimination, or of women's lack of qualifications of ability. Rather , it reflects the structured inequalities of a system in which men's values and priorities are systematically privileged over women's, and in which women's disadvantaged workplace situations helps in maintaining patriarchy in the home. This is mainly because if women's earnings are not sufficient to provide them with economic independence they remain at least

partially dependent on their male partner for economic survival. Such dependency clearly reduces women's negotiating power within the family and their ability either to leave an abusive relationship or to insist that family responsibilities are equally shared. Hence, changes in the traditional division of labour within the family are only possible by changes in the work place.

Hence, we see that all the feminist theories have advocated for women's entry into labour force and felt that it has empowering effects but at the same time they have also brought about the problems of balancing the public and private spheres and the dual burden of work.

As mentioned above, the high levels of stress generated by multiple roles often have damaging repercussions on the health and well being of women. Some of the effects of stress on the health as found in the literature review, is discussed henceforth:

Effect of Stress on Health

Sorenson and Verbugge (1987) suggested that "Women's Multiple Responsibilities and attendant role conflicts will have negative consequences for their health."(Sorenson and Verbugge, 1987). Prolonged negative stress can result in physical and psychological disorders. Studies have linked stress to high blood pressure which is a risk for heart disease. Stress can also disrupt eating and sleeping habits. Some people turn to alcohol, cigarettes or drugs during stressful times. Many feel "burned out" and show symptoms of excessive fatigue, low motivation, head aches and other vague pains and demonstrate frustration both at work and home (Snodgrass M, 2003).Diseases such as cardiovascular and bronchial disorders, diabetes, tuberculosis, migraine and gastrointestinal disorders, are also often found to be related to stress (Report on the Committee on Status of Women in India-1974). Anxiety has long played a key role in the sphere of adjustment/maladjustment to social roles.

The dangerous repercussions of stress on health has also been stated by Hans Selye who first defined Stress as "non specific response of the body to any demand characterized the secretion of glucocorticoids." Selye argued that stress plays a role in the development of every disease. According to Selye there is always one weak organ

or system (due to heredity or external conditions) that is thus likely to break down under stress, which is why he concluded that individuals can develop different types of diseases under the influence of same kind of stressor (Selye H, 1983).

The effect of Stress on Health is also stated in the International Encyclopedia of Social Sciences, according to which acute and chronic stress are significant risk factors for cardiovascular, immunological and psychological health problems as well as impairment of nervous system (CNS) (Kirscbaum and Kudeilka, 2001).

Hence, the literature above shows that the women facing stress due to multiplicity of roles (Role Stress) would have poorer health and well being than the women who don't face Role Stress. This hypothesis goes at par with the *Scarcity Hypothesis* described by social psychologist Sharon S Brehm, according to which more social roles invariably lead to more stress which leads to a decreased well being, since an individuals limited resources are spread to meet more demands. However, he has also given a contrasting hypothesis, *The Enhancement Hypothesis*, according to which defining oneself through multiple roles means less stress, since disappointments in one role can be compensated for the success in others (Brehm S, 1992). Supporters of the Enhancement hypothesis feel that multiple roles doesn't necessarily mean decreased well being as role involvement provides access to resources that may be instrumental in coping with demands of multiple roles. Brehm explains these two contrasting hypotheses by saying that "whether multiple roles increase or reduce stress may depend on such factors as the quality of one's job, one's commitment to working, and the social support provided by partners and other members of one's social network" (Brehm S,1992). Similar view is also given by Madhiwalla and Jessani (1997) according to whom the burdensome nature of household work depends on many factors, including the resources available to the household, the expected number of children they must bear and raise, the number of dependents and the sex wise and age wise division of work within the household. Hence, the association of work and health depends upon the totality of her life factors (Madhiwalla and Jessani, 1997).Similar to the physical health, it is said that the mental health effects of women's multiple role is not a straight forward one but appears to be mediated by a woman's social support network, her coping style, and how significant each roles is to her self esteem (Kapur and Sonpar,2001).Hence, a variety of factors decides as to

whether multiple roles can be detrimental of beneficial to the health of women. A whole lot of researches have tried to find this effect of multiple roles on the health of women by taking employment as a control variable. These researches have been based on the two hypotheses discussed above.

Some relevant studies exploring the relationship between Multiple roles, role stress and women's health & well being

Theoretical Frameworks & findings

Researches on the effect of Multiple Roles on the Health and well being of women have been done by comparing the health of working women (who performs an additional role of that of a wage earner) with that of a housewife who doesn't have to perform this arduous and demanding role. Hence, in these studies, Employment has been used as a parameter for measuring the role overload among women. As mentioned above, most of these researches have been guided by two competing models which forms a part of the Role Analysis Framework. These two models are:

1. The Role Stress Hypothesis also known as Role Strain or Scarcity or Role Overload or Role conflict
2. Role Enhancement Hypothesis also known as Role Expansion or Accumulation

Followers of the first model- Role Stress Hypothesis believe that employment has beneficial effect on health of unmarried women but have little or no effect for married women (Waldron, Weiss and Hughes, 1998) or that the benefits of job for mother's health are restricted to those working part time (Bartley, Popay & Plewis, 1992; Walters, Denton, French, Eyles and Newbold,1996; Bartley, Sacker, Firth,&Fitzpatrick,1999). Therefore it seems that when the total workload is high combining jobs and family demands can be health damaging for women (Artazcoz L, 2004). Hence these studies show that employed women have poorer health than the housewives and hence employment has negative effect on the health and well being of women.

On the other hand studies based on the second model- Role Enhancement Hypothesis shows that employment has a positive effect on the Health of Women, as the job

environment offers opportunities to build self esteem and confidence in ones decision making, provides social support for otherwise isolated individuals, and provides experiences that enhances life satisfaction, all of which has a positive effect on health (Sorenson and Verbugge,1987). Additionally, income provides women with economic independence, which increases their power in the household unit. This in turn draws the attention of the household members towards their health which they earlier ignored on account of her being an unproductive member of the household. A whole lot of studies have empirically proved this positive influence of employment on health of Women(Nathanson,1975;Nathanson, 1980;Verbugge, 1983; Waldron and Jacobs, 1988; Annandale & Hunt,2000,Khlat et.al.2000).A study done by Arber Sara (1991)which looked into the health of both employed and unemployed men and women found that this phenomena is not only restricted to men women but even unemployed men report poorer health in comparison to the employed(Arber S,1991). A recent study which deserves special mention among the studies of this group is that conducted by University of Pennyslavania by Jason Schnittker (2004) which found that Employed women regardless of their hours of work report better health than those who don't work. Hence, this study concludes that the most important factor required to improve women's health is an increase in women's employment rates (Times of India, 2004).

Methodology:

Almost all these studies have used secondary sources for data collection like the different health surveys like General Household Survey(Arber,1991), Barcelono Health Interview Survey (Borrel C, Munatner C, Artazcoz L et.al., 2004), U S health interview survey (Nathanson C,1980) etc, Health and Life style survey & health survey for England(Bartley, Sacker, Firth and Fitzpatrick,1999). None of them have used primary data collection. From these nation wide sample surveys most of the studies have chosen married working women and housewives assuming that marriage increases the domestic responsibilities of women.(Nathanson,1975;Nathanson, 1980; Verbugge, 1983; Waldron and Jacobs, 1988; Annandale and Hunt,2000, Artazcoz L, 2004).Some studies that have taken single or unmarried women have found lower levels of stress amongst them. Apart from considering the health of housewives and working women few studies have also taken into account the health of employed and unemployed men (Arber S ,1991). Some other studies have only considered the health

of employed men and women (Borrel C et.al., 2004).And some other studies have compared the health of married working women and divorced working women to see the effect of combining family and work (Fokkema T,2002). Single variate, bivariate and multivariate analysis has usually been used by these studies to find the association between different variables.

Measurement of Health

Health in these studies are usually measured by ratings of respondents general physical health or complaints which is referred as morbidity (Bartley, Sacker, Firth, & Fitzpatrick,1999; Waldron and Herold,1986).Some studies have also used mortality information(Martikainen,1995; Passonate M and Nathanson C,1974-1980). However, these days morbidity is considered as a better indicator of health than mortality. Morbidity is usually measured by the prevalence of illness, (both physical and mental) and self perceived health status(Artazcoz L, 2004;Khlat et.al.2000,Walter Vivian et.al. 2002, Nathanson C,1980). Limiting long standing illness is most often used as an indicator of morbidity(Arber S,1991).Besides measuring the health status by considering the morbidity and mortality figures some of the recent studies(Artazcoz L, 2004;Khlat et.al.,2000)have also tried to measure the health related behaviours which have an impact on the health status. The study by Artazcoz L. (2004) have measured the health related behaviors with regard to leisure time physical activity and sleeping hours. This study has tried to test whether the employed women have poorer health than housewives on account of having less leisure time to practice health related behaviours(Artazcoz L,2004).Some studies have also measured health related behaviours by tobacco consumption and excess weight, measured by BMI (Khlat et.al.2000).However, such studies which considered health related behaviour were very few.

However, hardly any study has tried to compare the health seeking behaviour of the two groups of women. However, in one of the papers, Rivkins (1972), it was hypothised that women's responses to symptoms of ill health would vary with the number and character of their other role obligations. This hypothesis leads to two more specific predictions:

1) Women with heavy role obligations (eg: employed women with respect to housewives) will be relatively less likely to take any action with response to perceived symptoms, on account of their being busy.

2) Women with heavier role obligations will respond to perceived symptoms by visiting a physician, while fewer responsibilities will be associated with self treatment at home, as their illness would affect greater number of tasks (Rivkin, MO, 1972.). Similar to this view is the view expressed by Sagar in her paper according to which women often ignore their illness and avoid seeking help till the time that it starts affecting her function as a mother, wife and wage earner (Sagar A, 1994).The first study which tried to test this hypotheses regarding health seeking behaviour was that of Nathanson(1980). Nathanson in his hypotheses found that women with larger number of role obligations were more likely to utilize the health services (Nathanson C, 1980).

Other factors responsible for Role Stress and Enhancement

Some studies have shown that the beneficial (Role Enhancement) and detrimental (Role Stress) nature of employment and health depends upon a whole lot of conditions. One such condition is **Income** as income provides access to resources which better equips a woman to cope up with the stresses of multiple roles. However, very few studies have considered the socio economic gradient in analyzing the women's role and its resulting impact on health. Most of the studies have only considered the role framework inorder to measure the women's health. One of the first studies which combined both the role framework and class variable in assessing a woman's health is that by Arber in which he found out that the exercise of multiple roles had adverse health consequences for women working full time in lower non manual and in manual occupations, but not for those in professional and managerial jobs, whose greater financial resources could be used to ease some of the burdens of housework and childcare, so reducing role strain and fatigue. His study showed that conflicts between roles change over the life course, as do the underlying demands and resources. Middle aged women, blue-collar workers and those at the lower end of the status hierarchy are thought to be the most exposed to the stressors while having few resources available and consequently middle class women may be the only one to experience the positive relationship between employment and well being (Arber

S,1991)". According to Moen and Yu exposure to stressors and the availability of resources vary as a function of age, occupation or occupational status (Moen and Yu, 1999).Another such study was carried out in Barceleno (Spain)(Artazcoz et. al.,2001), which showed that among married female workers having a person hired for domestic tasks was negatively associated with poor self-perceived health status. Hence, from all these studies it can be concluded that combining job and family is more health damaging for women in the low income group who cant afford to employ a domestic help and who doesn't have the modern gadgets which makes household tasks easier. Similar results were shown by Muntaner et.al.(1998) who using a measure of managerial social positions found that low level supervisors had a higher level of anxiety and depression (Muntanner et.al.1998). However, an opposite result came out in the study done by Warr and Parry (1982) where he found that the working class women may benefit more from employment because their non-occupational environment is less favorable than that of middle-class women (Warr and Parry, 1982). In order to assess the women's socio-economic position most of these studies have used the women's income rather than her husbands.

The better health of women in managerial or high paying jobs has been attributed to the greater power and control which they have on their work front (Borrel C et.al., 2004). Hence, **satisfying work environment or job satisfaction** is a very important factor that helps women cope up with the demands of work and help them to effectively combine work and family.

Another factor which has been most commonly attributed to the better health of women in skilled and better paying jobs is that they can employ poor women to care for their homes and children, while the unskilled workers cant afford such help. Hence, **household labour** is an important factor that determines a woman's ability to cope with multiple tasks. Several studies have noted the importance of household labor on women's health (Hall, 1992; Bartley, Popay & Plewis, 1992; Hunt & Annandale, 1993). Studies have shown that heavy workloads have particularly negative effect on women's health (Frankenhaeuser et.al., 1989; Lundberg et.al., 1994). The various determinants used to measure the household workload are the size of families, number of children, their ages, number of elderly, family members helping in domestic work, presence of domestic maid and household appliances. One

such study which has used the indicator of number of dependents(elderly and children) has shown that both employed women and housewives with larger families comprising of more number of elderly and children had poorer health status and didn't find much time for health related behaviours (Artazcoz L,2004).

Help received **by** the **husband** in domestic work is a very important factor that helps women in coping the demands of multiple roles as the amount of respite that women gets from household work is directly dependent on the contribution of men folk both regularly as well as occasionally .However studies have found that household labour is hardly done by men (Borrel C, 2004). An Indian study on women workers in drug and cosmetic industries done by Gothoskar (1997) showed that around 52% of the husbands of the respondents didn't do any of the domestic chores regularly, over 27% men helped marginally, over 8% rendered significant help and less than 1% of the men contributed as much as the women of the house. Most of the men were found to be doing the so called less gendered jobs like marketing, taking the children to school, or looking at the children's homework. Only 29% men did the gendered jobs which are traditionally identified as women's work of washing clothes, washing utensils and cooking. The gendered jobs were performed by the men only in situations when women could not perform (Gothoskar S,1997). Under these circumstances where the contribution of men to the household tasks is low it is obvious that women would feel stressed out balancing the domestic and household chores.

Education is found to be another factor having an influence on health of employed women. A study by Nathanson (1980) which has used this indicator found that employment makes a larger difference to the self perceived health of women with less than a high school education (Nathanson C,1980).This means that employed women with less than high school education reported better health than a housewife with same educational level.

Lack of time for themselves **(leisure time)** is another reason which is most often given for the ill health of working class women (Borrel C,2004; Artazcoz L et.al. 2004;Khlat 2000). Gothoskar'sstudy (1997) also found that lack of leisure time had a negative impact on the health and well being of women (Gothoskar S,1997).

Hence, these studies show that income level, job satisfaction, family demands, husbands help in household chores and leisure time are some of the important factors that helps women cope up with the multiple roles.

The literature review has shown that most of these researches have been done in the west. Indian literature on the theme is very scarce. Some of the Indian Studies have focused on the problems faced by the working women in terms of balancing the dual role of that of an employee and homemaker. For e.g. the study done by Pillai and Sen in 1998 which was conducted among 100 working women employed in diverse sectors showed that as low as 7% of working women were able to harmonize their dual roles (Sen and Pillai,1998). In contrast, another study done by Tata Institute of Social Science has shown that 60% of working women are efficiently able to manage work and home (Yesudian Y K et.al., 2000).

However, very few studies have focused on the effect of the multiple roles on the health and well being of working women. One such study done by Mediwalla and Jessani of CEHAT on the morbidity pattern among women in Urban slums of Mumbai found a strong correlation between labour and morbidity. The sample for the study was selected from 430 households from five different clusters, which were selected on the basis of class characteristics. Two of the clusters were slums, two were chawls and one was a building. Morbidity was measured according to the self reported illness which were grouped under reproductive problems; aches, pains and injuries; weakness; fever; respiratory problems; Gastro Intestinal problems; Skin, eye, ear problems; and others. The results of the study showed higher rates of morbidity among working women both staying in slum and non slum households. Thus, the study showed that an additional burden of earning an income tends to increase the morbidity among women (Madhiwalla and Jessani, 1997). However, this study didn't focus on the issue much; it mainly aimed at seeing the impact of the physical environment on the health of slum dwellers which included male and female of all ages. It doesn't specifically look at the problems of the working women.

There are few Indian Studies that specifically look into the effect of multiple roles on the physical and mental health. Many studies attest to the beneficial mental health effects of multiple roles. These studies show that working women report a great sense

of satisfaction from having an independent income and a work environment of some autonomy and control. However, power is a significant variable here. Eg. Chakraborthys' study (1990) showed that women in higher positions of power experienced less distress than did those in lower positions. But for women in low level positions, the distress was four times higher than for men in similar positions. This was attributed to the factor that employment caused friction at their homes, interfered with their household responsibilities or over burdens them where domestic help and labour saving devices either cannot be afforded or are not used for other reasons (Chakraborthy, 1990).Hence, this is very similar to the western studies (mentioned above) which shows that women in higher managerial jobs have better health than the women in lower paid jobs.

Another such Indian study which saw the health effects of employment among a group of middle class working women (college teachers) and housewives was conducted by Mukhopadhyay (1996) in Calcutta . This study tried to compare the physical and mental health of the two groups of women by seeing the morbidity pattern among them. The results of this study showed that diseases like asthma, colitis, migraine, and so on, were chronic more frequently among the working women (Mukhopadhyay S, 1997). However, the study couldn't observe any remarkable difference in terms of the morbidity of the two groups. The study also failed to present the class differentials among the health of housewives and working women as it considered only the women of the middle class.

Thus, we see that while majority of western studies show a beneficial effect of employment on health of women and supports the Role Enhancement hypothesis. The few Indian studies show the negative effect of employment on physical health, as they show greater prevalence of illness among the employed women than the housewives. However, employment was found to have a positive influence on a woman's mental health (Chakraborthy, 1990). These studies thus support the Role Stress or Scarcity hypotheses. This might be due to the fact that in a country like India where domestic work is still considered to be the prime responsibility of women and where participation of men in the household activities is quiet low working women might find it difficult to perform this dual role of a professional and a homemaker.

Gaps in literature and Rationale for the study

Hence, the literature review shows that while most of the Western studies look into the problem in great depth, the Indian studies are too narrow in scope and are too specific. Most of them have just looked into the morbidity among working women and housewives. They haven't used the Role analysis framework (Role stress and Role enhancement) to look at the effect of multiple roles, in this case employment and housework, on the health and well being of women. Besides they haven't looked at other aspects like health related behavior and health seeking behaviour which are very important determinants of health status. They haven't explored the health differentials amongst working women and housewives belonging to different socio-economic backgrounds. Similarly, they haven't even looked at factors like age, education, family support, family size, job satisfaction etc. that help the women in coping up with the stress associated with the multiple roles.

Hence, the present study tries to fill the above mentioned gaps by seeing the association of multiple roles on health of women, by comparing the health status, health seeking behavior and health related behavior of housewives who performs the familial roles of a wife, mother, daughter, daughter-in-law etc. with that of working women who besides these roles performs an additional role of an employee, across income groups. Hence, the study is mainly based on the Role analysis framework according to which multiple roles can lead to Role stress or Role enhancement which in turn can have negative or positive effect on health respectively. Besides, it also tries to see the effect of variables like age, income, education, family size, number of children, age of children, job satisfaction, travel time, help in domestic work by family members and domestic maids that play an important role in helping a woman cope up with the demands of the multiple roles. Since hardly any studies of the kind have been done in India the study would add immense value to the existing body of literature by bringing out the repercussions of the dual burden of work on the health of working women.

CHAPTER II

METHODOLOGY

2.1. Conceptualization of the Problem

As mentioned in the previous chapter, with the gender division of labour rigidly in place and with the entry of women in the labour market, it's becoming extremely difficult for working women to combine the multiple roles associated with home and work. Most of the women are stuck in striking a balance between family and work front and end up facing a Role Strain. However, some are effectively able to combine these roles. Infact, work offers them a greater sense of self esteem and social network, which makes them enjoy a greater sense of well being. This phenomenon is described as Role Enhancement. The present study is an attempt to understand these two phenomena among working women and housewives belonging to different socio-economic backgrounds and the factors leading to the same, it then tries to draw a correlation between these two phenomena and the health of women. Health has been measured by considering health status, health seeking behavior and health related behavior. Health status has been assessed by morbidity, as reported by the women (self reported morbidity) and the women's perception about their own health and wellbeing (self perceived health status). On the basis of the literature review, the study has been guided by a set of assumptions which have been mentioned below:

Similar to most of western studies that are mentioned in the literature review, this study is also based on the Role Analysis framework which consists of two competing models of Role Stress and Role Enhancement. According to the first model multiple roles have detrimental effect on the health and well being of women and according to the second it has a positive influence on health and well being. The present study tries to test the applicability of these two hypotheses among the study population by comparing the stress levels among working women who besides the role of a homemaker has to perform an additional role of an employee, with that of a housewife who doesn't have to perform this arduous and demanding role. It then tries to see the effect of the stress levels on the health of women. If the first hypothesis, i.e. Role Stress, is true for the sample population, then working women would have poorer health in comparison to the housewives and if the second hypothesis, i.e. Role Enhancement, is true then the working women would have better health in comparison to the housewives. Hence, the present study tries to test these two hypotheses by comparing the health of housewives and working women.

Besides, it also tries to explore the factors under which a woman might experience role stress and role enhancement. These are age, income, education, job satisfaction, travel time, size of the family, number of children and their ages, family support, presence of domestic maid etc. Here, the assumption is that a woman who belongs to higher economic background, has the modern domestic gadgets, has a small family, has lesser number of children, has a supportive husband and has a domestic maid to help in household chores would experience less of role stress in comparison to a woman who doesn't have these supportive factors. Here income is a very important factor, as it determines the presence of other factors. Hence, the study also tries to look at the health differentials among women belonging to different socio-economic backgrounds. The problem conceptualized above can be very well depicted by figure 2.1(pg.37).

With regard to the relationship between health seeking and health related behavior, it is commonly assumed that women with better health seeking and health related behavior will have better health status. Hence, the study tries to test this assumption too, by exploring as to which of the two categories of women (housewives and working women) practices more of heath seeking and health related behaviors, and whether it has a direct relation with their health status or not. The research questions which are addressed here are: Who practices more of health related behaviors, Housewives on account of having more of leisure time or working women on account of being more aware and hence more conscious about their health? Who has a better health seeking behavior a housewife who has more of leisure time and no money of her own or a working woman who has no leisure time but has money of her own? Is there a direct relation between these two behaviours and health status? Besides, the differentials in the health seeking and health related behaviors of women are also seen across income groups.

In order to test the assumptions mentioned above, the following methodology was used for the study:

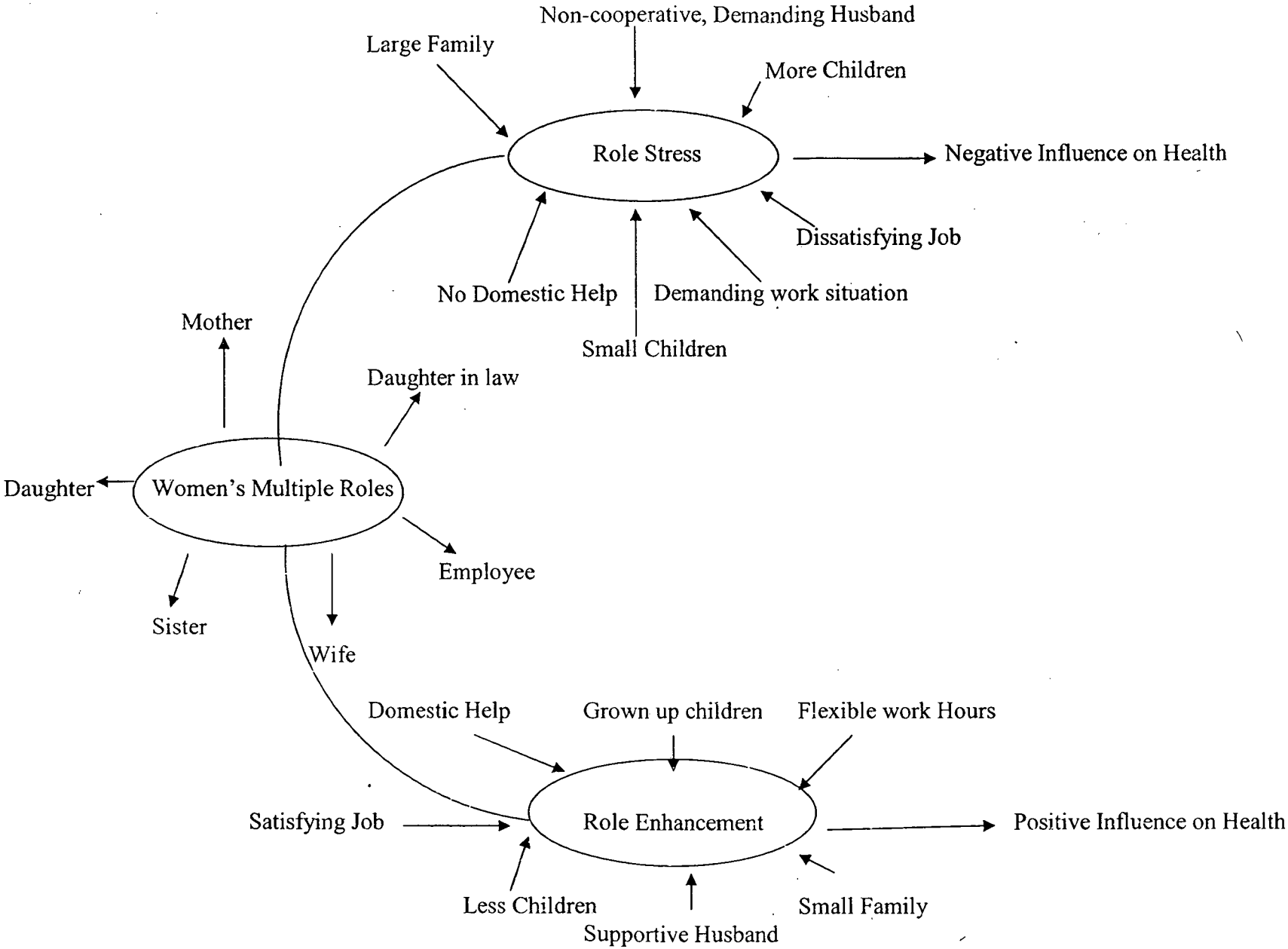


Fig 2.1: Effect of Multiple Roles on the health of Women according to Role stress and Role Enhancement Hypothesis and the various factors responsible for the two phenomena.

2.2. Purpose of the Study

Broadly the study attempts to see the effect of multiple roles on the health and well being of women by comparing the health of a housewife who performs the roles of a wife, mother, daughter, daughter-in-law with that of a working woman, who besides these performs an additional role of an employee, across a range of income groups. Besides, it also tries to explore the different variables like age, income, family size, number of children and their ages, job satisfaction, travel time, family support, the presence of domestic maid etc. which helps the women of the two categories to cope stress.

The **Specific** objectives of the study are as follows:

1. To explore the difference between the health of housewives and working women.
2. To explore the differentials in the health of women belonging to different income categories of high, middle and low within housewives and working women.
3. To explore the phenomena of role stress and role enhancement faced by working women and housewives belonging to different socio-economic and familial backgrounds and the factors leading to the same.
4. To find the association between role stress/ role enhancement and the health status of the working women and housewives.

2.3 Some Key Concepts

1. Employment refers to the paid work or women's productive work outside the household.

2. Working women or Employed women: Refers to women involved in paid work outside the household. Women working as full time or part time in BARC or residing in BARC colony (Anushakti Nagar) and working outside are included in this category.

3.Housewives: Refers to women who are not involved in any paid work outside the household and are just responsible for the household related work which includes cooking, cleaning, looking after the children etc. Most contemporary

feminist literature are now using the term "Homemakers" for housewives. But for the sake of the present study the term housewives had been used as it is a more conventional term and is widely understood by a lay person too.

*4. **Health*** is measured by taking 3 indicators namely:

Health Status-Has been measured by understanding the morbidity pattern or the prevalence of illnesses among the sample population as reported by them. This has been assessed by asking the woman to report about the major and minor illnesses that they suffered in the recent past. This is often named as perceived morbidity or self reported morbidity and it refers to reporting of episodes of illnesses occurring in a span of a specified time period (recall period) by the respondent himself/herself

Major illness: An illness which took longer to cure, which was painful and which affected the physical output of women was considered as major. Illnesses that doesn't happen very regularly and that requires prolonged treatment are included in this category. These illnesses were categorized as intestinal, communicable, chronic, heart related, reproductive etc. and the recall period was three years.

Minor illness: An illness that could be cured easily in a shorter time and did not involve pain or involved pain which was of shorter duration was considered as minor. Illnesses which occur among individuals much more often and which can be cured in a much shorter duration are included in this category. These illnesses were categorized under cold, cough, backache, head ache, fever, accident, tension & related disorders, and the recall period was three months.

Besides self reported morbidity a woman's perception about her own health was also considered. They were asked to rate their health as excellent, very good, good, fair and poor. Hence forth, this would be referred as Self perceived health status. Women's perception about the health of the other group (if housewife then that of working and vice versa) was also asked.

4.2. *Health seeking behavior*- Is most commonly understood as an individual's response to his or her illness. In this study health seeking behaviour has been understood by assessing the health services that the respondents seek for the treatment of major and minor illnesses, the stage at which the treatment is sought and also the amount of money spend on health care (monthly and routine checkup).

4.3 *Health related behavior*- Is defined as any behavior that influences, or is believed to influence the physical health outcomes, either by increasing or decreasing their risk and severity. For the purpose of the study health related behaviors were categorized into exercise, meditation, dietary pattern, leisure time, leisure time activities and sleeping hours. Specifically the variables that are considered under this are the type of health related behaviors followed by the two groups of women, money spend for these behaviors which is termed as money spent on well being, weekly leisure time, type of leisure activities and Sleeping hours. Leisure is understood as the free time which the woman gets in which she is free from any form of work.

5. *Role Stress:* Also known as Role Strain is the general stress experienced when the demands of one or more roles are inappropriate, unfair or unrealistic. Role stress is many times also referred as stress in the thesis.

6. Role Enhancement: When an individual is successfully able to combine the demands of the different roles that he or she performs. When an individual experiences role enhancement he or she usually experiences a better sense of well being as the disappointments in one role are compensated with the success in the other.

7. Socio Economic Categories: The Socio Economic Background of the respondents has been mentioned by total family income. The family income of the respondents has been broadly divided into three categories namely:

1. Low Income Group: This would include families with income in the range of Rs.1, 500-Rs.10, 000 /-.

2. **Middle Income Group:** This consists of women with family income ranging between Rs.10, 001-20,000/-.

3. **High Income group:** This consists of women with a family income of Rs.20, 001/- and above.

2.4. Area of the Study

Mumbai, the Commercial capital or the Fashion capital of India has one of the largest working population. Millions of people migrate to the city from various parts of the country in the pursuit of job as it has a wide range of job opportunities right from working in small production units to working in big multinational companies. As a result, even the population of female workers in the city is quite large in comparison to that of the other metros. Working women of diverse, caste, creed and socio-economic backgrounds forms a very vital component of the city's population. The diversity of this group can be easily seen by simply getting into the ladies compartment of any local train(which is the life line of the city). On one side one can see the housemaids, sweepers and vegetable vendors and on the other hand one can see the hip, hop and happening executive who works in multinational companies and earns a handsome salary. While for the first group job is a dire necessity for the other it is just a means of improving ones status. In spite, of the differences between these two groups of women the problems faced by them is quiete the same, both are constantly struggling to fulfill the demands of their familial and occupational roles. One often seen sight which tells this story, is the women buying and cutting vegetables in local trains on their way back home.

This problem universally faced by working women all over, becomes all the more pertinent for the working women of Mumbai city. Mainly because of the extremely fast pace of the city, the long and arduous distances that are usually required to travel to the work place and the lack of social support (as most of these women are migrants).Hence, Mumbai seemed to be the ideal city to study the problems experienced by working women in balancing the multiple roles and it's resulting implications on their health and wellbeing.

Specifically the study was conducted in Anushakti Nagar, Mumbai, which is the residential colony of the employees of Bhaba Atomic Research Centre (BARC) and

is commonly known as BARC colony. This colony is located in Chembur, on the Mumbai Pune highway. The colony is well connected to all the places by BEST buses and the nearest station for local trains from the colony is Mankhurd.

BARC is a premiere multidisciplinary nuclear research centre of India. It was set up by Dr. Homi Jahangir Bhaba who realized the immense potential of nuclear energy as a viable alternative source for electric power generation in the early 1950's.It was around this time that the Anushakti Nagar colony was also set up for the residences of the BARC employees. The lush green sprawling colony is in the form of a township stretched over an area of nearly 2,500 acres (approximately).It has several shopping complexes, gymnasiums and community centres for its employees. Besides there are three Central Schools which provides free education to the employees of BARC. For health care, the colony has three CGHS dispensaries which provides free treatment to all it's employees and one hospital which has general, orthopedic and pediatrics wards. It also has two creche's for the children of the working women.

BARC provides employment to a wide range of people which includes engineers, academicians, technicians who are employed on the high rung. In the middle rung it employs clerks and administrative staffs and the lower rung employees consists of sweepers, drivers, malis, mechanics etc. Each of these three types of employees are allocated houses in three different sections of the colony. The engineers, scientists and academicians who belong to the high income group reside in the central part of the colony. The eastern part is allocated to the lower grade employees which comprises of drivers, malis, sweepers and helpers and the western side of the colony is allocated to the middle level employees which consists of clerks and other administrative staff. Since, the colony is already divided into these three clusters, on the basis of income of the employees, it was easier for the researcher to select the respondents belonging to three income groups of high, middle and low, which is one of the important objectives of the study. Hence, this was the primary reason for the researcher to choose this area as she wanted to cover working women and housewives belonging to different socio-economic groups. Another peculiarity of the colony is that it has employees from different parts of the country. So, one can say that the colony represents the culture and traditions of people from different regions. This was another reason for the researcher to choose this area as she wanted to get views of women belonging to

varied cultural backgrounds as well. The researchers familiarity with the area and it's proximity to her place of residence served as other important reasons for the choice of this colony. Besides a fair amount of both housewives and working women belonging to different socio economic backgrounds, reside in the area hence allowing for higher probability of fulfilling the research objectives of the study.

2.5. Research Design

The present study is both quantitative and qualitative in nature. A sample of 150 women were obtained to conduct the field survey. To substantiate the findings of the quantitative survey in-depth interviews were also taken of few respondents. Universe, sample, sampling, and methods of data collection are discussed as follows-

2.6. Selecting the Respondents of the study

The universe of the study included all women who were married, working and housewives, cohabiting with their husbands or his family, working or residing in Anushakti Nagar, and falling in the age group of 25 to 60 years. From this universe, a set of 150 respondents (75 housewives and 75 working women) were selected by using Purposive Sampling Technique. As mentioned earlier, in Anushakti Nagar, a residential unit reflects an individual's professional hierarchy and therefore the income group. Since the research intended to cover women belonging to diverse socio-economic backgrounds, hence the researcher divided the colony into three clusters of high, middle and low income on the basis of the income of the respondent's husband who was an employee of BARC. Fifty households were then purposively selected from each cluster, after which an equal number of housewives and working women were selected from each of these 50 households.

Purposive sampling is a technique in which the respondents are chosen on the basis of their availability. For, the purpose of better generalization the researcher wanted to use random sampling by choosing every 3rd or 4th household in each of the clusters. But this proved to be difficult as the researcher wanted to select an equal number of housewives and working women, and it happened so that many times the researcher would come across more number of housewives than working women since the working women were out of the home most of the time. Hence, in order to have an

equal distribution of housewives and working women the researcher felt that purposive sampling would be the most suitable method.

2.7. Methods, Sources and Tools of Data Collection

Quantitative and Qualitative methods of data collection was used. Interviews with the women were used to gather quantitative data. Case study method and narratives were used to document qualitative data. Some data were collected from secondary sources as well.

The tools that were used to collect primary data are as follows:

1. **Interview Schedule:**

Quantitative data was gathered from the respondents by using a structured interview schedule. This method of gathering information was followed mainly because of the following reasons:

a. In this method as the two parties, interviewer and interviewee are face to face to each other, they can encourage and stimulate each other and thus better answers can be arrived at.
b. The interviewer can check information while recording them and can also seek clarifications in case of any doubts.
c. This method facilitates easy flow of thought and enables the respondent to understand the questions better by clarifying doubts with the interviewer (Kothari C R, 1985).

The interview schedule used for this study tried to cover information about the demographic characters of the respondents, the work details of working women, marital details, social roles and social support, health and health related behaviors of the women of the two categories. The interview schedule divided into five subheadings covering the above details can be seen in the Annexure1. The same schedule was administered both on working women and housewives. For, housewives the third section on the work details was skipped. For, the purpose of analysis in SPSS all the questions were made close ended. Open ended questions were also used for in-depth interviews.

Qualitative data was collected by using non participant observation and case study method.

2. Case Study Method:

Case Study is a way of organizing social data so as to preserve the unitary character of the social object being studied. Expressed somewhat differently it's an approach that views any social unit as a whole (Good & Hatt, 1981).

Some respondents whose case was found unique or who represented an ideal example of role stress or role enhancement among the two groups of respondents were studied in great detail. In-depth interview was used as a tool for gathering case studies. For the sake of confidentiality the names of the women whose cases are presented in this dissertation have been changed and a Pseudonym (false name) has been used.

3. Non Participant Observation:

According to Goode & Hatt (1981) "Science begins with observation and must ultimately return to observation for it's final validation." (Goode & Hatt ,1981).

In non participant observation the observer doesn't actually participate in the activities of the group, but simply observes them from a distance (Bajpai SR, 1960). This is a very important and useful tool for data collection, as it helps in assessing the intangibles like the living conditions or the personality type of the respondents.

Observation was done while taking interviews as well as while moving around the colony. This method was used to supplement and validate the data collected by interview schedule. It gave an idea of the houses, the relationship of respondents with their spouses and children, their nature, attitude etc. Many times it also helped the researcher in making out the health status of the respondents from the look on their faces. Eg. in the low income group there were cases where some women reported of having good health but they looked anaemic, malnourished and weak. Besides it also helped the researcher to make out the total family income of the respondents family when they were trying to hide the same.

Secondary Sources were gathered from books, journals, reports, unpublished dissertations, websites and news paper clippings.

2.8. Data Analysis

Quantitative data was analyzed by using SPSS package. Descriptive statistics, bivariate and multivaraite analysis were done to understand different variables and to see their effect on the health status, health seeking behavior and health related behavior of the working women and housewives belonging to diverse socio economic groups.

Qualitative data is presented in the form of case studies and narratives. Narratives are used to present some very relevant remarks, or responses of women to some specific questions.

2.9. Limitations of the Study

The study has been done in Anushakti Nagar popularly known as Bhabha Atomic Research Centre (BARC) colony. Most of the BARC employees reside in this colony and are covered under a comprehensive CGHS scheme and were availing free health services in the CGHS dispensary of BARC. This is the reason for the preference of public sector by most of the respondents. A greater differential with regard to the source of health seeking behavior would have been observed if another set of respondents were taken who were not covered by this scheme, but due to time constraint this set of respondents could not be taken. However, the study does reflect the differential between the health seeking behavior among the working and non working women in terms of time of treatment and the money spend on treatment. Besides, the purpose of the study was to investigate the relationship between Employment and health of the working women and housewives. Source of care seeking is just one component among many others.

A greater number of sample covering two, three areas in Mumbai could help in better generalization. However, this could not be done due to time constraints.

2.10. Problems Faced in the Study

One major problem that the researcher had to face in the course of data collection was that in the lower income group most of the households consisted of housewives as women in this income group were not qualified enough to take up jobs. Hence, it was really difficult to locate working women in this group and so the researcher had to consider housemaids who were working in the households within the campus but who were staying outside.

Similarly in the high income group most of the households consisted of working women and it was difficult to locate housewives. This can again be attributed to the educational qualifications of the women in this income group due to which most of them were professionally qualified to take up some jobs and the ones who were not, had enough money to start up some petty business in their homes.

CHAPTER III

SOCIO-ECONOMIC PROFILE OF THE RESPONDENTS

The present chapter gives a brief profile of the respondents of the study. It covers details about the socio-demographic and economic background of working women and housewives and their families. The socio-demographic and economic profile includes information about the age, educational background, income, religion, family details, marital details of the housewives and details about their husband's education, income and employment. For employed women besides the above information it also includes details about their job. The chapter is divided into three sections; the first presents a picture about the demographic details like age and family size, the second talks about the education and income and the last section deals with the employment details of the respondents.

I DEMOGRAPHIC DETAILS

1) Age Profile & Religion

As seen in section 3.1 a of table 3.1, out of the total of 150 respondents 48.7% fall in the age group of 25-35 years, 40.7 % belongs to the age group of 36-45 years and 10.7 % belongs to the age group of 46-60 years. Hence, the maximum number of respondents belongs to the age group of 25-35 years. Also the mean age of the respondents is 36.53 year. So it can be concluded that most of the respondents are middle aged.

93.3% of the respondents belong to the Hindu religion and the rest 6.7% belongs to the Muslim (4) and Christian (6) community.

2) Family Details

2.1. Marital Status

As seen in section 3.1(b) of table 3.1, 142 women are married and cohabiting with their husbands and 8 are not cohabiting with their husbands, as they are either widowed or divorcee. It is interesting to note that all these 8 women who are not staying with their husbands are working mainly as housemaids and sweepers and hence belong to the low income group. They are working mainly to sustain themselves and their families. For them employment is a compulsion and not choice. This can come out more clearly from

the statement made of a 50 year old sweeper, when she was asked as to whether she was satisfied with her job

"I don't like my job, it's too strenuous for my age but still I've to do it as I don't have any other option. I have to feed my children anyhow."

Another widow who stays with her in-laws shared:

"Its only because I earn that I am tolerated in the house. I have two daughters aged 3 and 6 years. My husband was mysteriously stabbed 3 years ago. I was expecting my younger daughter then. My earnings are largely spent to meet basic household expenses and children's education".

TABLE 3.1: Demographic Details of the respondents (Age, Marital Status, Size of the family & Number of earning members)

3.1(a)Age		
Age Group	**Frequency**	**Percent**
25-35	73	48.7
36-45	61	40.7
46-60	16	10.7
Total	150	100.0
3.1(b)Marital Status		
Married	142	94.7
Widow	3	2
Divorcee	5	3.3
Total	150	100
3.1(c)Size of the Family		
Upto 4	104	69.3
More than 4	46	30.7
Total	150	100
3.1(d)Number of Earning Members		
Upto 2	133	88.7
More than 2	17	11.3
Total	150	100.0

Similar statements were shared by other single women who were working in similar low rung jobs. In the absence of their husbands support these women were heavily burdened with both familial and economic responsibilities.

3.2. Family Size

Table 3.2: Size of Family v/s Income & Number of children v/s Income

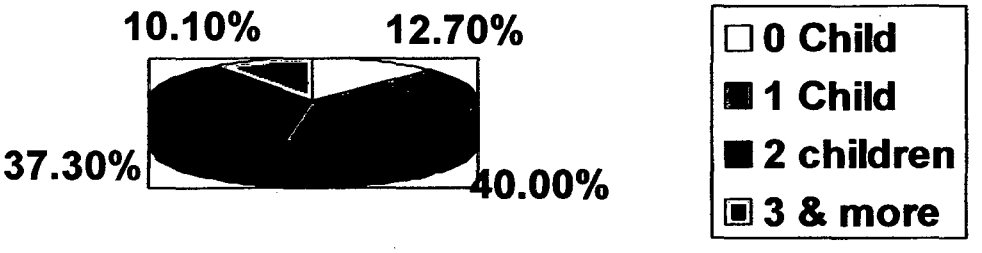
3.2(a)Size of Family v/s Income (Percentages in Parenthesis)				
Number of Family Members	**Total Family Income**			**Total**
	Rs.1500-10000	**Rs.10001-20000**	**Rs.20001 & above**	
Upto 4	20(19.2)	32(30.8)	52(50)	104(100)
More than 4	29(63)	11(23.9)	6(13)	46(100)
Total	49(32.7)	43(28.7)	58(38.7)	150(100)
3.2(b)Number of Children v/s Income				
Number Of Children	**Total Family Income**			**Total**
	Rs.1500-10000	**Rs.10001- 20000**	**Rs.20001 & above**	
2 and less	37(27.4)	41(30.4)	57(42.2)	135(100)
More than 2	0(0)	2(13.3)	1(6.7)	15(100)
Total	49(32.7)	43(28.7)	58(38.7)	150(100)

Section 3.1(c) of table 3.1 shows that almost 70% of the respondents have 4 and less than 4 family members and only 30% of the respondents have a family size of more than 4 members. It's a common notion that people in the low income group have bigger families. The data presented in section 3.2(a) of table 3.2, also shows a similar result as 63% of the families having more than 4 family members belonged to the low income group.

Section 3.1(d) of table 3.1 shows a significant difference in the percentage of women having 2 or less than 2 earning members(88.7 %) in comparison to those having more than 2 earning members (11.3 %).Number of earning members in the family is a good indicator of the economic status of the family. It's commonly assumed that the more the earning members the more will be the family income. However, this isn't the case here. More than 2 earning members are mainly present in the low income group where the families are big. An explanation to this can be that in the low income group families don't have enough money to sustain themselves and hence all the family members have to engage in some kind of productive activity in order to fetch in some extra money.

Families in the high and middle income have only one or two earning members as they are usually nuclear families comprising of husband, wife and children.

Figure 3.1: Number of children present in the respondent's family



The pie chart (Fig 3.1) above, shows that the maximum number of family's of the respondents have only one child and nearly the same percentage have 2 children. Only 10% of the respondents have 3 and more than 3 children. This can mainly be attributed to the fact that majority of the respondents were educated and would thus be aware of family planning methods. This can be further elucidated from the table 3.3 which shows the presence of number of children in families with different educational backgrounds.

As seen in the table 3.3, a significantly high percentage of the families having more than 2 children have mothers who are illiterate and educated up to 10^{th} (80%), where as only 20% of graduate women have more than 2 children and none of the postgraduate women have more than 2 children. Thus, the data proves that illiteracy is a major factor which leads to high population. It is also observed that most of these families having more than 2 children belong to the low income group (refer section 3.2 b of table 3.2). This is again because people in the low income group are less educated and hence may not be aware of measures to control their family size. Also, for people in the low income group more children acts as an asset which contributes to their family income (Mamdani, 1976). Hence, they don't want to limit their family size. It's mainly because of this reason that they don't even educate their children, thereby there investment on them is almost nil. As mentioned by Zubrigg in her Rakku's story, "For over half of the village families, sending children to school is entirely out of reach economically- not because the village schools are costly for primary education, for primary education technically is "free". But

rather, because most landless families cannot afford even a single non producing family member. At present only 25% of all Indian children complete primary school" (Zubrigg S, 1991).

Table 3.3: Mother's education and the number of children

Number of Children	Respondents Education (Percentages in Parenthesis)				
	Illiterate	Upto 10	Graduate	Post Graduates	Total
2 and less	19(14.1)	16(11.9)	61(45.2)	39(28.9)	135(100)
More than 2	4(26.7)	8(53.3)	3(20)	0(0)	15(100)
Total	23(15.3)	24(16)	64(42.7)	39(26)	15(100)

II. EDUCATION & INCOME

1) Year of Schooling

As seen in table 3.4, out of the 150 respondents 43 % are graduates, 26 % have done their post graduation, 16 % are educated up to class 10 , and 14.8% % are illiterate.

The distribution of respondent by education in different income groups can be analyzed as follows-

The respondents are distributed across the three income groups of high, middle and low, on the basis of their total family income. Families with the monthly family income ranging from Rs.1,500-10,000 are considered to belong to the low income group, those with income in the range of Rs.10,001-20,000 are considered to belong to the middle income group and those with a monthly income of Rs.20001 & above are considered to belong to the high income category. As seen in table 3.4, 32.6% of the respondents belong to the low income group, 28.6% belongs to the middle income group and 38.6% belongs to the high income group. So, the respondents are more or less uniformly distributed across the three income groups.

Table 3.4: Distribution of respondents and their spouses by education across income groups

Total Family Income of the Respondent (in Rs)	Education level of The Respondents And Their Husbands (Percentages in Parenthesis)								Total	
	Illiterate		Upto 10		Graduate		Post Graduate			
	Res	Hus	Res	Hus	Res	Hus	Res	Hus	Res	Hus
1,500-10,000	23 (45.8)	18 (36.7)	18 (37.5)	20 (40.8)	8 (16.7)	11 (22.4)	0(0)	0(0)	49 (100) (32.6*)	49 (100)
10,001-20,000	0(0)	0(0)	6 (14)	1 (2.3)	31 (72)	18 (41.9)	6 (14)	24 (55.8)	43 (100) (28.6*)	43 (100)
20,001 & above	0(0)	0(0)	0(0)	0(0)	25 (43.1)	7 (12.4)	33 (56.9)	51 (87.9)	58 (100) (38.6*)	58 (100)
Total	23 (15.3)	18 (12)	24 (16.1)	21 (14)	64 (43)	36 (24)	39 (26.2)	75 (50)	150 (100)	150 (100)

***Percentages across columns**

All the illiterate women of the sample (23 women) belonged to the low income. Out of the total (49) women belonging to this category a little less than 50% are illiterate, 38% are educated up to 10^{th} and 17% are graduates. In contrast to this, in the high income group there is hardly any woman who is illiterate or educated till class 10^{th}.

Hence, the data here shows that the level of education is directly related to the family's income. The high income families have most (84.6%) of the postgraduate degree holders, while the low income group has almost all of the illiterate women. It's not only that the women of this income category who are illiterate, but their children too are unable to access schooling or any other form of education. This can be said from the fact (refer table 3.5) that out of the total 123 families having children in and above the school going age, only 6 families are not sending any of their children to the school and all of these belong to the low income group. On the other hand, in the other two income groups of high and middle there is no such family which is not sending any of their child to school.

Besides, in the low and middle income groups there are families who are sending their boys to the school and not educating their girls, mainly because they can not afford education of all their children. When it comes to prioritize one child's education, it's more likely the boy in the family who gets the advantage. This is largely because of

socio-cultural values which attaches a whole lot of importance to the boys. The number of families that are selectively sending their children to school is highest amongst the low income group with 6 families as compared to the middle income group with 3 families. In contrast to this, in the high income group all the families are sending their children to school, there is no family in this group who is not sending or selectively sending their children to school. This is mainly because of the fact that the low income families don't have enough money to educate their children even though they want to.

This fact was further revealed when one of the domestic maids who doesn't send any of her children to school expressed her feelings-

"I want to send my children to school but I can't afford the same. I hardly have the money to give two square meals to my children, then where do I bring the money for their school fee?"

Hence, it is evident from the data that education has become the privilege of the rich. The situation has deteriorated further with the privatization of education due to which good quality education has become so costly that it has almost become out of the reach of the poor. The govt. schools which often provides rescue to these people provides education just for the name sake as it lacks infrastructure and committed teachers. Hence, the poor at large are deprived of good, quality education.

The gender differential in education is also evident from the table 3.4.In each of the three income categories the husband's educational standard is better than their spouses. In the lower income category while there are 22 women who are illiterate, there are only 18 men who are illiterate. Similarly, in the high income group the number of women having postgraduate degree is 33, while there are 75 men in this category who are postgraduates. This trend is seen in all the other categories and across all levels of education. Hence, across all income groups it's the men who are more educated as compared to their counterpart. This is mainly because of the prevailing social structure where men are given preference for education. It is interesting to note that the gaps between men and women

increase with income! If, we consider one category of graduates, in the low income group the difference between the number of males and females is 3, while in the middle income group this difference increases to 13, and in the high income group it further increases to 18.This shows that in the low income category due to poverty the general levels of education are low as people in this income category can't afford it. But, in the middle and high income group where money is not a constraint for education, still priority is given to the education of males.

Table 3.5: Children's education across income groups

Total Family Income of the Respondent (in Rs.)	Children's Education- attending/attended school			Total no. of families with children in and above school going age
	Few	All	None	
1,500-10000	6	31	6	43
10,001-20,000	3	25	0	28
20,001 & above	0	52	0	52
Total	9	107	6	123

2) Professional Education

Any form of education that helps one get a job after its completion is known as professional education. The most commonly pursued professional degrees in India are Engineering, Medical, MCA, MBA, Banking etc. Any individual having done any of these courses is known as professionally qualified.

With regards to professional education of the respondents, 14% of the respondents are professionally qualified. Out of these 12 have degree and 9 have diplomas. As seen in the table 3.7, none of these professionally qualified women belong to the low income group; all of them either belong to the middle or high income group. Around 66.7% of the professionally qualified women belong to the high income group and the rest 33.3 % belongs to the middle income group. This again proves the above mentioned fact that professional education has now become a commodity which only the rich can buy. Under these circumstances how can one ever expect the poor to break the vicious cycle of poverty?

The gender differential is evident here as well. While only 14 % of women are professionally qualified, 58.5 % of their husbands are professionally qualified. Table 3.7 also shows that across all income groups the number of men receiving professional education is more than the women.

Table 3.6: Professionally qualified men and women

Professional Qualification	Respondents	Husbands
	Percentages in Parenthesis	
Professionally qualified	21(14)	83(58.5)
Not qualified	129(86)	59(41.5)
Total	150(100)	142(100)

Table 3.7: Distribution of women and the husbands by professional education across the income groups

Professional Education	Income (Percentages in Parenthesis)						Total	
	Rs.1,500-10000		Rs.10001-20000		Rs. 20001 & above			
	Res	Hus	Res	Hus	Res	Hus	Res	Hus
No	49(38)	41(49.4)	36(27.9)	24(28.9)	44(34.1)	18(21.7)	129(100)	83(100)
Yes	0(0)	0(0)	7(33.3)	19(32.3)	14(66.7)	40(67.7)	21(100)	59(100)
Total	41(28.8)	43(28.7)	43(30.2)	58(38.7)	58(38.6)	150(100)	49(32.6)	142(100)

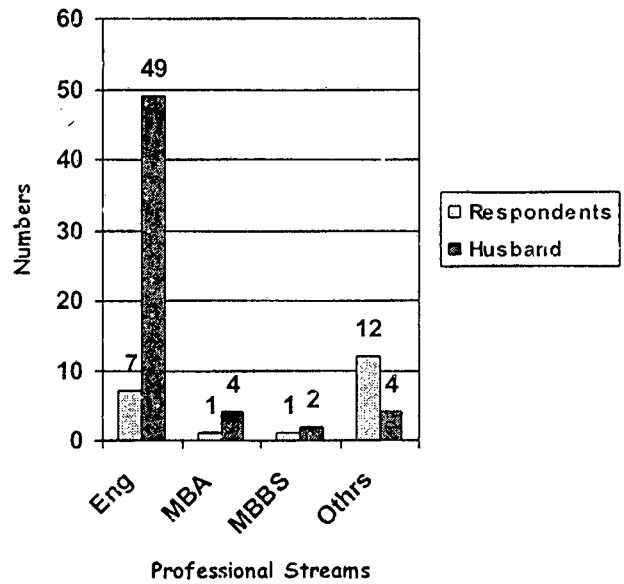
3) Type of Professional Education

Out of the 21 women with professional education 33% are engineers, 5% are doctors and engineers and 52% have done other professional courses like nursing, food and nutrition, chartered accountancy etc. The high number of women with engineering background can be attributed to the fact that the respondents are selected from Bhaba Atomic Research Centre (BARC) which employs the maximum number of engineers.

The bar diagram (Fig. 3.2) below, shows that there's a marked difference between the number of men and women in the engineering field, while in MBA and MBBS there is a

marginal difference between the two. Since the respondents are selected from BARC hence the maximum number of men are engineers. While there are 7 women who are engineers, there are 49 men engineers. It's only in the fourth professional type which includes nursing, food and nutrition etc. that women outnumber men. While 57.14% of women have received their professional qualification in other streams, only 6.8% of the men belong to this category. This can mainly be attributed to the fact that very less expenses are involved in these courses and women undertake them just for the name sake. However, men are not interested in these professional disciplines as they don't bring good job prospects.

Figure 3.2: Men and women in different professional streams.



4) Income-Respondents, Husbands and Total Family Income

As seen in table 3.8 while half of the women earn a salary of less than Rs.5000, 1/4th of their spouses belong to this income category. However, the number of women earning a salary between Rs. 5001- 15,000 is the same as that of their counterparts. Around 19% of the women earn a salary above Rs.15001, 43.3% of their spouses earn salary in this category. If we compare the percentages of men and women within each category, again we find that the percentage of men employed in better paying jobs is far more than the women. Out of the total number of people employed in jobs with salary less than Rs. 5000, 70% are women and 30% are men. However, among the people employed in jobs

with salary more than Rs.15000/- the majority (67%) consists of men, women constitutes 33%of the population.

Table 3.8: Income of the working women and their Husbands

Income in Rupees	Respondent	Husband	% R*	% H*	Total*
Less than 5000	40(53.4)	17(25.4)	70	30	57(100)
5001-15000	21(28)	21(31.3)	50	50	42(100)
15001 and above	14(18.6)	29(43.3)	33	67	43(100)
Total	75(100)	67(100)	53	47	142(100)

Contribution of women to the family income

Working women were found to contribute a substantial chunk to their family income. Most of the women were found to be contributing more than 20% to their family income as only 6% of the women were found to contribute less than 20% to their family income. Twenty percent of women are contributing around 21-40% to the family income, 14.7% are contributing 41-60% to their family income and 9.3% of the women are contributing more than 60% to their family income. So, the percentage of women contributing more than 60% to their family income (9.3%) is more than the percentage of women contributing less than 20% to the family income (6%). Hence, the working women of the sample population are making major contributions to their family income. Housewives on the other hand felt guilty of the fact that they were not able to contribute anything to the family income.

The data in table 3.8 shows that more than 50% of the women are earning less than Rs.5000 and very few of them are earning more than Rs.15,001, in contrast a little less than 50% of their spouses are earning more than Rs.15,000 and very few of them are earning less than Rs.5000. Hence it can be inferred that the contribution of working women to the family income is mostly less than their husbands in the low and high income group. Even the most well paid working women had husbands who had a much higher salary. However, in the middle income group the contribution of women is almost the same as that of their spouses. Though the maximum working women were earning

less than their spouses some were found to earn more than their spouses and thus making a significant contribution to the family' s income. One such woman shared:

"My husband has resigned from his job as the work was much and the payments were delayed for three months. At present he is supervising construction work on a plot that we have. I expect little money out of him. My job is important as I have two daughters aged 3 and 6 years to take care; in-laws are the other dependents in the family".

But the numbers of such women supporting the entire family were very few. Around 20% of the working women are contributing more than 50% to their family income. Hence, it can be inferred that though the women of the sample population are contributing substantial chunk to their family income but very few are contributing more than their husbands contribution. It's popularly believed that women are commonly (though unrealistic) perceived as wives or mothers to be, further perpetuating the fallacy that they have a male member to support them life long (Krishnaraj, M) and thus seek employment for pocket or pin money. Similar views have been given by Sen and Sen (1985) according to whom 'Women work only for "pin" money and the wives income rarely exceeds that of her husband' (Sen and Sen, 1985). Though the data supports the second part of the statement but it goes against the first, as even though the respondents were earning less than their husbands but they were contributing a substantial chunk to their family income and were not just earning "pin" money. Infact the presence of a working woman substantially added to the family income. Single women who didn't have their husbands to support them, were more heavily burdened with economic responsibility.

An interesting observation which needs a mention here is that while working women had no hesitation in sharing their income as well as that of their spouses. Most of the housewives were hesitant in disclosing their husband's income. Also most of these women were not aware of the exact income figures and shared the rough amount.

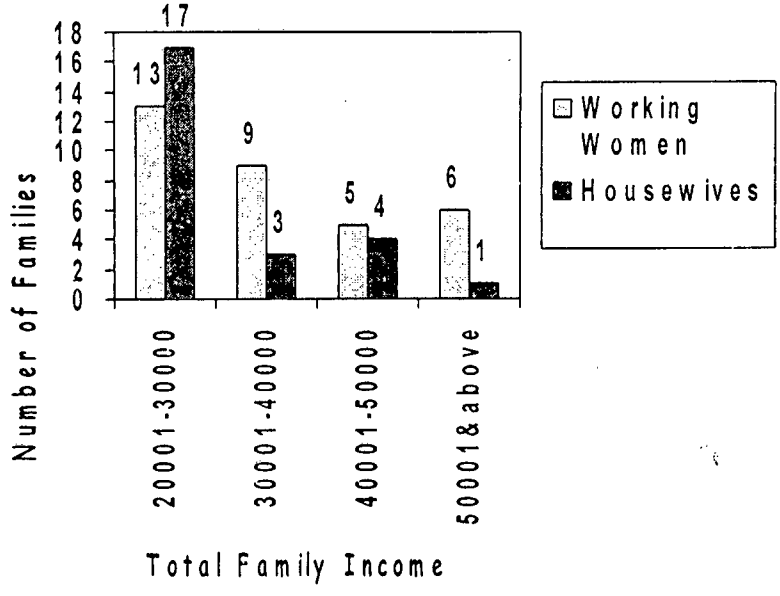
Table 3.9: Distribution of working women and Housewives across the three income groups

WORK STATUS OF RESPONDENT	TOTAL FAMILY INCOME (in Rs.) (Percentages in Parenthesis)			Total
	1500-10,000	10,001 -20,000	20,001 and above	
Employed	25(33.3)	17(22.7)	33(44)	75(100)
Housewife	24(32)	26(34.6)	25(33.4)	75(100)
Total	49(32.7)	43(28.7)	58(38.7)	150(100)

As seen in table 3.9, a greater percentage families having a working women (44%) fall in the high income category with family income more than Rs.20,000, in comparison to 33% of families having a housewife and falling in this income category. A more distinct picture can be seen by the bar diagram (Figure 3.3) given below, which specifically shows the distribution of families of the working women and housewives in further categories of the high income group.

The bar diagram (Fig.3.3) clearly shows that the percentage of families having a working woman belonging to the income groups of Rs.30,001-40,000,Rs.40,001-50,000 and Rs.50,001 and above is more than the percentage of families not having a working woman. This shows that the presence of a working woman adds to the family income and raises the economic status of the family.

Figure 3.3: Showing the families of working women and housewives belonging to the further categories of high income group.

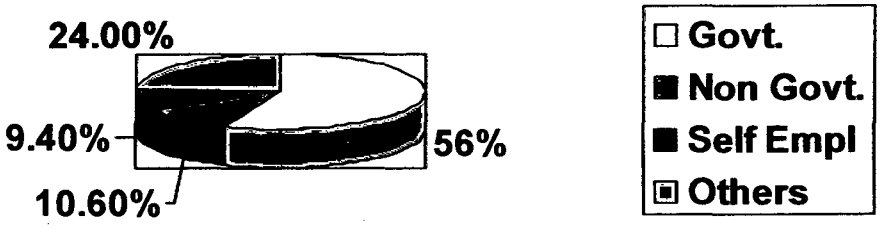


III. WORK & EMPLOYMENT

1. Sector of Employment

It has been mentioned earlier that 50 % of the respondents are working women and the rest 50 % are housewives. The pie chart below (figure 3.4) shows that more than 50% of the working women are employed in the govt. sector, 10.6 % are employed in the non govt. sector and 9.6% are self employed. This again can be attributed to the choice of the study area. The maximum number of respondents are employed in BARC which is a govt. sector enterprise. The self employed women are primarily housewives belonging to high income group who are running some petty business in their homes like opening up of boutique or selling of tubber ware, taking tuitions at home or running a beauty parlour. Around $1/4^{th}$ of the working women are employed in other sectors, which primarily includes the unorganized sector and comprises of sweepers and housemaids.

Figure 3.4: Sectors of employment of the working women



2. Type of Employment

As seen in the table 3.10, 29.4 % of the working women are employed as housemaids and 28 % are employed in clerical jobs, 10.6% are employed in administrative jobs and an equal percentage is employed as scientists. 8 % are employed in teaching and the same percentage of the women are entrepreneurs. This data further throws some light as to why more than 50% of the working women have a wage less than Rs.50,00/-.This is mainly because of the fact that more than 50 % of the women are employed as housemaids and lower division clerks, which are very low paying jobs. The table shows a difference in the number of women and their husbands. This is mainly because 8 women of the sample population are widows and divorcees.

Gender differential is also seen in the type of employment. While most (60%) of the working women are employed in lower rung and low paying jobs, their husbands are mostly (70 %) involved in higher rung and higher paying jobs. Hence, the data clearly shows that women are mostly occupying jobs of low wages and low status in comparison to their husbands. This is also due to the fact that a very less number of these women are professionally qualified in comparison to their husbands (refer section 3.3 (a) of table). Another information that comes across through this table is that teaching is a profession which is restricted only to the women.

Table 3.10: Professions of all the working women and their Spouses

Type of Occupation	Respondent	Husbands
	Percentages in Parenthesis	
Housemaid/laborer	22(29.4)	13(19.4)
Clerical	21(28.0)	4(6.0)
Administrative	8(10.6)	3(4.5)
Teaching	6(8.0)	0(0)
Scientist/engineer	8(10.6)	16(23.9)
Executive	2(2.6)	17(25.4)
Entrepreneur	6(8)	7(10.4)
Others	2(2.6)	7(10.4)
Total	75(100)	67(100)

Similar to the husbands of working women, more than 50% of the husbands of the housewives are employed as engineers. This is mainly because of the fact that these women are residing in BARC colony and are married to its employees who are mostly engineers.

Conclusion

The major findings that come across from this chapter are as follows:

- Most of the respondents fall in the age group of 25-35 years.

- Almost all the respondents are of the Hindu religion, 4 are Muslims and 5 are Christians.
- The respondents are equally distributed across the three income groups of high, middle and low. More families of the working women fall in the high income group. Thus, the presence of a working woman raises the socio-economic standard of the family.
- Most of the respondents are married and are cohabiting with their husbands, some working women of the low income group are widowed and divorcee.
- Most of the respondents have a family size of 4 and less than 4 family members. Most of these families with larger family size belonged to the low income group.
- Most of the families have 2 or less than 2 earning members in their family. The families having more than 2 earning members mostly belonged to the low income group.
- Most of the families have one or two children and very few have more than 3 children. The families with greater number of children are usually the ones with low educational backgrounds of the mother. Hence, family size is a direct function of education level.
- Most of the respondents are graduates. Women of the high income group are better educated than women of the low income group. Hence, the level of education is directly related to family's income.
- All the children in the school going age who are not going to school belong to the low income. Some families of the low and middle income group are selectively sending their boys to school.
- Across all income groups men are better educated in comparison to their counterparts.
- Gaps in the education level of men and women increase with income. In the low income category due to poverty the general levels of education are low as people in this income group can't afford it. However, in the middle and high income group where money is not a constraint for education, still priority is given to the education of males.

- Very few women are professionally qualified in comparison to men. While 14 % of the women are professionally qualified, 58.5 % of their husbands are professionally qualified.
- Most of the professionally qualified women belonged to the high income group. Most of these women are qualified in fields like nursing, food and nutrition, etc. and very few are doctors or engineers.
- Most of the working women earn a salary of less than Rs.5000/-, while their husbands are employed in better paying jobs. This is mainly because more than 50 % of the women are employed as housemaids and lower division clerks, which are very low paying jobs.
- Working women of the sample population are contributing substantial chunk to their family income but their contribution hardly exceeded that of their husbands.

Hence, the findings of this chapter exhibit a strong gender and class differential. Women are less qualified and educated than men, so they are mostly employed in lower paying jobs and contribute lesser to the family income in comparison to their spouses. Hence, even this small sample population could exhibit the larger scenario in the labour market where women are usually employed in lower rung and lower paying jobs. Radical feminists explains this subordination of women in the workplace as a means of maintaining their subordination at home. If women's earning are not sufficient to make them economically independent they remain at least partially dependent on their men which reduces their negotiating ability in the family and their ability to leave an abusive relationship.

Similarly, a class differential can also be seen in the demographic profile of the respondents. Women of the high income group are better qualified and educated than women in the low income, and families of the low income group are not able to send their children to school even if they want to. Hence it's evident that the division of society on lines of class and gender strongly comes in the way of development.

After taking a look at the profile of the respondents, the next chapter looks specifically into the first objective of the study which is to draw a comparison between the health of working women and housewives.

CHAPTER IV

EMPLOYMENT AND HEALTH-EXPLORING RELATIONSHIPS

Public Health circles in the west have constantly been debating on the effect of employment on the health and well being of women. Various studies have tried to explore this relationship by comparing the health of housewives with that of the working women. Most of these studies have constantly found higher rates of reported illness among housewives than among employed women (Nathanson C, 1980), and have empirically proved this positive influence of employment on health of Women (Artazcoz L et.al., 2003).In most of these studies the positive effect of employment on health are attributed, first, to the self esteem and feelings of accomplishment that come from engaging in a socially productive activity and second to the social contacts that work provides. Housewifery, by contrast (and particularly housework as opposed to child care) is seen as both devalued and socially isolating (Nathanson C, 1980).

Most of these studies have been done in developed countries where women still enjoy a comparatively better social status and have somewhat succeeded in breaking the shackles of patriarchy. In a country like India where domestic work is still considered to be the primary responsibility of the women and where the participation of men in the household activities is quite low, this simplistic equation between employment and health may not hold true. The present chapter tries to look into this relationship between employment and health of women in the Indian context by comparing the health of working women with that of the housewives within the study population.

Health has been measured by using three indicators namely:

1)Health Status-

Health status is measured by considering Self Reported health Status which is mainly the women's perception about their health. Health surveys are increasingly using this indicator of measuring the health as it is the most valid predictor of morbidity because it captures the average health of a population rather than the prevalence of specific conditions or high risk (Borrel C, Muntanner C et.al., 2004).

In the present study self reported health status has been measured by assessing the women's perception about their over all health, which is done by asking them to rate their over all health as '*excellent, very good, good, fair, poor*'. Women were also asked to rate

the health of the other group-housewives in case of working women and working women in case of housewives. This was mainly done to assess the women's satisfaction from her existing roles. Here, the assumption was that a woman who is less satisfied with her role or is having role stress, would definitely find the health of the other group to be better and vice versa.

Besides, women were asked to report about their morbidity as it is also being increasingly considered as a valid indicator of health and well being. This is often named as perceived morbidity and it refers to reporting of episodes of illnesses occurring in a span of a specified time period (recall period) by the respondent himself/herself(Medhiwala N and A Jessani, 1997).Morbidity was measured by asking the women to report about the major and minor illnesses suffered by the women in recent past. An illness which took longer to cure, which was painful and which affected the physical output of women was considered to be major, where as an illness that could be cured easily in a shorter time and did not involve pain or was less paonful was considered as minor (Gittelsohn Joel et.al.,1994). For the sake of the study the recall period for major illnesses was three years, while that of minor illnesses was three months.

2) *Health seeking behavior-*

A woman's health in general is neglected both by herself as well as her family members. According to Sagar Alpana (1991) a woman is rarely considered in need of medical care unless her functioning as a bread winner, mother, wife, or housekeeper is severely impaired. This was seen when women with obvious illness e.g. Malaria, pneumonia, gastroenteritis, bring other family members for medical care (often for the same illness that they are suffering from): often these women go away without seeking aid for themselves- they feel they "will get well anyway, besides it is not anything very major (Sagar A, 1994)."

The reasons for their not seeking care can be many, some of which are poverty, lack of time, distance to clinic, lack of acknowledgement of their illness by their family members etc. A study conducted by *Stree Hitkari (a woman's welfare organization)* on perception

of Bombay Slum Workers regarding refusal to participate in gynecological health programme reveals that most women didn't seek health care due to poverty, loss of wages, lack of time, unsuitable time schedule, distance to clinic and social hardships (Thapan M, 1997). Hence, it can be said that the health seeking behavior of a woman depends on the above factors. In case of working women if the empowering effect of employment is considered, it can be assumed that they have better health seeking behavior than housewives, mainly because of the fact that employment raises the status of women within their family and draws the attention of the family members towards their health which they earlier neglected on account of their being unproductive members of the household. Also employed women don't have to depend on the money of their husbands or other male members of the family to seek medical care. Hence if these two factors are considered, then employed women would have better health than the housewives. However, if the time factor is considered then it can be assumed that a working women has poorer health seeking behaviour than that of the housewives as they don't have enough time for the same. Hence, a working woman though has money of her own to seek medical care, doesn't have enough time for the same. So, the question that arises here is that which one of the two has better health: a working woman who has money of her own but who doesn't have any time, or a housewife who has enough time but no money of her own?

Another aspect which needs further investigation is the kind of services that are sought by the women of the two groups. A working woman, who is well read and more aware of the outside world may expect higher standards of quality of medical care and may not be satisfied with the free or low cost services delivered by the Public sector. This chapter further tries to explore this assumption by comparing the health seeking behavior of housewives and working women belonging to the study population, in terms of the kind of services sought for major and minor illness, the time of treatment and the amount spend on treatment.

3) *Health related behavior*

Health behaviors have been defined in various ways. Conner and Norman (1996) define them as an activity undertaken for the purpose of preventing or detecting disease or for improving health and well being (Conner M, Norman P, 1996). Gochman (1997) in the Handbook of Health behavior research defines them as "behavior patterns, actions and habits that relate to health maintenance, to health restoration, to health improvement (Gochman D S,1997). Behaviors under this definition include medical service usage (e.g. physician visits, vaccination, screening), compliance with medical regimens (e.g., dietary, diabetic, antihypertensive regimens), and self directed health behaviors (eg. diet, exercise, smoking alcohol consumption).

For, the sake of the present study, health related behaviors mostly include the third type of activities, namely self directed health behaviors like exercise, meditation, diet, sanitary measures. Besides, two other health related behaviors like leisure time physical activity and hours of sleeping, which are closely related to constraints of time were also operationalised. It is interesting to note that time use, particularly relative access to leisure and sleep is considered as one of the important dimensions for measuring the status of women according to Gender Equality Index [1] (Kapur R and S Shobna,2001). Here, the assumption is that, since a working woman has less of leisure time due to the arduous working hours, she might be having less of time to practice health related behaviors like exercise, meditation and for that matter even sleeping, all of which might have a negative impact on her health. There can be another facet to this as well, which is is working women are more aware and more conscious to maintain their health and hence they make sure that they find out some time for health related behaviors, where as housewives doesn't understand it's importance much. Similarly, there is another assumption that less of leisure time would prevent one from engaging in activities like watching TV, reading or socializing which are absolutely necessary for the mental and physical well being of an individual. Hence, this chapter also tries to explore this further by comparing the health related behaviors of a housewife and working woman and its

[1] Gender Equality Index was propounded by Wieringa(1999), and is in the process of further development by researchers at and around the Institute of Social Studies at the Hague

resulting impact on their health. In order, to understand the health related behavior, variables like the number and type of health related behavior, the amount spend on these activities, leisure time, leisure activities and sleeping hours are taken into account.

With the above understanding of defining health in terms of the health status, health seeking behavior and health related behavior, the rest of the chapter tries to look at these among the two categories of the sample population namely housewives and working women to analyze the effect of employment on the health of the study population. The income differentials, within each of the two groups of women, and the influence of socio-economic status of the family on the health, which is quiete significant, is analyzed in the next chapter.

The present chapter is divided into three sections. The first section compares the health status of the working women and housewives in terms of the presence of the major, minor and total illness, the second looks at the health seeking behaviour for these illnesses in terms of the source of treatment, the time of treatment and the money spent and finally, the last section tries to compare the health related behaviour practiced by the women of the two groups.

I. HEALTH STATUS:

1.1 MORBIDITY

a)Major Illnesses

As seen in Table 4.1, major illnesses are prevalent more among the working women in comparison to the housewives. While 54.7% of the working women suffer from one or more major illness listed in table 4.2, only 45.3% of the housewives are affected by these.

Table 4.1: Major illness present among Working women and Housewives

Work Status Of respondents	Presence of Illness (Percentages in Parenthesis)		Total
	Illness absent	Illness present	
Employed	34 (45.3)	41(54.7)	75(100)
Housewives	41(54.7)	34(45.3)	75(100)
Total	75(50)	75(50)	150(100)

A clearer picture of the presence of different types of illness grouped under the major illnesses among the two categories of women can be seen in table 4.2. This table shows that each of these diseases is much more common among working women. A significant difference is seen in the percentage of working women and housewives suffering from intestinal and heart related ailments. Very few women suffer from intestinal diseases and heart ailments but the number of working women suffering from these is more than the housewives. Similarly, there is a significant difference in the percentage of working women and housewives suffering from chronic diseases like migraine, asthma, diabetes, arthritis etc. While 62.2% of working women suffer from these diseases only 37.7% of the housewives suffer from the same. However, a marginal difference exists in the percentage of working women (53.1%) and housewives (46.8%) suffering from other illnesses like anaemia, skin diseases etc. which are not included in this category. Almost the same number of working women and housewives suffer from communicable diseases, and reproductive problems. Very few women reported of suffering from reproductive problems, however more might be suffering from the same but they must be shy in sharing with the researcher at the first go. This can be said, on the basis of a large number of studies done in the last decade that have shown that while very less women report of reproductive of illness on actual investigation a very large number of them were found to be suffering from the same.(Madhiwalla N and A Jessani, 1997).

When the frequency of major illnesses is compared among the housewives and working women, working women are again found to be suffering from more number of major illnesses than the housewives. This can be seen in table 4.3.

Table 4.2: Different types of major illnesses present among the Working women and Housewives.

Employment status	Type of Major illness (Percentages in Parenthesis)						Total
	Intestinal	Communicable	Chronic	Heart Related	Reproductive	Others	
Employed	6(66.6)	3(42.9)	28(62.2)	1(33.3)	6(46.1)	17(53.1)	61(56)
Housewife	3(33.3)	4(57.1)	17(37.7)	2(66.6)	7(53.8)	15(46.8)	48(44)
Total	9(8.25)	7(6.42)	45(41.3)	3(2.7)	13(12)	32(29.3)	109(100)

As seen in table 4.3, 50% of the respondents don't suffer from any of the above major illness. The majority belonging to this group are housewives with their percentage being 54.7% and the rest 45.3% are working. Hence, more housewives are free from any kind of major illness than the working women. The rest 50% of the population suffer from one or more kind of major illness, the percentage of working women (54.6%) belonging to this group is more than that of the housewives (45.3%). Hence, it can be said that the presence of these illnesses grouped under major illness is more among working women than among housewives. A further look into this group of population suffering from major illnesses reveals that while 33.3% of the working women have one type of illness, 32% of the housewives belong to this group. Similarly, while 16% of the working women have two type of illness only 8% of the housewives belong to this group and while 5.3% of the working women have three type of major illness none of the housewives belong to this group. Hence, it can be said that in terms of the presence of the number of these illnesses, it is the working women who have more number of major illnesses than the housewives.

Table 4.3: Frequency of major illness present among the working women and housewives

Work status of the respondents	Number of illnesses (Percentages in Parenthesis)					Total
	O	1	2	3	4	
Employed	34(45.3)	25(33.3)	12(16)	4(5.3)	0(0)	75(100)
Housewife	41(54.7)	24(32)	8(10.7)	0(0)	2(2.7)	75(100)
Total	75(50)	49(32.7)	20(13.3)	4(2.7)	2(1.3)	150(100)

Hence, the data here shows that the percentage of working women suffering from major illnesses is more than the housewives, also working women suffer from more number of major illnesses than housewives. Though more number of working women suffer from each of the illnesses but there is a remarkable difference in the numbers of working women and housewives suffering from Chronic illnesses hence it can be said that the most common major illness suffered by the working women is chronic illness like arthritis, migraine, asthma, diabetes etc. This result is very similar to the study done by

Susmita Mukhopadhyay on the health of working and non working mothers which showed a greater prevalence of chronic illness more among the working mothers than among the housewives (Mukhopadhyay S, 1996).

b) Minor Illnesses

Table 4.4: Minor illness present among Working women and Housewives

Work Status Of respondents	Presence of Illness (Percentages in Parenthesis)		Total
	Illness absent	Illness present	
Employed	2(2.7)	73(97.3)	75(100)
Housewives	11(14.7)	64(85.3)	75(100)
Total	13(8.7)	137(91.3)	150(100)

A similar trend can also be seen with reference to the minor illness. Table 4.4 shows that women in general suffer from minor illness much more than the major illness, but here again the percentage of working women (97.3%) suffering from these illnesses exceeds that of the housewives (85.3%).

As seen in the table below 4.5, the percentage of working women (54.7%) suffering from one or more minor illness is more than that of the housewives (45.2%). This table also shows that the working women suffering from each type of illnesses categorized under minor, outnumbers housewives. Cold is the most common minor ailment suffered by the sample population as (25.3%) of the respondents suffered from the same. This is followed by cough (23.9%), tension & stress related disorders (14.85%) and backache (13.2%). Head ache and fever are also very common. A look at the distribution of these illnesses among the two categories of women reveals that more working women suffer from these ailments than housewives. The percentage of working women suffering from cold (52.3%) and cough (50.5%) is marginally high than the percentage of housewives suffering from these diseases, 47.7% for cold and 49.5% for cough. The percentage of working women (58.6%) suffering from backaches is much more than the housewives (41.4%). Similarly head ache is more common among working women. A significant difference exists in the percentage of working women (71%) and housewives (29%)

suffering from tension and related disorders like irritation, fatigue, insomnia and forgetfulness. The only two ailments where the housewives outnumber working women are fever and accident but there is only a marginal difference in the numbers.

Hence, it can be concluded that more number of working women suffer from the minor illnesses than the housewives and tension & related disorders and backaches are the ailments which are more common among working women than among housewives. All these ailments are related to stress. Hence the mere presence of these illnesses indicates a high level of stress among the working women.

Table 4.5: Different types of minor illnesses present among the Working women and Housewives.

Work Status of the Respondents	Type of Minor Illness (Percentages in Parenthesis)								
	Cold	Cough	Backache	Headache	Fever	Accident	Tension & related disorders	Others	Total
Employed	58(52.3)	53(50.5)	34(58.6)	25(52)	21(49)	1(20)	46(71)	2(66.6)	240(54.7)
Housewife	53(47.7)	52(49.5)	24(41.4)	23(48)	22(51)	4(80)	19(29)	1(33.3)	198(45.2)
Total	111(25.3)	105(23.9)	58(13.2)	48(10.9)	43(9.8)	5(1.1)	65(14.8)	3(0.6)	438(100)

As seen in the table 4.6, in terms of the number of minor illnesses it is again the working women who have more diseases than the housewives. Significantly high percentage (14.7%) of housewives didn't report of any minor illness, compared to just 2.7% of working women. Hence, it can be said that more number of housewives are healthy in comparison to the working women.

Among the population having one or more than one illness it's again the working women who outnumber housewives. While 10.7 % of the working women suffer from one type of illness, 6.7% of the housewives suffer from the same. Simialrly, while 30.7% of the working women suffer from three type of illnesses and only 25.3% of the housewives suffer from the same. Working women are outnumbering housewives in terms of the presence of 4 type and 6 type of illnesses as well. The mean values substantiates this

finding. While housewives have an average of 2.67 minor illnesses, working women have 3.17 illnesses.

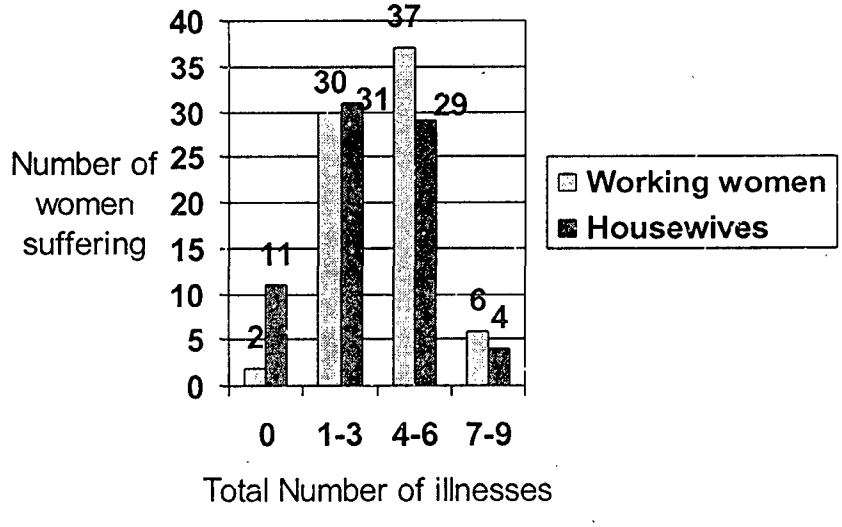
Table 4.6: Frequency of minor illness present among Working women and Housewives

Work status of the respondents	Number of illnesses (Percentages in Parenthesis)							Total
	O	1	2	3	4	5	6	
Employed	2(2.7)	8(10.7)	13(17.3)	23(30.7)	16(21.3)	7(9.3)	6(8)	75(100)
Housewife	11(14.7)	5(6.7)	18(24)	19(25.3)	11(14.7)	8(10.7)	3(4)	75(100)
Total	13(8.7)	13(8.7)	31(20.7)	42(28.0)	27(18)	15(10)	9(6)	150(100)

c) Total Number of Illness

A similar trend is also seen in terms of the total number of illness. When the total number of illnesses including the major and minor illness is calculated for each respondent it is seen that the working women have more number of illnesses as compared to the housewives. This can be seen from the bar diagram (Fig. 4.1) below which shows a significant difference in the percentage of housewives(15%) and working women 2.6% who reported to be free from any illness. The number of housewives having 1-3 types of illness is almost same as that of the working women. However, more number of working women have more than 4 types of illness.

Figure 4.1: Total number of illnesses suffered by the Housewives and Working women



Hence, from the data presented in the above section, it can be concluded, that housewives of the sample population are healthier than working women, as working women suffer from more number of illnesses than the housewives, in terms of major, minor and total number of illnesses.

So, from the above section one can infer that employment leads to the poor health status of women. The adverse effect of employment on the health of woman can be clearly depicted from the case study of Reena Joy (Pseudonym)

Reena Joy, belonging to the low income group and working as a nurse in Chembur's Roosnals Nursing Home is a victim of severe role stress as she is stuck between a highly uncooperative family and an extremely demanding job. Reena's working hours are extremely long and on some days she even has to work for 2 shifts. When it is a night shift she can hardly sleep for 2-3 hours. For so much of hard work she is only receiving a sum of Rs.3000.As a result of the demanding working hours Reena is hardly able to find time for herself and her family. Her family members are highly demanding and uncooperative and seldom help her with the domestic chores. Hence she is having a severe role stress. The stress is so high that it is having a very adverse impact on her health...Due to lack of sleep she is having a range of diseases which are mainly digestive in nature.. She also feels tensed and irritated most of the times...and is suffering from arthritis and backache.. The greatest agony is that in spite of working as a nurse; she doesn't get any health benefits and has to spend most of her money on her health. She said that she wants to leave her job as it is having a bad impact on her health as well as her family life but due to extremely difficult economic conditions she is left with no choice but to work.

Hence, from this case study it can be inferred that role stress faced due to the multiplicity of roles is a major cause for the poor health status of majority of working women. The extremely demanding work conditions, poor wages and lack of family support is causing severe stress on this lady. Since, the stress levels are so high it is having bad repercussions on her physical health which is quiet apparent. Most of the working woman of the sample population, especially those belonging to the middle and low income

group, shared similar problems in managing the job and work front which was a major cause of their poor health.

However, this isn't the case always. In a very peculiar case study of Deepali (Pseudonym) employment was seen to help the woman in coping with severe and chronic illness.

Ms. Deepali a senior scientific officer in the heavy water division of BARC is suffering from rheumatoid arthritis for the past 10 years, this is a genetic disorder which leads to the degeneration of the joints, finally leading to disability. The disease occurs mainly in two stages: Aggravation and Remission .In the Aggravation phase Deepali's joints get swollen and she has to be hospitalized for at least 4 days, after which she has to take bed rest for around a month. In this period she can't do anything and has to take leave from her work. The worst part about the illness is that there is no cure for it, medicines can only slow the process of degeneration.

When 32 year old Deepali first came to know about her illness which would finally make her disabled in some years, her whole world came tumbling down, she was completely bedridden and depressed for the initial two years. But, with her strong mind and supportive family she came out of it. She not only came out of it, but she also learnt to come in terms with the illness and even resume her job....

Deepali's knee joints have been severely affected as a result of which she can hardly walk a distance of 20 meters that too with the help of clutches...She is constantly having pains in almost all her joints but still she has somehow learnt to cope with it and carry out her daily work...

Deepali has taken treatment from all possible sources. At present she is taking allopathic treatment from Hinduja hospital, along with Ayurvedic and homeopathic medicines.. She is also doing exercises with the help of a physiotherapist, who takes Rs.3000 per month...the allopathic medicine that she takes causes a hormonal imbalance in her body

which leads to severe depression, besides it also leads to a decrease in the body immunity due to which she has become susceptible to a whole lot of other illness.. Some of the other side effects of the medicine includes hair loss, acidity and ulcers...

Despite , suffering so much from her illness Deepali has not given up her job. With the help of a supportive husband and family she is still able to manage her highly demanding job...she has hired an auto which drops her to the workplace. She has kept two full time maids who manage her house completely, so that she doesn't have to bother about the household chores...But, this doesn't free her from the responsibilities of a mother, Deepli makes it a point that she takes her 13 year old son for outings etc...Besides, her husband is on a touring job, which adds to her responsibilities.

Inspite of all these support Deepali feels pressurized at times mainly because of her highly demanding job, so she plans to take Voluntary retirement after a year when she would have completed 20 years of her service..But Deepali doesn't want to sit at home after this,,she plans to open a flower shop ,besides she also wants to help the society by spreading awareness about the disease so that others can check the disease at its onset and don't suffer the way she is suffering .

Deepali is very glad that she is working, She feels that had she been a housewife she would have surely died of depression as all the time she would have been thinking about her illness, now because of her work and the regular exercises her mind remains occupied with other things as a result of which she doesn't get much time to think....

In this case the lady is managing mainly because of her strong willpower and the support that she gets from her family both monetary as well as emotional. It is mainly because of the strong economic support that she has been able to keep a domestic maid and get the costliest of the treatment. Poor socioeconomic background and uncooperative family members would have compelled her to leave the job long back. Also, because of her rich family background, and financial independence provided by the job, Deepali has been

able to take treatment from the best of places and is also trying multiple sources of treatment.

Also in this case we have seen that the employed status of Deepali helped her to cope with a chronic and incurable illness like this. Work deviates her mind from the constant pain and suffering of the illness. If Deepali would have been a housewife, she would have possibly not been able to cope up with the illness. Hence, in this case Deepali's employed status is helping her cope up with the illness, as it is giving her the economic independence to seek treatment from diverse sources and also deviates her mind from constantly thinking about her illness.

Hence, employment can have both negative as well as positive impact on a woman's health. The beneficial and detrimental effect of employment completely depends upon other factors like job environment, family support, economic background etc. However, the number of such women for whom employment was beneficial for their health was rarely found among the study population

Housewives in contrast don't have to perform the additional role of an employee and are comparatively much healthier and happier and hence enjoy a greater sense of well being. This can be depicted from the case study below:

Smita Pathak(Pseudonym) a 37 year old housewife is just one of the many housewives of the high income group who exuberated an extreme sense of well being. Smita has two children- a son who is 10 year old and a daughter who is of 14 years.

Smita is extremely satisfied with her family life. According to her theirs is an ideal example of a happy family and its only because of the fact that she is able to efficiently fufill her roles of a wife and mother which is the prime duty of any woman. She shares an excellent relationship with her husband who works in BARC as a scientist and who often helps her with the household chores.

Besides having time for her family, Smita has ample time for herself which she utilizes by going for yoga classes and socializing with friends.

Smita reported of having an excellent health and she didn't suffer from any of the illnesses minor or major in the past. When asked as to whether she ever wanted to work she said that "I am absolutely satisfied with my life, I don't want to work and add on stress to my other wise peaceful and happy life."

Hence, this is an ideal case which depicts that housewives are able to fulfill their familial roles much better, which is still considered to be the primary responsibility of a woman in the Indian scenario. This gives them an immense sense of well-being, which working women are deprived off. Also since housewives can give much more time to themselves they are healthier and happier.

1.2 Self Perceived Health Status

The respondents were asked to rate their health as excellent, good, fair and poor to understand their perception about their own health. The results of this can be seen in table 4.7:

Table 4.7: Self Perceived Health Status of the working women and Housewives

Work Status of the Respondents	Self Perceived Health Status (Percentages in Parenthesis)					TOTAL
	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT	
Employed	3(4.0)	23(30.7)	30(40)	13(17.3)	6(8)	75(100)
Housewives	0(0)	13(17.3)	46(61.3)	11(14.7)	5(6.7)	75(100)
TOTAL	3(2)	36(24)	76(50.7)	24(16)	11(7.3)	150(100)

As seen in the table 4.7 above, more working women report their health as excellent and very good in comparison to the housewives. While, there is not much difference in the percentage of housewives (6.7%) and working women (8%), who reported their health to be excellent, there is a slight difference in the percentage of working women (17.3%) and housewives (14.7%) who reported their health as very good. This result is contradictory to the morbidity figures shown in the above section, where working women are seen to be

suffering from more number of illnesses than the housewives. This might be due to the fact that work raises the self-esteem of women and gives them a sense of worth, due to which they feel that they have a good health even when they are actually not enjoying the same.

However, the number of working women who reported their health to be good is less than that of the housewives. This is seen in Table 4.7, which shows a significant difference in the percentage of working women (40%) and housewives (61.3%) who reported their health to be good. Similarly, a significant difference was also found in the percentage of working women (30.7%) and housewives (17.3%) who reported their health as fair. Also, while 4 % of the working women reported their health to be poor, none of the housewives reported the same. Hence, all these figures go at par with the morbidity figures shown in the first section of this chapter.

It is interesting to note that while 6 (refer figure 4.1) working women are found to have more than 7 illnesses which means that they are having poor health only 3 reported to have a poor health. Similarly while 4 housewives fell into this category none of them reported of having a poor health. This shows that an individual's perception about his or her own health is always better than what he or she actually enjoys.

Table 4.8: Perception about the health of the other group

Work status of the Respondent	Perception about the health of the other group (Percentages in Parenthesis)					Total
	Its better than us	It's worse than us	It's like ours	Cant say	Others	
Employed	15(20)	36(48)	16(21.3)	6(8)	2 (2.7)	75(100)
Housewives	26(34.7)	26(34.7)	12(16.0)	4(5.3)	7(9.3)	75(100)
TOTAL	41(27.3)	62(41.3)	28(18.7)	10(6.7)	9(6)	150(100)

As mentioned earlier the women were also asked to mention about their perception about the health of the other group, mainly to gauge their satisfaction with the existing roles. As seen in the table 4.8, 20% of the working women felt that the health of housewives is better than theirs and 34.7% of the housewives felt that the health of the working women

is better than theirs. Hence, more housewives felt that the health of the working women is better than theirs. The reason most commonly given by them was that the working women are more active and hence they have a better health and that the sedentary lifestyle of the housewives is dangerous for their health. Many housewives also felt that they have more tension as they keep brooding about their problems all the time, where as a working woman forgets most of her household tensions once she steps out of the house.

The reason most often given by working women who felt the housewives health to be better than theirs was that they usually had to miss breakfast in a hurry to go to office, while housewives take regular meals. The irregular eating habits of working women is well depicted from this narrative:

"Daily after completing all the work at home, when I go to work, I feel fed up. In all the hurry, I do not feel like eating in the morning. So I do not eat in the morning at all but after reaching the office and at the time of starting work, my stomach starts burning. I feel hungry and I feel like eating anything/something. But what can I do. I can eat only at lunchtime. Lunchtime is for ½ hour only. That time just flies because this is the time for everyone to talk, laugh, go to the bathroom, wash ones hands. In the remaining time I can not eat with satisfaction, I just eat as if it's a routine, a duty. Similarly in the evening, after overtime, I go home very tired after 8 pm. As soon as I get home I feel I could just sleep. Sometimes I have no appetite and do not eat at all. I eat contently only on leave days"

Similar views were shared by other working women as well. Hence, the irregular eating habits of the working women can be considered as an important reason for their poor health, as perceived by them.

The other reasons shared by the working women for the better health of the housewives was their having more of leisure time. This comes out clearly from the narrative below:

"Housewives get more time to relax and pursue the activities that they enjoy but we hardly have any time to rest so it's obvious that our health will be worse."

It's worth noting here that the housewives who felt that the health of the other group is better than theirs were mostly the ones who were not satisfied with their role of only a housewife, and the working women feeling the same were usually the ones who were finding it stressful to manage the roles of a homemaker and wage earner.

Apart from these there were some women who considered the health of the other group to be worse than theirs. Among this category the percentage of working women (48%) who considered the health of the housewives to be worse than theirs was much more in comparison to the housewives (34.7%) who considered the health of the working women to be worse than them. This again can be attributed to high self esteem of the working women which makes them feel that they enjoy better health. This data goes at par with the self-perceived health status where more working women reported of having excellent and very good health status as compared to the housewives. Around 21% of working women felt that the health of the housewives is just like theirs and 16% of the housewives felt that their health is the same as that of the working women. The women who gave this response were mostly the ones who apparently didn't want to think through the question much.

Some working women also shared the response that, "Both working women and housewives can enjoy good health and that It depends from individual to individual, if the working women can manage her roles well and if she has a supportive family she is able to enjoy a good health status, while a housewife who has a lot of free time and doesn't indulge in any physical activity can have worse health than working women".

Many women also felt that they are not in a position to comment upon the health of the other group, 8% of these women were working and 5.3% were housewives.

Hence, the data above shows that the housewives have better health status than the working woman in terms of morbidity and self-perceived health status. This finding is against the findings of most of the western studies mentioned in the literature review, which shows that the working women are healthier than the housewives.

The next section tries to explore the reason for the better health status of the housewives by looking at the health seeking behavior and the health related behaviors of the two groups of women.

II. HEALTH SEEKING BEHAVIOR

a) For major illness

2.1 Treatment Taken

Table 4.9: Women seeking treatment for major illnesses after being affected by the same.

Presence of Illness	Treatment (TT) taken for major illness (Percentages in Parenthesis)		Total
	TT not taken	TT taken	
Illness absent	72(96)	3(4)	75(100)
Illness Present	14(18.7)	61(81.3)	75(100)
Total	86(57.3)	64(42.7)	150(100)

It's a common belief that women ignore their health and delay seeking care. However, this belief is proved wrong for the respondents of the study mainly in terms of the major illness. Table 4.9 shows that the health seeking behaviour of the study population for major illness is good as 81.7 % of the women suffering from these illnesses seek treatment for the same, and only 18.7% of the women don't. This might be because of the fact that it's difficult for women to pull through their daily activities with illnesses of these kinds.

The data also shows that the health seeking behaviour of working women is better than the housewives. This can be inferred from the fact that out of the 14 women who don't seek treatment in spite of the presence of illness, the maximum are housewives (12) and only 2 are working.

b) For Minor Illness

Table 4.10: Women seeking treatment for minor illness after being affected by the same.

Presence of illness	Treatment (TT) taken for minor illness (Percentages in Parenthesis)		Total
	TT not taken	TT taken	
Illness absent	11(84.6)	2(15.4)	13(100)
Illness Present	7(5.1)	130(95)	137(100)
Total	18(12)	132(88)	150(100)

The health seeking behavior of the sample population for minor illness shows a similar trend as that of the major illness. In fact the health seeking behavior of women for minor illness is better than that of the major illness as 95% of the women suffering from these illnesses seek treatment and only 5.1% of the women suffering from these illnesses don't seek treatment (refer table 4.10).But when the health seeking behaviour of working women and housewives are compared the trend is reversed from that of the major illness. Out of the 7 women (5.1%) who don't seek treatment inspite of the presence of the minor illness 6 are working and 1 is a housewife. So, in case of minor illness the health seeking behaviour of the housewives is better than the working women. This can mainly be attributed to the fact that since minor illnesses don't interfere much with the everyday functioning, hence a working woman who doesn't have much time, delay seeking treatment for the same, while housewives who comparatively have more time, don't mind going to the CGHS dispensary where treatment is provided free of cost.

2.2 Source of treatment

a) For Major Illness

Table 4.11 shows that 90 women seek treatment from one or more sources of treatment when they suffer from any type of major illness and the rest 40 don't seek treatment at all. This shows that almost $1/4^{th}$ of the respondents don't seek any treatment for major illness, the reason mainly being the fact that they never have any major illness. However, as mentioned in the previous subsection (2.1), there were a few women who didn't seek treatment even when they were having one or more major illness, but the numbers of these women were very few and these were mostly housewives.

As mentioned earlier, data in table 4.11 also shows that the health seeking behavior of working women is better than that of housewives, as a significant difference exists in the percentage of working women (71%) and housewives (28.8 %) seeking treatment for major illnesses from all the sources combined. This can be attributed to the fact that working women suffer from major illnesses more than the housewives. However, when the health seeking behaviour of women of the two groups is compared with the morbidity figures in table 4.1, it is seen that this remarkable difference in the percentage of working women and housewives seeking medical care exists inspite of the fact that there is not much difference in the percentage of housewives and working women suffering from one or more major illness. Hence, it can be said that even when the housewives are falling prey of the major illnesses they delay seeking care and ignore their health much more than working women. This can be attributed to the larger social order where the health of a working woman is given more importance both by her as well as her family (in comparison to a housewife) mainly because of the fact that she is an earning member of the family and her falling ill means economic loss to the entire family. Another reason for this can be the fact that a working woman has her own money to seek medical care but a housewife has to depend on her husband's money, who often ignores her health. Hence, the health seeking behaviour of housewives is poorer than that of the working women for major illness. So, the assumption made in the beginning of this chapter for the difference of the health seeking behavior of working women and housewives is proved right. These housewives who didn't seek treatment for their major illnesses were mostly the ones belonging to the low income group. They might be having poor health status but since their numbers are very few, hence it didn't make any difference on the overall morbidity pattern of the sample population which shows housewives to have better health than working women.

Since the number of working women seeking medical care for major illness is much more than housewives, so it is rightly seen in table 4.11 that the number of working women seeking services from each of the sectors is more than that of the housewives.

While 91.7% of the women seeking help from the private sector are working, only 8.3% are housewives. However, almost the same number of working women and housewives are seeking help from the public sector.

So, it can be said that while housewives prefer seeking treatment from the public sector which offers services free of cost in the BARC colony, working women prefer seeking care from the private sector. This is further elucidated by the bar diagram below which shows the percentage of women preferring treatment from each source out of the total number of working women and housewives seeking care from all the sources combined (percentage across columns in fig 4.11).

Table 4.11: Health Services Preferred for Major & Minor Illnesses by Working Women and Housewives

Source of Treatment	Work Status of the Respondent (Percentages in Parenthesis)				Total	
	Employed		Housewives			
	Major	Minor	Major	Minor	Major	Minor
Pvt. Sector	22(91.7) (34.3*)	19(82.6) (13.5*)	2(8.3) (7.6*)	4(17.4) 3.5%*	24(100)	23(100)
Public Sector	26(57.8) (40.6*)	35(42.2) (25*)	19(42.2) (73*)	48(57.8) 42.1%*	45(100)	83(100)
Alternate system	6(75) (25*)	27(61.4) (19.3*)	2(25) (7.6*)	17(38.6) 15%*	8(100)	44(100)
Home Remedies	9(90) (37.5*)	35(50.7) (25*)	1(10) (3.84*)	34(49.3) 30%*	10(100)	69(100)
Other sources(reiki,accu Pressure etc.)	1(33.3) (4.16*)	0(0) (0*)	2(66.7) (7.6*)	0(0) (0*)	3(100)	0(0)
Self Medication	0(0) (0*)	24(68.6) (17.1*)	0(0) (0*)	11(31.4) (9.6*)	0(0)	35(100)
Total	64(71.1) (100*)	140(55) (100*)	26(28.8) (100*)	114(45) (100*)	90(100)	254(100)

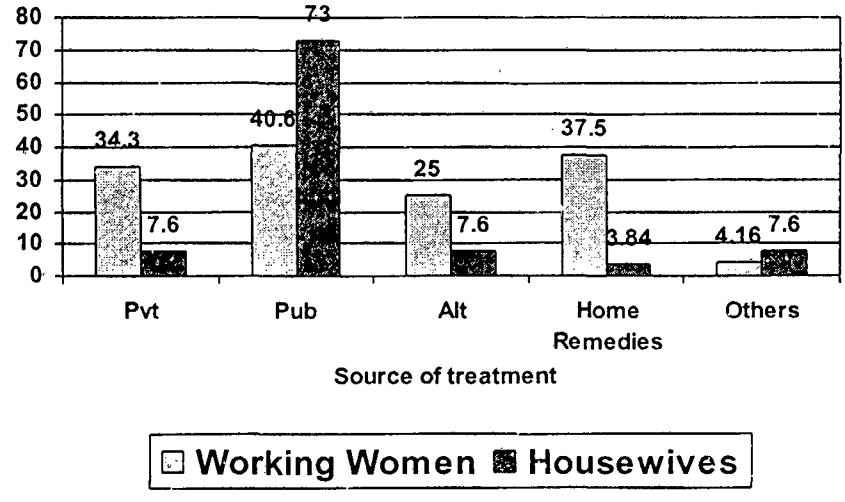
*Percentage across columns

The bar diagram (fig.4.2) clearly shows a significant difference in the percentage of housewives (73%) and working women (40.6%) seeking care from the public sector. A remarkable difference is also seen in the percentage of working women (34.3%) and housewives (7%) seeking treatment from the private sector. Hence, it can be inferred that far more number of working women prefer seeking treatment from the private sector than housewives. This can mainly be attributed to the fact that most of the working women

were not satisfied with the services offered by the CGHS dispensary of the colony. This can be illustrated from the narrative of one working women, who when asked the reason for not seeking treatment from the CGHS dispensary stated that :

"Though the CGHS dispensary of the colony offers treatment free of cost but I am not satisfied by the quality of services offered by it. I prefer going to a private practitioner outside the campus and I don't mind paying money for the same."

Figure 4.2: Source of treatment preferred by Housewives and Working Women for Major Illnesses



Another reason given by working women for not seeking care from the CGHS dispensary was lack of time. One of the working women shared:

"I don't have time to stand in such a big queue outside the CGHS dispensary, hence I prefer going to a private clinic where I don't have to wait for long, I don't mind paying for the same. My time is more precious."

Hence, due to time constraints and poor quality of services offered by the public(CGHS) dispensary a large chunk of working women of the study population didn't mind paying

extra money or traveling a longer distance and seeking medical care from a private practitioner who according to them offered better services. In contrast to this, most housewives were satisfied with the services offered by the CGHS dispensary and were elated by the fact that it was free of cost. This can mainly be attributed to better education and awareness level of the working women which makes them consider the same services poor, which the housewives consider as good. The economic independence of the working women can be another major factor leading to the preference for private sector.

Similarly, the percentage of working women seeking treatment from alternate sources and home remedies is more than that of the housewives. While 25% working women seek treatment from alternate sources only 7.6% of the housewives use alternate system of medicine. Similarly, a significantly high percentage of working women (37.5%) prefer home remedies as opposed to the housewives (3.84%).This shows that while working women delay seeking treatment and try home remedies, housewives immediately go to the doctors and hence don't try home remedies. Hence lack of time can be a major reason for working women to prefer home remedies than housewives. Jaya an extremely busy working women who works in a software firm in Andheri and has two small children shared that:

"*I usually delay going to the doctor and try taking some home remedies mainly because of time constraints. I hardly have time for my children, how can I afford to spend hours and go to doctor for treatment*".

Another reason for the preference of home remedies and alternate systems by the working women can be the dissatisfaction with the public sector which makes them search for alternative sources of treatment.

Table 4.12 clearly shows that the number of working women seeking treatment from various categories of private sector is much more than the housewives. Among the private sector the private practitioner is most preferred after which most people seek help from private hospital. Very few women seek help from the private dispensary. In contrast

(as seen in table 4.13) within the public sector the most preferred source is the public dispensary. While 84.4% of the respondents go to the public dispensary only 28.8% seek help from the public hospital.

Table 4.12: Different sources of treatment under the Private sector preferred by the two categories of women for Major Illnesses and Minor illnesses

Source of treatment	Work Status of the Respondent (Percentages in Parenthesis)				Total	
	Employed		Housewives			
	Major	Minor	Major	Minor	Major	Minor
Private Practitioner	12(54.5)	12(60)	1(25)	0(0)	13(50)	12(100)
Private Dispensary	1(4.5)	3(15)	1(25)	4(100)	2(7.6)	7(100)
Private Hospital	9(41)	5(25)	2(50)	0(0)	11(42.3)	5(100)
Total	22(100)	20(100)	4(100)	4(100)	26(100)	24(100)

Table 4.13: Different sources of treatment preferred under the public sector preferred by the two categories of women for Major & Minor illnesses

Source of Treatment	Work Status of the Respondent (Percentages in Parenthesis)				Total	
	Employed		Housewives			
	Major	Minor	Major	Minor	Major	Minor
Public Practitioner	0(0)	2((5.1)	0(0)	3(5.5)	0(0)	5(5.5)
Public Dispensary	19(65.5)	32(82)	19(90.4)	49(90.7)	38(84.4)	81(87)
Public Hospital	10(34.5)	5(12.8)	3((14.3)	2(3.7)	13(28.8)	7(7.5)
Total	29(100)	39(100)	21(100)	54(100)	45(100)	93(100)

b) For Minor Illness

As seen in table 4.11 a marginal difference exists in the percentage of is not much of housewives (45%)and working women (55%) seeking treatment for minor illnesses. This difference in percentage can be attributed to the fact that working women suffered for more number of minor illnesses than housewives. However, as mentioned earlier the health seeking behaviour of housewives for theses illnesses is better than that of the working women as the few women who don't seek treatment after falling ill were

working. These figures goes at par with the data shown in table 4.5, according to which 55% of the working women and 45% of the housewives suffer from one or more kind of minor illness. This means that almost all the women who are falling ill of minor illness are seeking treatment from the same.

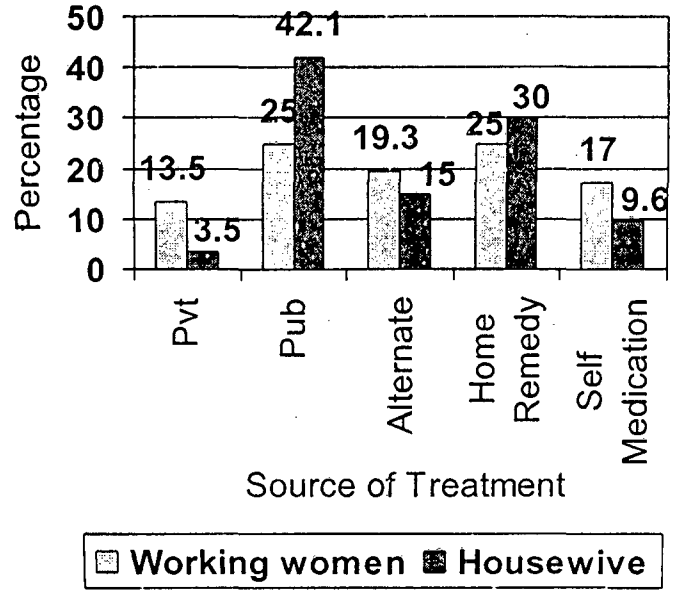
The preference for different services of treatment by both working women and housewives follows the same trend as that of the major illness. Similar to the major illness, a significant difference exists in the percentage of working women (82.6%) and housewives (17.4%) seeking care from the private sector. However, much more percentage of housewives (57.8%) seek help from the public sector in comparison to the working women (42%).The poor quality of services offered by this sector and the long hours of waiting in the public dispensary are the two major reasons which deter most of the working women from seeking help from the public sector even though it provides treatment free of cost. A significant difference exists in the percentage of working women (61.4%) and housewives (38.6%) who seek help from the alternate sources of medicines. This can mainly be attributed to the working women's dissatisfaction with the public sector which makes them explore other sources of treatment. Similarly, the percentage of working women (68.6%) seeking self medication is much more than housewives (31.4%).This clearly shows that working women delay seeking treatment for minor illness much more than housewives and prefer taking self medication mainly because of time constraints.

The comparison between the two groups for the preference of the source of treatment can be better depicted by the bar diagram below:

A cross column analysis of the figures in table 4.11, as seen by the bar diagram (fig.4.3) further confirms the findings mentioned above. Out of the 140 working women seeking care for minor illness 13.5% seek treatment from the private sources, and out of 114 housewives seeking treatment for minor illness 3.5% seek treatment from the private sector. Similarly, a far greater percentage of housewives (42.1%) seek treatment from public sector than working women (25%).

As seen in table 4.12 within private sector the most preferred source of treatment is the private practitioner, the next in the preference list is the private hospital. However, both of them are used by working women alone. The four housewives who are seeking help from the private sector go to the private dispensary. Within the public sector maximum percentage (86%) of women go to the CGHS dispensaries in the BARC colony, 7.5% go to the public hospital, 5.5% go to the public practitioner and only 1% go to the public nursing home(refer table 4.13).

Figure 4.3: Percentage wise distribution of housewives and working women seeking different types of treatment for minor illnesses.



When the sources of treatment for each of the two ailments are compared it is seen that the percentage of women seeking home remedies for minor ailments is much more than major. Also in case of minor ailments a whole lot of women take self medication, however none of the women go in for self medication for major ailments. Similarly, while 34.3% of the working women go to private sector for major ailments, only 13.5% of them go to this source for minor ailments. Also, more number of working women go to the public sector for minor ailments in comparison to the major. Hence, this finding supports the Zolla's Model of health seeking behavior, according to which health seeking

behavior depends upon the severity of illness (Mechanic D, 1969). While working women are very prompt interms of taking treatment for major illnesses they delay seeking treatment for minor illnesses like cold, cough, fever etc. and take home remedies and self medication. The same is true for housewives also, while only 3% of the housewives seek home remedies for major ailments, 30% of them take home remedies for major illness. This is mainly because these illnesses don't affect much with the day to day functioning and can be easily cured by home remedies and self medication.

2.3 Time of Treatment.

Table 4.14: Time of Treatment for Working Women & Housewives

Time of Treatment	Work Status of the Respondent (Percentages in Parenthesis)		Total
	Employed	Housewives	
After home remedy	55(57.8)	40(42.1)	95(100)
After self medication	46(61.3)	29(38.6)	75(100)
Immediately	13(28.2)	33(71.7)	46(100)
Routine check up	3(50)	3(50)	6(100)

As seen in table 4.14, women in general delay seeking treatment immediately after falling ill and most of them tried home remedy and self medication first. The percentage of working women (57.8%) seeking medical care after trying home remedy is more than that of the housewives (42.1%). The same is also true for self medication. While 61% of the working women go to the doctor after trying self medication only 29% of the housewives do the same. The percentage of housewives (72%) seeking treatment immediately is far more than the working women (28%). So the data here clearly shows that while most of the housewives seek medical care immediately after falling ill, most working women delay seeking treatment and try using home remedies and self medication. As mentioned in the earlier section this is mainly due to the lack of time for working women. Housewives have enough time so when they fall ill its not difficult for them to take out some time and go to the doctor, however working women who always struggle in finding out time for her house and kids avoids going to the doctor unless it becomes absolutely essential.

d) Money spent on treatment

i) Monthly Expenditure

Table 4.15: Average monthly Expenditure of the Working women and Housewives on health.

Average Money Spent on Health per month	WORK STATUS (Percentages in Parenthesis)		Total
	Employed	Housewives	
No money spent	3(4)	1(1.3)	4(2.7)
Upto Rs. 50	15(20)	20(26.7)	35(23.3)
Rs. 51-100	29(38.7)	25(33.3)	54(36)
Rs. 101-150	4(5.3)	15(20)	19(12.7)
Rs. 151-200	12(16)	7(9.3)	19 (12.7)
Rs. 201& above	12(16)	7(9.3)	19(12.7)
Total	75(100)	75(100)	150(100)

A significant difference exists in the average monthly expenditure of working women and housewives on medical care. Housewives are seen to spend less money on medical care than working woman. The average monthly expenditure of housewives on medical care is Rs.123, where as the average monthly expenditure of working women on medical care is Rs.165 (mean values).This can mainly be attributed to the high prevalence of morbidity among the working women The other reason for this can be the economic independence of working women due to which they can afford to spend more money on their health. Beside their better health seeking behaviour for major illness can be another important reason for their spending heavier amounts on health. Table 4.15 shows that more number of housewives are spending lesser money on health and the percentage of working women spending higher amounts on their health is much higher than housewives. The chi square value of the two variables is also significant as it is .051.

ii) Individual Episodes

Table 4.16 again substantiates the fact stated above which is, housewives spend lesser money on their health. As seen in the table, only one housewife has spend money on individual episodes of illness, While 10 working women have spend money ranging from

Rs.200 to Rs.50,000 on specific episodes of illness in the past. This data goes at par with the data in table 4.1 which shows that the number of working women suffering from major illnesses is much more than the housewives. The maximum number of women is spending money between Rs.501 -1000 and the number of women spending money in the range of Rs.201-500 and Rs.10000-50000 is same.

Table 4.16: Money spent by Working women and Housewives on Individual Episodes of Illness.

Money spent on individual Episodes of Illness	WORK STATUS (Percentages in Parenthesis)		Total
	Employed	Housewives	
No money spent	65(86.6)	74(98.7)	139(92.6)
Rs.201-500	3(4)	0(0)	3(2)
Rs. 501-1000	4(5.3)	0(0)	4(2.7)
Rs. 1000-50000	3(4)	1(1.3)	4(2.7)
Total	75(100)	75(100)	150(100)

Hence the findings of this section shows that working women in general delayed seeking treatment mainly because of the lack of time, housewives on the other hand were prompt in taking treatment. However, working women were very prompt in seeking treatment for major illnesses even more than the housewives. This can be attributed to their greater awareness levels which makes them more conscious about their health. Also for working women major illnesses means economic loss to the family and hence their health is given much more importance by their families in comparison to the housewives. Besides the spending for the treatment of major illness is usually more which working women can afford as they have their own money, but housewives had to depend on the money of the family members for the same hence their ill health first needed to be accepted by the family members who usually didn't pay much importance to their health. This delayed their seeking treatment for the same. Thus housewives had a low health seeking behaviour for major illnesses. However, for minor illnesses housewives didn't have to spend money as they could be easily cured even in the CGHS dispensary and hence they were prompt in taking treatment for the same. Working women on the other hand didn't

have enough time and hence delayed seeking treatment for these illnesses which didn't interfere much with their day to day functioning. It's important to note here, that the delay in the health seeking behaviour of some housewives for major illness didn't make a difference on the over all health status of the housewives of the sample population which was found better than working women, mainly because the number of these housewives who suffered from major illnesses and delayed seeking treatment for the same was very less.

III. HEALTH RELATED BEHAVIOURS:

3.1 *Health related behaviors*

The health related behaviors that are measured among the two groups of women includes exercise, meditation, eating of balanced diet, following sanitary measures and other related activities practiced to maintain a good health. As seen in table 4.17, a significant difference exists in the percentage of working women (34.3%) and housewives (65.6%) who exercised. Working women explained this by giving the reason of lack of time. Most working women responded by saying:

"*I want to exercise but I hardly find time for the same.*"

Some working women also responded by saying:

"Going and coming back to the work place is itself a big exercise and hence we don't need to exercise further".

However, some health conscious working women, working in BARC and residing in the colony, made it a point to walk down to their work places so that they could indulge in some physical activity.

Housewives on the other hand seemed to be very conscious about the fact that they are not engaging in any physical activity, the whole day and so they must exercise to maintain a good health. The most common form of exercise was walking. Housewives in

the high income group had also joined yoga or aerobic classes. Utilization of free time is another major reason which made the housewives exercise.

A marginal difference exists in the percentage of housewives and working women practicing other health related activities like meditation, eating of balanced diet and following of sanitary measures. Infact the number of working women performing the other health related behavior is slightly more than the housewives. This can be attributed to the better education of working women which makes them more conscious about health and fitness and makes them follow the health related behavior more in spite of time constraints. Following of sanitary measures and eating of balanced diet were the most preferred health related activities which almost all the women seemed to practice irrespective of their employed status. On the whole the percentage of housewives (51.2%) practicing one or more health related behaviors is slightly more than the working women (48.8%).This is mainly because of housewives have more leisure time as compared to the working women.

When the number of health related behaviors practiced by the two groups of women are compared, more working women (17.3%) are seen not to practice any health related behavior as compared to the housewives (13.3%). Hence, it can be said that the health related behaviors of housewives are more than that of the working women. The number of health related behavior practiced by a housewife on an average is 2.12. Working women on the other hand practice an average of 1.93 health related behavior (mean values). The number of working women and housewives practicing one type of health related behavior is same. However, much greater number of housewives performs 3 and four type of health related behaviors. This again can be attributed to the more leisure time that the housewives have.

Table 4.17: Type of Health Related behaviors practiced by Working women & Housewives

Health Related Activities	Work Status (Percentages in Parenthesis)		Total
	Employed	Housewives	
Exercise	22(34.3)	42(65.6)	64(100)
Meditation	21(52.5)	19(47.5)	40(100)
Balance Diet	42(51.2)	40(48.7)	82(100)
Sanitary Measures	57(50)	57(50)	114(100)
Other activity	3(75)	1(25)	4(100)
Total	62(48.8)	65(51.2)	127(100)

Table 4.18: Monthly expenditure of Working women and Housewives on their Well being

Monthly Expenditure on Well being	Work Status (Percentages in Parenthesis)		Total
	Employed	**Housewife**	
No money spent	13(17.3)	1(1.3)	14(9.3)
Upto Rs.100	19(25.3)	41(54.7)	60(40)
Rs. 101-200	9(12)	15(20)	24(16)
Rs. 201-300	16(21.3)	8(10.7)	24(16)
Rs. 301-500	10(13.3)	4(5.3)	14(9.3)
Rs. 501 & above	8(10.7)	6(8)	14(9.3)
Total	75(100)	75(100)	150(100)

Money spent on well being includes the average monthly expenditure of the sample population on activities like going to the gym, attending yoga, music and dance classes. Money spend on parlors is also included under this category. While 17.3% of the working women don't spend any money on their well being as less as 1.3% of the housewives fall into this category. As seen in the table 4.18, the percentage of working women spending more than Rs.200 on their well being is much more in comparison to the housewives. Hence, it can be inferred that the working women spend more money on their well being in comparison to the housewives. This is further substantiated by the fact that the average

money spent by working women on their well being is Rs.328.60 , housewives on the other hand spend Rs.160 (on an average) per month on their well being. Even though the working women spend greater amount of money on their well being yet they report of poorer health status. This shows that the money spent on the above activities no way results in a better health status of women.

3.2 *Leisure time and leisure related activities*

As stated by Gothoskar S (1997) leisure time has important implications not only for the mental and physical well being of women but also for their organizational possibilities. In order to be able to better their lot, women need to have some time for themselves and their entertainment (Gothoskar S, 1997). Also, leisure time is also somewhat related to the health seeking and health related behavior of women. Hence, it was important to assess the leisure time of the study population.

Table 4.19: Weekly leisure time enjoyed by Working women and Housewives

Work Status of the respondent	Leisure time per week in hours (Percentages in Parenthesis)			Total
	Upto 10 Hours	11-20 hours	More than 20 hours	
Employed	60(80)	15(20)	0(0)	75(100)
Housewife	7(9.3)	18(24)	50(66.7)	75(100)
Total	67(44.6)	33(22)	50(33.3)	150(100)

Table 4.19, shows that working women have much less leisure time than the housewives. A significant difference exists in the percentage of working women (80%) and housewives (9.3%) having leisure time of less than 10 hours. In contrast to this none of the working women enjoy leisure time of more than 20 hours and 50 % housewives enjoy the same. On an average a working woman enjoys a total of 6.8 hours of weekly leisure time; housewives on the other hand enjoy a total of 23.25 hours of weekly leisure time, on an average. The less leisure time of the working women can be attributed to the long working hours both inside the house and at the work place.

As the leisure time of working women is much less than that of the housewives so it's obvious that the housewives are able to practice more leisure time activities than the working women. Table 4.20, shows the different leisure time activities practiced by housewives and working women.

Table 4.20: Different type of Leisure time activities practiced by Working women and Housewives

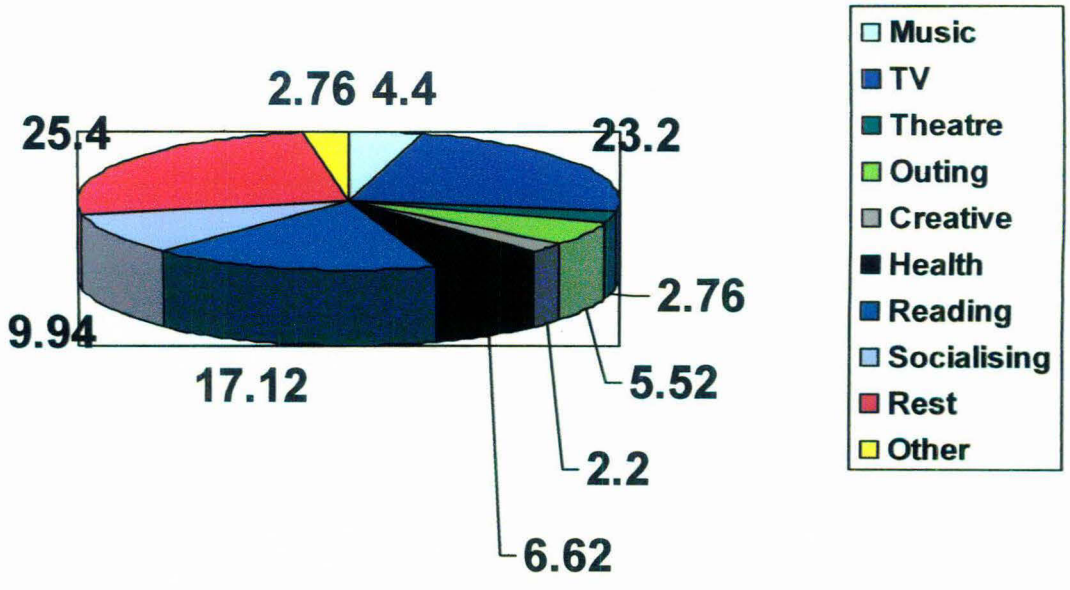
Type of Leisure Time Activities	Work Status of the respondent (Percentages in Parenthesis)		Total
	Employed	Housewives	
Music	8(40)	12(60)	20(100)
TV	42(43.75)	54(56.25)	96(100)
Theatre	5(71.4)	2(28.6)	7(100)
Outing	10(50)	10(50)	20(100)
Creative	4(33.3)	8(66.6)	12(100)
Health	12(37.5)	20(62.5)	32(100)
Reading	31(45)	38(55)	69(100)
Socialising	18(38.3)	29(61.7)	47(100)
Rest	46(52.8)	41(47.2)	87(100)
Other activities	5(71.4)	2(28.6)	7(100)
TOTAL	**75**	**75**	**150**

As seen in table 4.20, the most preferred leisure time activity by women in general is watching TV, this is followed by taking rest, reading and socializing. Also it can be seen from the table that much more number of housewives are engaging in the different types of leisure time activities except going to theatre, taking rest and some other activities like gardening etc. Working women hardly get an average of one or two hours of leisure per day in which they prefer watching TV, reading or taking rest. As seen by the pie chart below the most preferred leisure time activity of working women is taking rest and watching TV as 25.4% of the respondents take rest when they come back from work and 23.2% watch TV. This is mainly because working women are so tired after coming back from work that they hardly have the energy left to do any other activity like exercising or doing creative activities or going for outing and hence watching TV seems the best option

to them as it relaxes them and entertains them too. It was also observed that the working women made it a point to read newspapers or magazines and hence 17.3% of the working women indulged in reading.

As seen in Figure 4.6, Watching TV is the most preferred leisure time activity even for housewives. Taking rest and reading are the other two preferred activities. This is very similar to the activities preferred by working women. So, it can be said that the preference of leisure time activity is the same for women of both the groups and didn't change with the work status. Due to abundance of time a large number of housewives are able to engage themselves in other leisure time activities like socializing, exercising or walking, painting or doing embroidery, which working women are not able to engage themselves in, due to time constraints.

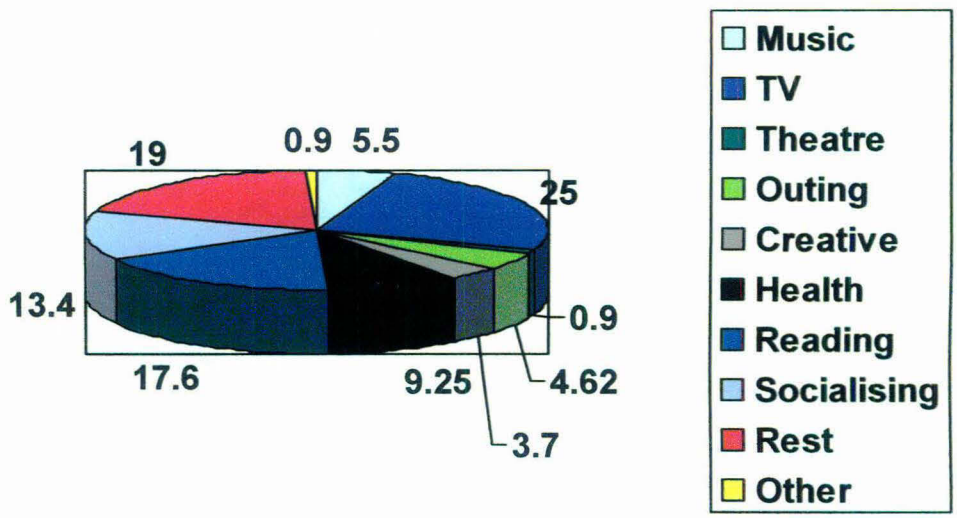
Figure 4.4: Different leisure time activities pursued by working women.
(in Percentage)



However, inspite of the lack of leisure time the percentage of working women going for outing or movies exceeds that of the housewives. This is mainly because of the fact that

working women feel it necessary to unwind or to take a break from their hectic schedule and going out and watching movies is considered to be the best break for them. Also working women can indulge in these activities with their friends or children but housewives most often depended on their husbands to take them out

Figure 4.5: Different leisure time activities pursued by Housewives (in Percentage)



As mentioned earlier housewives perform more leisure time activities as compared to the working women, mainly due to the large amount of leisure time that they have. This is further elucidated by table 4.21, which shows that as the number of leisure time activities increases the percentage of working women performing the same decreases. While, 2.7 % of the working women don't practice any leisure time activity, none of the housewives fall into this category. All of them practice one or more leisure time activities. The percentage (21.3%) of working women performing one type of activity is more than that of the housewives (9.3%). However, as the number of leisure time activities increases, housewives start outnumbering working women. While, 29.3% of the housewives perform 3 types of leisure time activity, only 21.3% of the working women perform the same. Similarly 16% of the housewives perform 4 types of activities and only 12 % of the working women fall under this group.

Table 4.21: Number of leisure time activities practiced by Working women and Housewives

Number of leisure Time Activities	Work Status of the Respondent (Percentages in Parenthesis)		Total
	Employed	Housewife	
No Activity	2(2.7)	0(0)	2(1.3)
1	16(21.3)	7(9.3)	23(15.3)
2	27(36)	26(34.7)	53(35.3)
3	16(21.3)	22(29.3)	38(25.3)
4	9(12)	12(16)	21(14)
5	4(5.3)	6(8)	10(6.7)
6	0(0)	1(1.3)	1(0.7)
7	1(1.3)	1(1.3)	2(1.3)
TOTAL	75(100)	75(100)	150(100)

3.3 Average sleeping hour

Sleeping hours is considered to be a good indicator of health and well being. Researches have shown that people who sleep less are supposed to be more stressed out than those who sleep adequately. Hence, the study also tried to look into the sleeping pattern of the women of the two categories.

Table 4.22: Average sleeping hour of Working women and Housewives

Work Status of The Respondent	Sleep Hours (Percentages in Parenthesis)		Total
	Less then 7 hours	More then 7 hours	
Employed	71(53.7)	4(22.2)	75(50)
Housewife	61(46.3)	14(77.7)	75(50)
Total	132(100)	18(100)	150(100)

As seen in table 4.22, out of the total number of women who sleep for less than 7 hours the majority are working (53.7%) and the remaining 46.3% are housewives. This trend

reverses in case of women who sleep for more than 7 hours as the majority of this group is comprised of housewives (77.7%).Working women in general, sleep for lesser number of hours as compared to housewives, this can also be seen from the mean values of sleeping hours of the two groups of women. Housewives on an average sleep for 7 hours and working women on an average sleep for 6 hours in the night.

Conclusion

The major findings that are brought about in the present chapter are as follows:

- Self reported morbidity is present more among working women in terms of both major and minor illness.
- Working women suffer from greater number of illnesses in comparison to the housewives.
- The most common major illness suffered by the working women is chronic illness like arthritis, migraine, asthma, diabetes etc.
- Minor ailments like tension & related disorders like irritation, fatigue, insomnia, forgetfulness etc. and backaches are more common among working women than housewives.
- The self perceived health status of housewives is better than the working women. However, the self perceived health status of working women is much better in comparison to their actual health status, as reported by them.
- Majority of the housewives felt that the health of working women is better than theirs. However, most of the working women felt their health to be better than that of the housewives.
- The over all health seeking behavior of the sample population is good both for major and minor illness as most of the women falling prey of these illnesses seek the treatment for the same.
- For major illnesses the health seeking behavior of housewives is poorer than that of the working women.
- For minor illnesses the health seeking behavior of housewives is better than that of the working women.

- The most commonly preferred source of treatment for both major and minor illnesses is the CGHS dispensary which provides treatment free of cost, to all the BARC employees and their family.
- Due to the lack of time and dissatisfaction with the CGHS services, a large number of working women also preferred the private sector, home remedies and alternate sources of treatment.
- Housewives spend less money on medical care than the working women.
- In general housewives practiced more health related behaviors than the working women, mainly because of the more leisure time that they have.
- Working women spend more money on their well being in comparison to the housewives.
- Working women have much less leisure time than the housewives. Hence, they practice lesser number of leisure time activities. Watching TV, taking rest, reading and socializing are the most preferred leisure time activities by women of the two groups.
- The sleeping hours of the housewives is more than that of the working women.

In the light of the above findings this chapter clearly shows that housewives have better health status than the working women mainly because they seek medical care immediately after falling ill, they exercise, have abundant of leisure time and sleep adequately. All these are directly related to the fact that housewives have more leisure time than the working women and hence they can afford to go to the doctor immediately after they fall ill, can exercise and can engage in leisure time activities like socializing which gives them a sense of well being. Working women on the other hand are not able to do these activities so they suffer from poor health even though they are spending more money on their health and well being.

The next chapters tries to explore the other reasons responsible for the health and ill health of housewives and working women by looking at other factors like income and role stress.

CHAPTER V

HEALTH DIFFERENTIALS AMONG DIFFERENT SOCIO-ECONOMIC CATEGORIES

In the previous chapter we saw the impact of the employed status on the health of working women. A comparison was drawn between the health status, health seeking behavior and health related behavior of both working women and housewives and it was established that the working women face much more health problems than the housewives mainly because of poor health seeking and health related behaviour. This chapter further explores the health differentials among working women and housewives belonging to different socio-economic backgrounds. For the purpose variables like major and minor illnesses, self perceived health status, source of treatment, time of treatment, health related behaviors, leisure time and leisure time activities have been measured across income groups.

It's commonly assumed that those who live in poverty, degraded living environment , are involved in occupations which are hazardous to health , etc, should have a lower sense of well being and hence complain more of ill- health and illness. This has also been empirically proved by various studies. To begin with the early epidemiologist Robert Snow found that cholera was present most among the deprived pockets of England than in the well developed ones (PAHO, 1989).Similarly, Mckewens theses proved that the major communicable diseases prevalent in the 18^{th} century England declined merely by the improvement of the living conditions through the sanitary reforms, this was much before vaccines were devised for them (Mckeowen T, 1971).Various Indian studies have also shown the relation of poverty and ill health. One such study by Banerjee of nineteen villages in eight different states has shown a clear relationship between mortality and socio-economic groups (Banerjee D,1991). Similarly, Sheila Zubriggs Rakku's story also shows that the burden of ill health falls on the poor (Zubrigg Sheila, 1991).However; some studies have come out with contradictory results. One such study by Duggal and Amin (1989) has shown that the rich and well placed strata complained of illness more often than the poorer strata (Duggal and Amin,1989) or that people in the underdeveloped states in India reported less morbidity than those in the developed states(NSS, 1998).

Specifically, with regard to employment, socio-economic conditions and health of women, some researchers feel that rather than asking whether employment is adverse or beneficial for the health of women, the question which needs to be addressed is under which conditions it becomes adverse or beneficial (Klumb and Lampert, 2004).One such condition which plays a major role in determining whether employment has beneficial or detrimental effect on health of women is the socio-economic status of the family. This is mainly because it determines the presence of other factors like educational background, domestic maid, household appliances etc. which makes a woman better equipped to cope up with the demands of multiple roles associated with family and work. One such study on the health consequences of multiple roles on women employed in different kind of jobs found out that the "exercise of multiple roles had adverse health consequences for women working full time in lower non manual and in manual occupations, but not for those in professional and managerial jobs, whose greater financial resources could be used to ease some of the burdens of housework and childcare, so reducing role strain and fatigue" (Arber S, 1991).

Hence, the present chapter tries to look at the role of income in helping a woman cope up with the demands of multiple roles by exploring its association with health. This has been done by looking at the health status, health seeking behavior and health related behavior of women across income groups. The assumption which is addressed here is that woman of lower socio-economic background will have more role stress and hence will have poorer health in comparison to those in the high income group. Here, income means the total family income and it is categorized into three groups namely:

1. Low Income Group- Monthly Family income between Rs.1,500-10,000.
2. Middle Income Group- Monthly Family income between Rs.10,001-20,000.
3. High Income Group- Monthly Family income of Rs.20,001 & above.

This categorization of income has been done on the basis of the income within which the different household of the sample population are distributed. The chapter is divided into three sections: the first looks at the association between income and

health status, the second looks at the health seeking behavior and the third looks at the health related behavior of the women of the two categories.

I HEALTH STATUS

1.1. Morbidity- Major Illness & Self Perceived Health and Morbidity

As seen in table 5.1 chronic diseases are most commonly present among women across all income groups. However, it is concentrated more among the employed women that too of the high income group. This is followed by other illnesses like anaemia, skin diseases etc., which is then followed by reproductive ailments. The respondents were rarely found to be suffering from heart related ailments. Communicable diseases like TB, malaria, typhoid etc. was present most among the women of the low income group, more so among the employed than among the housewives. In contrast intestinal diseases occurred most among the women of the high income group.

Table 5.1: Major illness suffered by the working women & housewives across the income groups

HH by Income Groups	MAJOR ILLNESS (Percentages in parenthesis)												Total	
	Intestinal Disease		Communicable Disease		Chronic Disease		Heart Related Disease		Reproductive Problem		Others			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Rs.1500-10000	1 (20)	0 (0)	2 (66.6)	2 (50)	10 (35.7)	3 (17.6)	1 (100)	0 (0)	0 (0)	3 (42.8)	8 (47)	3 (20)	23	9
Rs.100001 - 20000	1 (20)	1 (33.3)	1 (33.3)	1 (25)	6 (21.4)	6 (35.3)	0 (0)	0 (0)	3 (50)	4 (57.2)	3 (17.6)	4 (26.6)	14	16
Rs.20001 & above	3 (60)	2 (66.6)	0 (0)	1 (25)	12 (42.85)	8 (47)	0 (0)	2 (100)	3 (50)	0	6 (35.3)	8 (53.3)	24	21
Total	5 (100)	3 (100)	3 (100)	4 (100)	28 (100)	17 (100)	1 (100)	2 (100)	6 (100)	7 (100)	17 (100)	15 (100)	61	46

Almost same number of working women belonging to the high (24) and low (23) income group reported of suffering from one or more major illness mentioned above. The working women who are least affected by these disease belong to the middle income group (14). Among housewives the ones who suffer most from these diseases belong to the high income group and the group that is least affected by these belong to the low income group. There can be two explanations to this finding, first women in the high income group may actually be having poor health than those in the low income group. Second is that they may not be having poorer health than those of the

low income group but since their health seeking behaviour is much high, hence they report of more illness in comparison to the women of the low income group, who hardly seek medical help due to poor economic conditions and hence are unaware of the diseases that they are suffering from.

The table also shows that working women were affected more by ***intestinal diseases*** like amoebiasis, ulcers, acidity etc. in the past three years in comparison to the housewives. These diseases are concentrated most among women of the high income group. Out of the total working women suffering from this disease 60% belonged to the high income group, similarly out of the entire lot of housewives affected by this ailment 66.6% belonged to the high income group.

Almost the same number of housewives and working women suffered from ***communicable diseases*** like malaria, Typhoid, TB, cholera etc. in the past three years. These diseases are concentrated most among the low income group as 66.6% of working women and 50% of the housewives affected by this disease belonged to the low income group. This can mainly be attributed to their poor living conditions.[1]However, none of the working women of the high income group were found to be affected by communicable diseases.

Chronic diseases like arthritis, migraine, diabetes, asthma, etc. occurred more among working women than among the housewives and that too among the high income group, with 42.8% of the working women and 47% of the housewives in this income group being affected by these diseases in the past three years.

Very few women of the study population suffered from ***heart related diseases*** which includes high and low blood pressure, coronary heart disease, high cholesterol etc, in the past three years. Hence, no significant difference could be seen with regards to the prevalence across income groups.

[1] It has long been established by Mckewen's theses that the presence of communicable diseases are directly related to the physical environment. Mckewen's analysis showed that the prevalence of the major communicable diseases like malaria, typhoid, cholera in the 18th century England declined merely due to the improvement in the living conditions as brought about by the sanitary reforms, this was much before vaccines were invented for them.

Reproductive problems like those related to pregnancy or child birth, use of contraception, menstrual problems etc. occurred more among housewives than among working in the past three years. These ailments were concentrated most among the housewives and working women of the middle income group. More women might be suffering from these ailments but they might be shy in reporting to the researcher in the very first meeting.

Quite a lot of women reported of suffering from ***other illnesses*** like anemia, skin diseases etc. which are not included in the above categories. These illnesses again occurred more among working than among housewives in the past three years. Among working, women in the low income group were affected the most and the one's in the high income group were affected the least. This can mainly be attributed to the poor dietary intake of women in the low income group which leads to iron deficiency among them. It is interesting to note here that a lot of studies have indicated anaemia as the most common cause of maternal mortality (Soman Krishna, 1994), this means that though most women suffer from anemia, but in reality very few cases are reported.

1.2 Morbidity- Minor Illnesses

As seen in the table 5.2 cold and cough are the most common minor ailment suffered by women of the two categories across income groups. Tension & related disorders and backache are the ailments more common among working women.

Similar to the case of major illness, more number of working women suffer from minor illness in comparison to the housewives. The maximum percentage of working women (42%) suffering from these illnesses belong to the high income group, a little lesser (33.6%) belongs to the middle income group and the minimum percentage of women belongs to the low income group. This is similar to the case of major illnesses and the same explanation can be given for this as well.

Table 5.2 Minor illness suffered by the Working women & Housewives across the three income groups

HH by Family Income	MINOR ILLNESS																	
	Cold		Cough		Fever		Back Ache		Head Ache		Injury		Tension & Related dis		Other		Total	
	Emp	HW	Emp	HW	Emp	HW	Emp	HW	Emp	HW	Emp	HW	Emp	Hw	Emp	HW	Emp	HW
Rs.1500 - 1000	21 36.	19 35.8	21 39.6	18 34.6	8 38	5 22.7	7 20.6	5 20.8	4 17.4	5 20	0	1 25	18 39	3 15.7	1 50	0	80 33.6	56 28
Rs.1000 1-20000	13 22.2	14 26.4	12 22.6	15 28.8	5 23.8	8 36.3	10 29.4	10 41.6	7 30.4	11 44	0	1 25	11 24	10 52.6	0	0	58 24.3	69 34.5
Rs.2000 1 & above	24 41.3	20 37.7	20 37.7	19 36.5	8 38	9 41	17 50	9 37.5	12 52.2	9 36	1 100	2 50	17 37	6 31.6	1 50	1 100	100 42	75 37.5
Total	58 100	53 100	53 100	52 100	21 100	22 100	34 100	24 100	23 100	25 100	1 100	4 100	46 100	19 100	2 100	1 100	238 100	200 100

A similar trend was seen among housewives as well, as the maximum percentage of women from the high income group (37.5%) reported of suffering from minor illnesses and least percentage of women from the low income group (28%) reported of suffering from these illnesses.

Cold is the most common ailment affecting the sample population with 111 women being affected by it in the last three weeks. However, this ailment occurred more among working women than among the housewives. The maximum percentage (41.3%) of working women from the high income group reported to suffer from this ailment. Among housewives the ailment again follows the same trend, with women in the high income group affected by it the most (37.7%) and the women in the low income group affected by it the least (26.4%).

Cough is the next most common ailment affecting the study population, 107 women were found to be affected by it in the last three weeks. Almost the same number of women in the high and low income group are affected by this ailment ; however the percentage of women in the middle income group is slightly less. So, women in the middle income group are least affected by the ailment. This is true for the case of both working and housewives.

Fever is again a very common illness which uniformly affects the women of both the categories. The same percentage of working women among the high and low income group are affected by the illness and the women in the middle income group are affected least by it. Among housewives women in the high income group are affected most and the women in the low income group are affected least.

A significant difference exists in the number of working women (34) and housewives (24) suffering from ***backaches***. Working women of the high income group are affected most by this ailment and those of the low income group are affected least. Among housewives maximum number of women affected belongs to the middle income group, those in the low income group are least affected by backache.

Significantly high percentage of working women of the high income group (52.2%) suffer from ***head ache*** in comparison to the women of the middle and low income group. The distribution of head ache across the three income groups among housewives follows a similar trend as housewives in the high income group are most affected by the disease and women in the low income group are the least affected ones. This can be attributed to the fact that women in the low income group are so involved in problems of life that they hardly pay attention to minor ailment's like head aches and are often unaware of it even if they are suffering from the same.

Tension and related disorders like irritation, fatigue, insomnia, forgetfulness etc. are concentrated much more among the working women than among the housewives, as 46 working women are affected by these ailments in contrast to 19 housewives. Working women of the low income group are affected most and housewives of the middle income group are affected by these diseases. This is a clear indicator of the fact that working women that too of the low income group are more stressed out.

Very insignificant number of women suffered from ***injuries*** and ***other small ailments*** like rashes or stomach problems etc.

Hence, data in the above section shows that women in the high income group report of more illness in comparison to those in the low income group. This is similar to the findings of the study done by Duggal and Amin (1989) which showed that the rich

and well placed strata complained of illness more often than the poor strata (Duggal and Amin, 1989). Working women in the high income group have the highest reported morbidity both in terms of the presence of major and minor illness. While tension and related disorders are uniformly present among working women across income groups, chronic ailments, headache and backache are the ailments most common among working women of the high income group. On the other hand, communicable diseases are concentrated specifically among women of the low income group.

Under the socio-economic conditions prevalent among the lower socio-economic strata, it is quiet obvious that women would be having anaemia and nutritional disorders or even communicable diseases. Their not reporting of minor and major illnesses can mainly be because they are too involved in other problems of life, their health seeking behaviour is low and hence they often don't realize that they are suffering from ailments and don't report of the same. On the other hand working women in the high income group are conscious about their health, their health seeking behaviour is good and hence they immediately realize if they are suffering from any ailment and report of the same, hence they reported of suffering from much more number of illnesses. Hence, even when the working women of the high income group suffer from less number of illnesses, they are reported promptly in comparison to women of the low income group, who in reality might be suffering from more number of illnesses. Another explanation to this can be that the working women of the low income group may have more recall error in reporting their illnesses suffered in the past than the women in the high income group. This again can be attributed to the less importance given to health by women of the low income group. These assumptions are further tested in the rest of the chapter and in next chapter.

1.3 Self Perceived Health Status

Table 5.3 shows that the maximum number of respondents perceived their health to be good. The next most commonly perceived health status by the respondents is fair and this is followed by very good, excellent and poor. The percentage of working women who reported their health to be fair, very good and excellent is more in comparison to their unemployed counterparts. However, this trend is reversed in case of the women who perceived their health to be good, as significantly higher percentage of

housewives (61.3%) reported their health to be good in contrast to the working women (40%).

Table 5.3: Self Perceived Health Status of the Working women & Housewives

Households by Family Income	Self Perceived Health Status (Percentages in parenthesis)										Total	
	Poor		Fair		Good		V Good		Excellent			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Rs.1500-10,000	1 (4)	0 (0)	11 (44)	6 (25)	10 (40)	13 (54.2)	3 (12)	4 (16.7)	0 (0)	1 (8)	25 (100)	24 (100)
Rs.10,001-20,000	1 (5.9)	0 (0)	4 (23.5)	4 (15.4)	9 (52.9)	16 (61.5)	2 (11.8)	3 (11.5)	1 (5.9)	3 (4.2)	17 (100)	26 (100)
Rs.20,001 & above	1 (3)	0 (0)	8 (24.2)	3 (12)	11 (33.3)	17 (68)	8 (24.2)	4 (16)	5 (15.2)	1 (11.5)	33 (100)	25 (100)
TOTAL	3 (4)	0 (0)	23 (30.7)	13 (17.3)	30 (40)	46 (61.3)	13 (17.3)	11 (14.7)	6 (8)	5 (6.7)	75 (100)	75 (100)

More or less similar percentage of working women from each income group reported their health to be poor. However, none of the housewives perceived their health to be poor. Most of these women who reported their health to be poor were the ones having severe role stress. Hence, it can be said that women with more levels of stress are the ones who consider their health to be poor.

The percentage of working women reporting their health to be ***fair*** (which is average) is more than the housewives. The maximum percentage of women, both working and housewives, belonging to the low income group reported their health to be fair. This is quite contradictory to the morbidity scenario[2] (which shows that the women in the low income group suffer from lesser number of illnesses both major and minor in comparison to the other two income groups).Thus it can be interpreted that women in the low income group don't report of any illness either due to their low health seeking behaviour or due to the fact that they are used to living in morbid state. But they may actually suffer from malnutrition, anaemia etc. which makes them feel weak and gives them a low sense of well being, as a result of which they perceive their health to be poor.

As mentioned earlier the majority of respondents reported their health to be ***good.*** Significantly higher percentage of housewives in the high income (68%) group and working women in the middle income group(52.9%) felt that they had good health.

[2] Refer tables 5.1 & 5.2.

A significantly higher percentage of women in the high income group reported of having ***very good*** health.

The maximum percentage of working women (15.2%) and housewives (11.5%) belonging to the high income group reported of having an ***excellent*** health. However, hardly any woman in the low income group felt that they are having an excellent health status. So, it can be interpreted that self perceived health status is directly related to income, as a lot of women in the high income group felt their health to be excellent and none of the women in the low income group felt the same.

Hence, the above section shows that women of the high income group had a much better self perceived health status, even when they reported of suffering from more number of illnesses, both major and minor. This can be attributed to the high health seeking behaviour of women in this income group which makes them seek medical help even when they are slightly ill. So, they might be reporting more illness but since they seek medical help for all these and get cured immediately they feel that they are having good, very good and excellent health. However, women in the low income group don't seek medical help unless they are severely ill. So, they might be having illnesses but since their health seeking behavior is low they don't report of the same and feel sick and hence report of having poor and fair health. Another explanation to this can be that their are greater chances of a recall error to occur among women of the low income group in comparison to those of the high income group mainly because of the less importance that they give to their health. Hence, if we go by the self perceived health status, women in the low income group have poorer health than the women in the high income group. However, if we go by the self reported morbidity women in the high income have poorer health than those in the low income group. Considering the general understanding that women from the low socio-economic background have lower nutritional status, are anaemic and malnourished difference, have a poor health seeking behaviour and have a greater probability of having a recall error, the self perceived health status is a more valid indicator of measuring health than the self reported morbidity. Hence, it can be concluded that the women in the low income group would have poorer health than those in the high income group. This will be further explored in the next chapter in which role stress is measured among women across income groups and it's relation is seen with health.

II. HEALTH SEEKING BEHAVIOR

2.1 Source of treatment for Major Illness

As seen in table 6.4, the health seeking behavior of women in the high income group is more than that of the middle and low income groups. The table clearly shows a significant difference in the number of working women (22) and housewives (2) seeking treatment from the private sector. The two housewives who seek treatment from private sector belong to the middle and high income group. This was mainly because these women were suffering from severe illnesses like mental illness and chronic arthritis for which adequate treatment was not being provided by the CGHS dispensary. Maximum number of housewives in all the income groups seek health care from the public sector-the CGHS scheme under which they are covered. Housewives find time during the day to seek treatment from this sector and hence don't want to spend their limited family income in seeking treatment from the private sector. On the other hand, working women in the high income group have enough money to seek better treatment from the private sector as they are not satisfied with the quality of services offered by the CGHS. Also for them waiting in queue for long and taking out time during the office hours in order to seek the services from the CGHS dispensary is difficult for them. So, they prefer private medical care which has quick facilities and flexible timings. However, working women in the low income group who are mostly employed as housemaids and sweepers and who are not covered under the CGHS scheme have no option but to seek treatment from the private sector. They were mostly found to be taking loans in order to seek medical care.

This is the agony of it all, the section of the society who deserves free health care the most are not provided the same and the rich and the privileged who have everything are given free services. Under these circumstances how can one ever talk of equity and health for all? If the engineers, clerks and technical staff are provided free health services by BARC, why not these women? Even they are the employees of BARC! The empathetic attitude of government towards imparting free health care to the needy can also be seen by the recent disinterest shown by the centre towards the recommendation by Rajya Sabha committee on the petitions made for the extension of

medical facilties to the central govt. pensioners who were not covered under the Civil Services (Medical attendance) rules,1944 (Hindu, Feb 2005).

Table 5.4: Source of treatment taken for major illness by Working women and Housewives across income groups

Source of Treatment	Total Family Income (Percentages in parenthesis)						Total	
	Rs.1500-10,000/-		Rs.10,001-20,000/-		Rs.20,001& above			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Private Sector	9(40.9)	0(0)	4(18.2)	1(50)	9(40.9)	1(50)	22(100)	2(100)
Public Sector	6(23.1)	5(26.3)	6(23.1)	5(26.3)	14(53.8)	9(47.4)	26(100)	19(100)
Alternate System	1(16.7)	1(50)	0(0)	0(0)	5(83.3)	1(50)	6(100)	2(100)
Home Remedies	6(66.7)	0(0)	1(11.1)	0(0)	2(22.2)	1(100)	9(100)	1(100)
Other Sources	0(0)	1(50)	1(100)	0(0)	0(0)	1(50)	1(100)	2(100)
Total	22(34.3)	7(27)	12(18.7)	6(23)	30(46.9)	13(50)	64(100)	26(100)

The pitiable condition of the women in the low income group not covered by the CGHS scheme can be depicted from the following case study:

Sharda(Pseudonym) a 35 year old housemaid, working in nine households of the BARC colony is married to Rajesh who acts as a delivery man in a pharmaceutical company. Sharda has three daughters and she doesn't want to have a son as she says that she can't afford to have more children just for the sake of having a son. She has also undergone the birth control operation.

Sharda's day starts at 5 in the morning. After completing her household chores and sending her daughters to school, she leaves her house to serve the 9 houses where she is working as a domestic maid. Her work varies in each household and includes sweeping, swabbing, washing clothes, dishes and cooking food. She has to work non-stop for around 12 hours a day, without getting a single day off. The strenuous work combined with her poor dietary intake makes her tired and stressed out. She frequently suffers from headache, body ache and back ache. Sharda also suffers from low blood pressure as a result of which she feels weak and dizzy. The private practitioner whom she consulted recently suggested her to undergo Citi Scan and MRI, to meet the expenses of which she had to take loan from a local money lender

and now has to pay a monthly sum of Rs.1,800 as repayment of this loan. Sharda not even knows as to how many more instalements she has to pay. Around 1/4th of her salary is spent in paying the installments and she is hardly left with any money to fill the stomachs of her children. She feels that her greatest mistake was going to the doctor, had she not gone to the doctor she wouldn't have got stuck in a lifelong debt trap.

So, this case study depicts the pitiable condition of working women in the low income group who has to borrow heavy sums of money in order to seek medical care. This plight of most of the poor people in rural and urban areas has also been depicted in Sheila Zubrigg's Rakku's story, where one can see that falling ill is the worst thing to happen for a poor woman. In order to go to the doctor she has to miss a day's wage which means loss of a day's meal which further brings ill health. Also, since she doesn't have enough money to seek medical care she is forced to take loans , to pay back which means decrease in the amount of food eaten or making their children work as bonded laborers in landowning families (Zubrigg S, 1991).

Maximum percentage of women (both housewives and working) seeking treatment from the *public sector* belongs to the high income group. Here again the percentage of working women slightly exceeds that of the housewives. This can mainly be attributed to the higher consciousness about health among women of this income group. Another observation that comes across from the table is that though housewives prefer public sector most in comparison to the other sources, similar percentage of working women too seek the public sector. This can again be attributed to the higher prevalence of illness among working women.

Alternate sources of medicine like homeopathic and ayurvedic are preferred more by working women than the housewives. This can mainly be because a large number of working women suffered from chronic illnesses, for which they usually tried all possible sources. A significantly high percentage of working women (83.3%) seeking help from this source belong to the high income group. This can be attributed to the fact that working women in the high income group have enough money to try other sources of medicine besides the regular CGHS. Also alternative medicines are more

fashionable and have become expensive too, which only working women of the high income can afford.

Very few people try *home remedies* for major illness mainly because major illnesses can't be cured by home remedies. There is again a huge difference in the number of working women and housewives seeking home remedies. Nine working women as against one housewife prefer this type of treatment. This is mainly because working women don't have enough time for going to the doctor and hence they first try home remedies after falling ill. A significantly higher percentage of working women (66.7%) trying home remedies belongs to the low income group. This can again be attributed to the fact that women in this income group are not covered under the CGHS scheme; also they don't have enough money to go to the private sector. Hence they are left with no option but to take home remedies to cure their ailments.

There are hardly any women who tried other sources of medication like acupressure, reiki etc. The two housewives and one working woman trying these sources were the ones who were suffering from some chronic ailment and hence were trying all possible sources of treatment.

Table 5.5: Source of treatment for minor illness as preferred by Working women and Housewives across income groups

Source of treatment	Total Family Income (Percentages in Parenthesis)						Total	
	Rs.1500-10,000/-		Rs.10,001-20,000/-		Rs.20,001 & above			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Private Sector	6(31.6)	1(25.0)	4(21.1)	2(50)	9(47.4)	1(25)	19(100)	4(100)
Public Sector	4(11.4)	14(29.2)	11(31.4)	18(37.5)	20(57.1)	16(33.3)	35(100)	48(100)
Alternate System	6(22.2)	4(23.5)	5(18.5)	6(35.3)	16(59.3)	7(41.2)	27(100)	17(100)
Home Remedies	17(48.6)	7(20.6)	6(17.1)	10(29.4)	12(34.3)	17(50)	35(100)	34(100)
Self Medication	8(33.3)	4(36.4)	4(16.7)	5(45.5)	12(50)	2(18.2)	24(100)	11(100)
Total	41	30	30	41	69	43	140	114

As seen in table 5.5. the health seeking behavior of working women is better than that of the housewives even in the case of minor illnesses. While 140 of the employed women seek treatment for minor illness only 114 housewives seek treatment for the same. In comparison to the major illness, more number of women both housewives and employed try alternate system, home remedies and self medication.

A remarkable difference exists in the number of working women (19) and housewives (4) seeking treatment from the *private* sector. Within working women the maximum percentage of women in the high income group (47.4%) seek help from the *Private sector* in comparison to the women of the low and middle income group. This is due to the fact that women in the other two groups don't want to pay money and seek treatment from the private sector when they are getting free treatment from the CGHS dispensary. However, more women in the low income group are seeking treatment from the private sector than the women in the middle income group. This is because the working women in the low income group comprises of domestic maids and sweepers who are not covered under the CGHS scheme and have no option but to go to the private sector. This is similar to the case of major illness.

However, the trend is reversed for *Public sector,* as much more number of housewives (48) are seeking treatment from this source in comparison to the working women (35). Within housewives the largest chunk (37.5%) of women belonging to the middle income group seek help from the public sector after falling ill and the minimum percentage of women from the low income group prefer this source. This is mainly because women in this income group are not covered by the CGHS scheme and women in the high income group have enough money to try other sources of treatment. Hence, women in the middle income group who don't have enough money to pay for other sources of treatment are satisfied with the free services provided by CGHS and prefer it over other sources of treatment.

Similar to the case of major illness, for minor illness too *Alternate system* of medicine is preferred more by working women than housewives. This can again be attributed to the dissatisfaction of working women by the CGHS dispensary which makes them explore other alternatives. Maximum percentage of working women (59.3%) from the high income group are seeking alternate medicine. Among housewives the maximum percentage of women from the high income group and the minimum percentage of women from the low income group are trying alternate sources of medicine.

The number of women trying *home remedies* for minor illnesses is very high among both categories of women mainly because most people try to cure the minor ailments

at their own level, as these illnesses don't interfere much with the day to day functioning. The number of housewives and working women seeking help from this source is almost same. Among the working population maximum percentage (48.6%) of women seeking home remedies belongs to the low income group and the minimum percentage of women trying home remedies belongs to the middle income group (17.1%). This is mainly because working women in the middle income group immediately go to the CGHS dispensary after falling ill but women in the low income group who are not covered under this scheme try getting cured at home by trying home remedies before spending huge amounts of money in private sector. Hence, it can be said that much more number of working women in the low income group delay seeking treatment in comparison to the women in the middle and high income group mainly because of the fact that they are not covered under the CGHS scheme. This trend is reversed in case of housewives where the minimum percentage of women seeking home remedies belongs to the low income group (20.6%) and the maximum (50%) percentage of housewives seeking home remedies belongs to the high income group.

Self medication is again preferred by a whole lot of people for minor ailments. However, the percentage of working women trying self medication is much more than the housewives. Maximum percentages of working women (50%) from the high income group try home remedy. An explanation for this trend can be the fact that the working women in the high income group have extremely demanding work situations and hence are busy and avoid seeking treatment due to constraints of time. In contrast to this the least percentage of housewives (18.2%) from the high income group goes for self medication.

2.2 Time of Treatment

The general trend that came across in the study with regards to the health seeking behavior was that more number of employed women delay seeking treatment and try taking home remedies and self medication in comparison to the housewives mainly because of the constraints of time, this can be seen in table 5.6 as well. Maximum percentage (45.5%) of working women trying home remedies belongs to the high income group and the minimum percentage of women (21.8%) in the middle income group try home remedies. Among housewives the maximum percentage of women

seeking home remedy belongs to the high income group and the least percentage of women in the low income group try home remedies.

Similarly while 46 working women seek medical care after trying self medication, 29 housewives do the same. Among working, maximum percentage of women in the high income group (52.2%) prefers self medication as the first line of treatment.

So, we see that the maximum number of working women of the high income group seek home remedies and self medication and least number of working women in the middle income group seek treatment by these two sources. This is mainly because working women in the high income group are the most busy one's and often don't find time to go to the doctor and hence prefer taking treatment at home. This is same as the findings of the table 5.5.

Table 5.6: Time of treatment for Working women and Housewives across income groups

Time of Treatment	Total Family Income (Percentages in Parenthesis)						Total	
	Rs.1500-10,000/-		Rs.10,001-20,000/-		Rs.20,001 & above			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
After Trying Home Remedies	18(32.7)	7(17.5)	12(21.8)	12(30)	25(45.5)	21(52.5)	55(100)	40(100)
After Trying Self Medication	14(30.4)	8(27.6)	8(17.4)	7(24.1)	24(52.2)	14(48.3)	46(100)	29(100)
Immediately after falling ill	3(23.1)	6(18.2)	4(30.8)	13(39.4)	6(46.2)	14(42.4)	13(100)	33(100)
Go for Routine Check Up	0(0)	0(0)	0(0)	0(0)	3(100)	3(100)	3(100)	3(100)
Total	38	28	24	32	55	44	117	105

More number of housewives seek treatment immediately after falling ill in comparison to the working women. While 33 housewives go to the doctor immediately after falling only 13 working woman does the same. This is mainly because of time constraints. Among the housewives the maximum percentage (42.4%) of women seeking treatment immediately belongs to the high income group and the least percentage (18.2%) of women in the low income group go for treatment immediately. Among working women the maximum percentage (46.2%) of women who seek treatment immediately after falling ill belongs to the high income group and the minimum percentage of women (23.1%) belongs to the low income group.

Three housewives and 3 working women go in for a routine check up and all six of them belong to the high income group. Also these are the women who suffer from some serious major illness and hence need to go in for routine check-up.

2.3 Expenses on health- Routine and Individual episode

Table 5.7(a): Average monthly expenditure of Working women and Housewives and on medical care across income groups.

Average monthly expenditure on Medical Care	Total Family Income (Percentages in Parenthesis)						Total	
	Rs.1500-10,000/-		Rs.10,001-20,000/-		Rs.20,001 & above			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
0	1(33.3)	0(0)	1(33.3)	1(100)	1(33.3)	0(0)	3(100)	1(100)
Upto Rs. 50	6(40)	18(90)	5(33.3)	2(10)	4(26.7)	0(0)	15(100)	20(100)
Rs.51-100	12(41.4)	6(24)	5(17.2)	17(68)	12(41.4)	2(8)	29(100)	25(100)
Rs.101-150	0(0)	0(0)	0(0)	5(33.3)	4(100)	10(66.7)	4(100)	15(100)
Rs.151-200	3(25)	0(0)	2(16.7)	1(14.3)	7(58.3)	6(85.7)	12(100)	7(100)
Rs.201 &above	3(25)	0(0)	4(33.3)	0(0)	5(41.7)	7(100)	12(100)	7(100)
Total	25	24	17	26	33	25	75	75

All the employees of the colony are covered under the CGHS scheme for which an amount is deducted from their salaries on the basis of their basic salary. The figures mentioned here, is this amount in addition to the additional medical expenses on sources other than the public sector. Working women of the low income group which comprises of sweepers and housemaids are not covered under this scheme.

Table 5.7(a) shows that working women irrespective of their class spend more money on their health in comparison to their counterparts. A good percentage of women in the low income group are spending up to Rs.100 on their health. However, very few women in this income group are spending more than Rs.100 per month on their medical care and all these are employed women. Housewives from the low income group don't spend more than Rs.100 per month on their medical care. The table trend also shows that women from the middle income group spend much more and those from the high income group spend still more money on medical care. Hence, the higher the income level more is the spending on individual episodes of illness. This is

also an indication of the fact that women in the high income group have maximum health seeking behaviour and those in the low income group have minimum. The table also shows that the spending is less for housewives compared to working women. Hence, working women spend more money on medical care than the housewives. This is mainly because they have money of their own and don't have to depend on their family members.

Maximum women spending upto Rs.50 on medical care are concentrated in the low income group. As depicted in the case study of Sharda (mentioned before), it's extremely difficult for women of the low income group to manage even this small amount of money for their health care. A significant percentage of housewives (90%) spending this amount on health belongs to the low income group. Among working women too the maximum percentage of women spending this amount on health belongs to the low income group and the minimum to the high income group.

A significantly higher percentage of housewives (68%) from the middle income group are spending money ranging from *Rs.51-100* on their health and the minimum percentage of housewives (8%) from the low income group are spending this amount.

A far greater number of housewives spend Rs.101-150 on their health in comparison to the working women. A significantly higher percentage of housewives (66.7%) spending Rs.101-150 on their health belong to the high income group and all the working women spending this amount on health belongs to the high income group. None of the women in the low income group are spending this amount on their health.

More working women spend money in the range of Rs.151-200 in comparison to the housewives. Significantly high percentage of working women (58.3%) and housewives (85.7%) spending money in this range belongs to the high income group.

Again, while 12 working women in the low income group spend more than Rs.200 on their health, only 7 housewives spend money in this range. All these 7 housewives belong to the high income group. Among the working women the maximum percentage of women in the high income group are spending money in this range.

Hence, the table clearly shows that the money spend on health is directly proportional to the family income. Women in the high income group spend more money on their health where as those in the low income group spend less. Also it is observed that the amount spend by housewives is lesser than that of the working women. Another trend which was observed was that while none of the housewives in the low income group spend more than Rs.100 on their health, quite a lot of working women of this income group spend money in this range. The few housewives spending more amounts on health belonged to the high income group and none belonged to the low income group. However, among working women though most of the women spending high amounts on health belonged to the high income group, few belonged to the low and middle income group as well. This is mainly because working women have money of their own and don't have to depend on their other family members for treatment and that is why even working women in the low income group are spending high amounts on their health when needed. Hence, it can be inferred that working women gives more importance to her health in comparison to the housewives. Another explanation to this can be that less number of housewives is suffering from illness so it's obvious that they don't need to spend a large amount of money on their health. Also, housewives in general had the time to seek treatment from the CGHS (which provides treatment free of cost) and were also satisfied with its services; hence their spending on health was less.

A clearer picture of the findings from the above table can be had from the mean figures in table 5.7(b). As seen in this table shows huge difference exists in the average money spent by working women and housewives on their health. While, working women spend a mean amount of Rs.328.60 on their health, housewives spend Rs.160. This is mainly because of the fact that working women are economically independent.

Among working the maximum amount is spend by the women in the high income group (mean=Rs.619) and the minimum is spent by the women in the low income (mean= Rs.23.40).Among housewives again, the maximum amount of money is spent by women in the high income group (mean=Rs.313) and the minimum amount of money is spent by those in the low income group (Rs.28). Across all income groups

the money spent by working women is more than the housewives compared to marginal difference in low income category.

Table 5.7(b): Mean monthly expenditure of Working women and Housewives across income groups

	Employed				Housewives			
	Family income			Total	Family income			Total
	Rs.1500-10000	Rs.10001-20000	Rs.20001 & above		Rs.1500-10000	Rs.10001-20000	Rs.20001 & above	
Count	25	17	33	75	24	26	25	75
Mean	23.40	213.82	618.94	328.60	27.92	134.62	313.04	159.95

III. HEALTH RELATED BEHAVIORS

3.1 Type of Health related behaviors

As seen in the table 5.8(a) except exercise where there is a remarkable difference in the number of housewives and working women, there is not much difference between the two categories of women practicing the other health related behaviors like meditation, eating of balanced diet and following sanitary measures. Infact greater numbers of working women follow these measures. This can be attributed to the better awareness of working women regarding health and fitness which makes them take out time from their busy schedule and practice these behaviours. Also, women in the high income group practice these behaviors much more. This again can be attributed to the better education of the women in the high income group which makes them more aware in comparison to the women in the other two income groups.

A huge difference exists in the number of working women (42) and housewives (22) who exercise. This is mainly because working women felt that going to the office is itself an exercise and hence they didn't need to exercise again. Among housewives, women in the high income group exercised most, where as those in the low income group exercised the least. One reason for this can be that housewives of the high and middle income are more educated and hence they realize the importance of fitness and health much more than the women in the low income group. Walking is the most common exercise done by women across income groups. For the women in the high income group Yoga, meditation and aerobics were the other common forms of exercise. Women in this income group had joined one or the other of these classes.

Table 5.8(a): Different Type of health related behaviors practiced by Working women and Housewives across income groups

Type Of Health Related Behavior	Total Family Income (Percentages in Parenthesis)						Total	
	Rs.1500-10,000/-		Rs.10,001-20,000/-		Rs.20,001 & above			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Exercise	--	10(23.8)	8(36.4)	14(33.3)	14(63.6)	18(42.9)	22(100)	42(100)
Meditate	4(19)	1(5.3)	5(23.8)	5(26.3)	12(57.2)	13(68.4)	21(100)	19(100)
Balanced Diet	5(11.9)	8(20)	14(33.3)	14(35)	23(54.8)	18(45)	42(100)	40(100)
Sanitary Measures	9(15.8)	11(19.3)	16(28.1)	22(38.6)	32(56.1)	24(42.1)	57(100)	57(100)
Others	0(0)	1(100)	0(0)	0(0)	3(100)	0(0)	3(100)	1(100)
Total	18	31	43	55	84	73	145	159

More number of working women (21) meditates in comparison to the housewives (19). This can mainly be because working women have high levels of stress due to the dual burden of work and yoga acts as an effective measure to overcome the same. A significant difference exists in the percentage of working women in the high (57.2%) and low income group (19%) who meditates. This trend is repeated among the housewives also where the maximum percentage (68.4%) of women in the high income group meditates and only 5.3% of women in the low income group practices meditation.

A large chunk of the sample population ate *balanced diet.* There is a marginal difference between the number of working women and housewives who eat balanced diet; however the number of working women is slightly more. This can be attributed to the greater awareness level of the working women. The maximum percentage (54.8%) of working women in the high income group eat balanced diet and the percentage of women in the low income group eating balanced diet is the least (11.9%). The same trend is repeated among the housewives too where 45% of women in the high income group, and 20% women in the low income group eat balanced diet.

Almost the entire sample population follows *sanitary measures.* Equal number of housewives and working women practiced this health related behavior. The maximum number of working women (56.1%) following sanitary measures again belonged to the high income group and the minimum percentage of women (15.8%) practicing this

health related belonged to the low income group. The same trend was repeated among the housewives as well.

As usual the number of working women following other health related behaviors like eating specific diets, or doing reiki which are not included in the list is more than the housewives. All these working women belong to the high income group. This is mainly because these activities are very costly, which only women in the high income group can afford.

Table 5.8(b): Mean value of the number of health related behaviors followed by the Working women and Housewives across income groups.

	Employed				Housewives			
	Family income			Total	Family income			Total
	Rs.1500-10000	Rs.10001-20000	Rs.20001 & above		Rs.1500-10000	Rs.10001-20000	Rs.20001 & above	
Count	25	17	33	75	24	26	25	75
Mean	0.72	2.53	2.55	1.93	1.29	2.12	2.92	2.12

The mean values in the table 5.8(b) clearly shows that the number of health related behaviors practiced by the housewives are more than the working women. This is mainly because more number of housewives exercises in comparison to the working women. The table also shows that among the working women, women in the high income group follow the maximum number of health related behaviors and women in the low income group follow the least number of health related behaviors. The same is true in case of housewives too.

3.2 Leisure time and Leisure time activities

Table 5. 9 (a): Weekly Leisure time enjoyed by Working women and Housewives across income groups.

Leisure Hours	TOTAL FAMILY INCOME (Percentages in Parenthesis)						TOTAL	
	Rs.1500-10,000		Rs.10,001-20,000		Rs.20,001 and above			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Less than 10 hours	21(35)	1(14.3)	13(21.7)	5(71.4)	26(43.3)	1(14.3)	60(100)	7(100)
Between 11-20 hours	4(26.7)	4(22.2)	4(26.7)	4(22.2)	7(46.7)	10(55.6)	15(100)	18(100)
More than 21 hours	0(0)	19(38)	0(0)	17(34)	0(0)	14(28)	0(0)	50(100)
TOTAL	25	24	17	26	33	25	75	75

Table 5.9(a) shows that all working women have less than 20 hours of leisure time per week. While 60 working women have an average weekly leisure time of up to 10 hours, none of them across all the economic categories have more than 21 hours. So, most working women gets a leisure time of less than 10 hours per week.

In comparison to the working women, more housewives have leisure time between 11-20 hours. A significantly high percentage of housewives (56 %) in the high income have leisure time between 11-20 hours. While none of the working women had leisure time of more than 20 hours, 50 housewives had the same. Maximum percentage (38%) of housewives falling in this group belonged to the low income group and the minimum percentage of women (28%) belonged to the high income group. This trend is observed mainly because most of the housewives in the low and middle income group lived in joint families where there were other people to help them in domestic work also many of these women had older children after whom they didn't have to spend much time. However, women in the high income group usually lived in nuclear families and had smaller children to take care of, so domestic work and child care took most of their time and they were not left with enough leisure time.

Among working women again the maximum percentage of women having leisure time between 11-20 hours belongs to the high income group. This can be attributed to the fact that working women in the high income group had domestic maids who shared a major chunk of their domestic work and provided them some free time. However, women in the low and middle income group who didn't have a domestic maid had to spend a whole lot of their time on domestic work and so they hardly found any leisure time.

Table 5.9(b): Mean value of the leisure time enjoyed by the Working women and Housewives across income groups.

	Employed				Housewives			
	Family income			Total	Family income			Total
	Rs.1500-10,000	Rs.10,001-20000	Rs.20,001 & above		Rs.1500-10,000	Rs.10001-20,000	Rs.20,001 & above	
Count	25	17	33	75	24	26	25	75
Mean	5	6.88	8.12	6.80	27.54	20.62	21.88	23.25

The mean values shown in the table 5.9(b) gives a clearer picture of the average leisure time enjoyed by the women of the two categories across income groups. The table shows that the average leisure time of working women is much less than that of the housewives. While working women enjoy an average leisure time of 6.80 hours, housewives on an average enjoy a leisure time of 23.25 hours. Working women in the high income group have the maximum weekly leisure time of 8.12 hours and those in the low income group have the minimum weekly leisure time of 5 hours. In contrast, housewives in the low income group have maximum weekly leisure time of 27.54 hours; those in the middle and high income group have almost the same amount of leisure time which is 21 hours and 22 hours respectively.

As seen in table 5.10, the two most popular leisure time activities as practiced by working women and housewives across income groups, are watching TV and taking rest. Since working women have lesser amount of leisure time, it is obvious that they will practice lesser number of leisure time activities. Data in table 5.10 further confirms this, as across all income groups the percentage of housewives practicing most of the leisure time activities exceeds that of the working women. Working women of the low income group who have the least amount of leisure time engage themselves in limited activities of watching TV, listening to music, socializing and taking rest. They don't indulge in activities like theatre, out door, creative and fitness activities which are more elitist in nature. It is the middle income and more so upper income women who participate in these activities. Maximum percentage of working women in this (low) income group takes rest and socialize. However, women in the high income group who comparatively have more leisure time engage themselves in all kind of activities. Hence, the number of leisure time activities is directly related to the amount of leisure time that one has.

As seen in table 5.10 more women of the high income group listen to music as compared to those in the other income groups. Similarly a significant difference exists in the percentage of working women (59.5%) and housewives (29.6%) of the high income group who watch TV. Among working women the maximum percentage of women in the high income group watch TV. This is mainly because working women in the high income group are found to have more leisure time in comparison to the other

two groups. In contrast among housewives the maximum percentage of women from the low income group indulges in this leisure time activity. This can mainly be attributed to the fact that women in the high and middle income group can chose from a wide range of leisure time activities as they have more money and time. However, due to the scarcity of time and money women in the low income group aren't left with much of choice so they usually end up watching TV.

Going to theatre is an activity which is limited only to the high income group and is preferred by the working women. This can mainly be because working women can go to the theatre even with their friends or colleagues but housewives only have to depend on their husbands to take them out for movies.

Table 5.10: Leisure time activities as preferred by Working women and Housewives across income groups.

Type of Leisure Time Activity	Total Family Income (Percentages in Parenthesis)						Total	
	Rs.1500-10,000/-		Rs.10,001-20,000/-		Rs.20,001 & above			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Music	1(12.5)	3(25)	3(37.5)	3(25)	4(50)	6(50)	8(100)	12(100)
TV	3(7.1)	21(38.9)	14(33.3)	17(31.5)	25(59.5)	16(29.6)	42(100)	54(100)
Theatre	0(0)	0(0)	0(0)	0(0)	5(100)	2(100)	5(100)	2(100)
Outdoor Activity	0(0)	2(20)	2(20)	4(40)	8(80)	4(40)	10(100)	10(100)
Creative Activity	0(0)	3(37.5)	1(25)	2(25)	3(75)	3(37.5)	4(100)	8(100)
Fitness Activity	0(0)	2(10)	2(16.7)	6(30)	10(83.3)	12(60)	12(100)	20(100)
Reading	0(0)	5(13.2)	7(22.6)	15(39.5)	24(77.4)	18(47.4)	31(100)	38(100)
Socializing	7(38.9)	8(27.6)	5(27.8)	9(31)	6(33.3)	12(41.4)	18(100)	29(100)
Rest	22(47.8)	11(26.8)	7(15.2)	16(39)	17(37)	14(34.1)	46(100)	41(100)
Other activities	4(80)	0(0)	0(0)	2(100)	1(20)	0(0)	5(100)	2(100)
Total	37	46	41	72	103	87	181	216

Equal number of housewives and working women prefer ***outdoor activity*** like shopping, eating out or going for picnic etc. as a leisure time activity. While 80% of working women in the high income group practised this activity, no working woman in the low income group practiced this activity. This is mainly because the heavy expenses involved in these activities which only women in the high income group can afford.

Among housewives again, the maximum percentage of women (40%) engaging in these activities belong to the high and the middle income groups.

Creative activities like stitching, knitting, embroidery, painting or making handicrafts are preferred more by housewives than working women. Almost the same number of housewives practices this activity across income groups. Maximum percentage of women in the high income and middle income group (38%) and the minimum percentage (25%) of women in the low income group engage in these activities. Among working 75% of women in the high income and 25% in the middle income group engage in creative activities in their leisure time. None of the women in the low income group engage in these activities. This again can be attributed to the amount of leisure time which women of these groups have.

More number of housewives (20) use their leisure time for ***fitness related activities*** like exercise, walking, yoga, and meditation etc. in comparison to the working women (12). Significantly high percentage of housewives (60%) and working women (83.3%) in the high income group prefer these activities, while none of the working women in the low income group indulge these activities. This can be attributed to the higher levels of consciousness among women in the high income group regarding health and fitness. Another explanation to this can be that the women in the high income group usually have a sedentary life style as their daily routine work doesn't involve much of physical activity hence they feel the need to engage in these activities. However, the work of working women in the low income group involves excessive physical strain and labour and hence they don't feel the need to exercise.

Similarly, more number of housewives (38) ***read*** magazines, newspapers or novels in their leisure time in comparison to working women (31).Among both housewives and working women the maximum percentage of women from the high income group read. However, there is a significant difference in the percentages of housewives (47.4%) and working women (83.3%) in this income group. This again can be attributed to the education and awareness levels. Working women in the high income group are better educated than those in the low income, so even in their less leisure time they try to squeeze out some time to at least read newspapers. On the other hand working women in the low income group don't feel the need to be aware about the

worldly issues as they feel it does not concern them and will in no way benefit their position. They prefer watching TV in their limited leisure time than reading newspapers.

Socializing with neighbours and friends again, is preferred more by housewives than working women, mainly because of the abundance of leisure time that they have. Among housewives maximum percentage (41.4%) of women in the high income group prefer socializing in their leisure time, 31% in the middle income group and 27.6% in the low income group prefer the same. So, it can be interpreted that working women in the low income group and housewives of the high income group are most social.

Conclusion

The major findings that have come across from this chapter are put as follows:

- Women in the high income group both working and housewives reported the maximum presence of major and minor illness and women of the low income group reported the minimum presence of major and minor illness. This can be attributed to the poor health seeking behaviour of the women of the second category.
- In contrast to this the self perceived health status of working women and housewives of the high income group is much better than that of the other two groups as more number of women both working and housewives belonging to this income, felt that they have good and excellent health status.
- Tension and related disorders, chronic ailments, headache and backache are prevalent more among working women than housewives. While tension and related disorders is uniformly present among working women across income groups, chronic ailments, headache and backache are most common among the working women in the high income group. Communicable diseases are present most among working women of the low income group.
- The health seeking behavior of the working women is better than that of the housewives for both major and minor illness. Women of the high income group have better health seeking behavior than those in the low income group.

- Working women spend more money on their health in comparison to the housewives. Women in the high income group spend more money on their health in comparison to the housewives.
- While working women prefer taking treatment from private sector, alternate system of medicines and home remedies, most of the housewives are satisfied with the public sector (CGHS dispensary) and very few try these other sources of treatment.
- Private sector is preferred more by working women of the high and low income groups.
- The health related behaviors of women in the high income group is much better than those belonging to the other two groups.
- Working women of the high income group have the maximum weekly leisure time and those in the low income group have the minimum weekly leisure time. In contrast, housewives in the low income group have maximum weekly leisure time.
- Housewives practice more number of leisure time activities in comparison to the working women.
- Listening to music, going to theatre, Outdoor activities, fitness related activities are most common among women in the high income group.

Hence, the findings of this chapter shows that even though women in the high income report of suffering from more number of illness in comparison to their low income counterparts yet they have a better perception about their health status in comparison to women of the low income group. This is mainly because women in the high income group have better health seeking behaviour due to which most of their illness comes in the fore and are also cured. However, women in the low income group who have poor health seeking behaviour, are mostly unaware of their illness even when they are actually suffering from the same. This is precisely the reason for their poor sense of well being and poor self perceived health status. Besides, women in the high income group practice more health related behaviors than those in the low income group, which further makes one believe that they have a better health status. Now the question that arises is which one of the two groups of women are healthier- those in the high income who report of more morbidity but who perceive their health as good,

excellent and very good, or the women in the low income group who report of less morbidity but who perceive their health as fair and poor. The next chapter would further address this issue by exploring the presence of role stress among women across these income groups and drawing it's relation with health.

CHAPTER VI

ROLE STRESS, ROLE ENHANCEMENT AND IT'S RELATIONSHIP WITH HEALTH

I've got the children to tend
The clothes to mend
The floor to mop
The food to shop
Then the chicken to fry
The baby to dry
I got company to feed
The garden to weed
I've got shirts to press
The tots to dress
The cane to be cut
I gotta clean up this hut
Then see about the sick
And the cotton to pick
Shine on me, sunshine
Rain on me rain
Fall softly, dewdrops, And cool my brow again

-Maya Angelou, pp 37 (Shriram and Ganpathy,1997)

The above lines depict a woman's multiple tasks and the resulting role stress in the agrarian context. This situation exists for most women in the urban context as well, as besides the familial roles; most of them are performing an additional role of that of an employee which further increases their work load. Today's woman performs myriad roles of that of a homemaker, professional, mother, wife, daughter, daughter in law, neighbor, community member etc. Oppong (1998) has classified the various roles of women into seven categories namely, parental, occupational, conjugal, domestic, kin, community and individual roles (Oppong C and A Katherine, 1998). Some women are efficiently able to perform each of these roles, in fact they are able to compensate the dissatisfaction that they get in coping up with one role with the satisfaction that they derive in performing the other roles. This phenomenon is termed as Role Enhancement (Weber A, 2001). However, most women are stuck in striking a balance between the family and work front

and end up facing a Role Stress which is often due to the stress of balancing the multiple roles of a wife, mother, daughter, daughter-in-law and above all that of an employee.

Various researchers have tried to find the relationship between multiple roles and health. Two competing models guide research in the area: The Stress hypothesis, also known as role strain or scarcity; or multiple role or Role overload hypothesis (Goode, 1960). The other is Enhancement hypothesis, also known as role expansion or accumulation (Marks 1977; Sieber, 1974), both these models form a part of the Role Analysis Framework. According to the first hypothesis, combining the roles of wife, mother and an employee would have unfavorable repercussions on health of women as it leads to Role Strain, which is a concept involving continuous attempts to cope with the conflicting demands and expectation of the various roles. On the contrary, the second hypothesis emphasizes the beneficial aspects attached to multiple roles which are diversification of sources of self esteem, supportive social ties, and buffering effects of work on marital stress, all of which leads to a positive outcome on women's health (Khlat et.al.,2002). Another nomenclature to this is the Multiple Attachment Hypotheses, which predicts that multiple roles provide attachment to the community, which is likely to be beneficial to women's health (Lahelma et.al.,2002).

In Chapter 4 it was seen that employment has a negative influence on the health of women of the study population as housewives enjoyed better health than the working women mainly because they had more of leisure time to practice better health seeking and health related behavior. This chapter tries to explore other reasons for this difference in the health of the housewives and working women. Similar to the studies mentioned above, which has used the Role Analysis Framework to see the effect of employment on health of women; the present chapter too tries to see the effect of employment on the health of women by using the above mentioned framework. For the purpose various factors leading to the phenomena of Role Stress and Role Enhancement among the two categories of women are explored, after which association is seen between these two phenomena and the health and well being of women.

According to Weber A.(2001) "Whether multiple roles increase or reduce stress may depend on such factors as the quality of one's job, ones commitment to working, and the social support provided by partners and other members of one's social network (Weber A ,2001)."Similarly according to Moen & Yu (1999), exposure to stressors and the availability of resources vary as a function of age, occupation or occupational status. Conflicts between roles change over the life course, as do the underlying demands and resources. Middle aged women, blue-collar workers and those at the lower end of the status hierarchy are thought to be most exposed to stressors while having few resources available. Consequently, it may be that only middle class women experience a positive relationship between employment and well being (Moen & Yu, 1999). Based on these literature it is assumed that variables like age, income, occupation, education, family responsibilities (size, number of children, age of children) working hours, job satisfaction, husband's education, help and support by the other family members in domestic work, domestic help might play a major role in determining a woman's ability to cope up with the multiple roles which in turn determines the beneficial or detrimental effect of employment on her health. Hence, the effect of these variables on causing the phenomena of Role Stress and Role Enhancement among the sample population is studied in great depth.

Role stress and Role enhancement has been measured on the basis of the response of two questions that were asked to the respondents, the first question was, *"Are u able to manage all the roles that u perform?"* The responses of these questions were interpreted to understand whether a woman is facing role stress or not. The women who responded "No" for this question were assumed to be facing severe role stress, those who responded by "sometimes cant" were assumed to be facing a milder form of role stress, where as the ones who said "Yes" were assumed not to face any role stress , they were in fact facing a Role Enhancement.

The second question was *"Do u feel stressed out while managing these role?"* Women who responded by "Yes all the time" were assumed to have severe Role stress, the ones

who responded by "Yes sometimes" were assumed to have a lesser degree of role stress, where as the ones who responded by "No never" were assumed to have no Role stress.

Hence, this chapter tries to explore whether working women have more role stress than housewives and whether role stress is the reason for the poor health of working women. The chapter is divided into four sections; the first section describes the phenomena of role stress faced by working women and housewives. The second tries to explore factors like work status, job satisfaction, travel time to work place, income, age, education, family size, number of children, children's age, presence or absence of domestic maid, help in domestic work by other family members etc. which may lead to role stress or role enhancement among women. These factors have been clubbed under four broad headings of demographic factors, socio-economic factors, help in domestic work, and leisure & rest. The third section of the chapter tries to see the effect of Role stress on health of women, mainly to see whether women with more Role Stress have poorer health than the women in the other group, and finally the fourth section tries to substantiate the findings of this chapter with relevant case studies gathered during the course of data collection.

I. PHENOMENA OF ROLE STRESS & ROLE ENHANCEMENT

Table 6.1: Ability to manage multiple roles by Working women and Housewives

Manage multiple roles	Work Status of the Respondent (Percentages in parenthesis)		Total
	Employed	Housewife	
No, Never	28(37.3)	8(10.7)	36(24)
Sometimes, can't	15(20.3)	9(12)	24(16.1)
Yes, all the time	32(42.6)	58(77.3)	90(60)
Total	75(100)	75(100)	150(100)

Table 6.1 clearly shows that a significantly greater percentage of working women (37.3%) were not able to manage the multiple roles in comparison to the housewives (10.7%). Similarly, a significantly higher percentage of working women (20.3%) were not able to manage the multiple roles sometimes, in comparison to the housewives (12%). In contrast to this, a far greater percentage of housewives (77.3%) felt that they were

successfully able to manage the multiple roles in comparison to the working women (42.6%). Hence, it can be said that most working women of the study population were not able to manage the multiple roles of a wife, mother, employee etc. and hence were facing a Role Stress; however most of the housewives were successfully able to manage these roles. This is mainly because housewives were not performing the additional role of an employee and hence were devoting all their time and energies to their familial roles. The reason most commonly given by working women for not being able to manage the multiple roles was the lack of time. The few working women who were able to manage their multiple roles and were facing a role enhancement, said that with time they had gained the experience of managing the different kind of roles but initially they faced a whole lot of problem. Some women with supportive and understanding families felt that it was a major factor that helps them in managing the multiple roles. Some elderly working women with grown up children said that they don't face any problem in managing the roles now, but when their children were young they did face a whole lot of problem.

Table 6.2: Role Stress as faced by Working women and Housewives

Stress generated by Multiple Roles	Work Status of the Respondent (Percentages in parenthesis)		Total
	Employed	Housewife	
No Stress	20(26.7)	48(64.0)	68(45.3)
Mild Stress	28(37.3)	20(26.7)	48(32.0)
Severe Stress	27(36.0)	7(9.3)	34(22.7)
Total	75(100)	75(100)	150(100)

Table 6.2 also shows a similar result. A significantly higher percentage of housewives (64%) were found to be stress free in comparison to the working women (27 %).Women who sometimes faced role stress were concentrated more among the employed (37 %) than housewives (26.7%) and a significantly higher percentage of working women (36%) faced severe stress due to the multiple roles in comparison to the housewives (9.3%). Hence, this table shows a significant difference in the percentages of housewives (36%) and working women (73.3%) facing mild and severe stress. So, it can be inferred that

fewer number of housewives faced role stress in comparison to working women. However, the highly educated housewives who were working before but who quit their jobs due to inability to manage the additional role of an employee, reported of high levels of frustration, and hence role stress. Nineteen housewives in the study population belonged to this category. The levels of frustration among this group of women can be well depicted by the following case study:

Neelam Trivedi(Pseudonym) a 41 year old housewife belonging to the high income group is a mother of two sons, one 13 year old and the other 11 year old.

Neelam had always been a very ambitious and career minded woman. Her pursuit for a better career and her interest in academics made her do her doctorate as well as her post doctorate in Chemistry from Roorkee University. After finishing her studies Neelam worked as a scientist with BARC for almost about 7 years. After 4 years of her job she got married to Ravi Trivedi,an engineer working in BARC as a scientist. In the initial years of their marriage Ravi allowed her to continue her job as she was able to successfully combine the two roles of a wife and a homemaker mainly because the pressures were less. However, the birth of her first son simply made it impossible for Neelam to manage the home and work front as her husband was not very supportive and also the support from in-laws and parents was minimal , since they were staying in different cities. At this juncture Neelam was left with no choice but to quit her permananent government job. At that point she had thought of rejoining work after her child grows up a little. But this wish of hers could never materialize into a reality. Increasing family pressures, the birth of a second child and uncooperative demanding spouse reduced the ambitious, career minded, confident Neelam to a meek housewife who didn't have any identity of her own and whose world consisted on none, except her husband and two children.

When asked about her feelings, Neelam said with sobs" I feel highly frustrated for not utilizing my talents, I worked so hard to do my Ph.D and post doctoral and now they are like useless documents to me, I have not done justice to my self, to my studies, I wish I

had a more understanding husband who would realize the worth of my qualifications and make me utilize it for the welfare of the society." Neelam says that her frustration often came out on her children whom she would scold and beat for no reason at times, she also had a troubled relationship with her spouse. When asked about her plans about future, Neelam said "It's too long a break for my career and I don't think I can continue in the same field but I know that I must do something like taking tuitions or doing some social work otherwise I would go mad."

Hence in this case study, it is seen that Neelam is not facing stress due to the overburden of roles but due to the absence of a role, to which she had got so used to and which gave her an identity and a sense of worth. This shows that no doubt it's difficult for a woman to manage both work and home, but if highly qualified and ambitious women don't work then it leads to a whole lot of frustrations among them.

Table 6.3: Roles found most stressful by Working women and Housewives

Work status Of the Respondent	Most Stressful Role (Percentages in parenthesis)					TOTAL
	No role stressful	Wife	Mother	Daughter-in-law	Employee	
Employed	20(26.7)	8(10.7)	22(29.3)	13(17.3)	12(16)	75(100)
Housewife	48(64)	7(9.3)	12(16)	8(10.6)	0	75(100)
Total	68(45.3)	15(10)	34(22.6)	21(14)	12(8)	150(100)

Table 6.3 again shows that working women face more stress than housewives. While 64% of the housewives never faced any role stress, only 26.7% of the working women felt the same. Since, more number of working women faced role stress in comparison to the housewives, so the percentage of working women who found each of the above mentioned roles as most stressful exceeds that of the housewives. Not much difference exists between the percentage of working women and housewives who found the wife's role to be the most stressful one. However, a significant difference was found between the percentage of working women (29.3%) and housewives (16%) who considered the

mothers role to be the most stressful one. Similarly, 17% of the working women found daughter-in-laws role to generate the maximum amount of stress, compared to 10.6% of the housewives. Sixteen percent of the employed women found the employees role to be the most stressful one. None of the respondents found the daughters, community member's or neighbor's role to be the most stressful one.

Hence, the data above shows that the mother's role was found to be the most stressful role by most of the working women. Most working women were found to be engulfed with a deep sense of guilt for not being able to give sufficient time to their children. These feelings of guilt were even more when the children were young. The role which tops next in terms of generating most stress among working women is that of a daughter-in-law. It was surprising to know that most of these women who found the in-laws role to generate stress for them were not even staying with them. The reason most commonly given for the stress generated out of this role can be understood well from the narrative of one working woman who found this role to be the most stressful one.

"*Husbands and children can still understand the limitations of a working woman and won't demand so much, however the in-laws are least understanding, infact they are always trying to find faults, hence there is a constant tension in interacting with them. Though my in-laws are not staying with us still the times when they come to visit us are the most stressful ones.*"

However, lesser number of housewives found the daughter-in-law's role to be the most stressful role as they had ample of time to fulfill the demands of this role.

It is interesting to note that lesser number of working women found the employees role to be most the stressful one in comparison to the mother's and daughter-in-law's roles. Hence, it can be inferred that familial roles generate more stress than the occupational roles. Minimum percentage of women (16%) found the wives role to be the most stressful one.

Among housewives again the same trend was repeated. Significantly higher percentage of women (64%) found the mother's role to generate most stress, a little lesser percentage found the daughter-in-laws role and least percentage of women (9.3%) found the wives role to be the most stressful one.

Table 6.4: Roles found least stressful by Working women and Housewives

Work Status Of the Respondent	Least Stressful Role (Percentages in parenthesis)						TOTAL
	No role stressful	Wife	Mother	Daughter	Community Member	Neighbor	
Employed	24(32)	2(2.6)	5(6.6)	2(2.6)	14(18.6)	28(37.3)	75(100)
Housewife	53(70.6)	2(2.6)	0	5(6.6)	0	15(20)	75(100)
Total	77(51.3)	4(2.7)	5(3.3)	7(4.7)	14(9.3)	43(28.7)	150(100)

Table 6.4 again shows that much lesser number of housewives faced role stress in comparison to the working women as significantly high percentage of housewives (70.6%) didn't find any role to be the least stressful one in comparison to the working women (32%).This is mainly because housewives usually didn't find any of the roles to generate stress or they just found one or two roles to be stressful which they rated as the first and second most stressful one. In contrast around 60% of working women found all the seven roles to generate stress. None of the women rated the daughter-in-laws and employee's role to be the least stressful one as most of them rated them as the first, second or third most stressful role. Maximum percentage of women (both housewives and working) found the neighbor's role to generate least stress. The next most widely voted least stressful role for working women was that of a community member, followed by mother, wife and daughter. Among housewives the next most stressful role was that of daughter and the least percentage of women found the wife's role as the least stressful one. None of the housewives rated the role of a mother and community member as the least stressful one.

It is interesting to note that while the maximum percentage of working women rated the mother's role to be most stressful one a reasonably good percentage also voted it to be the

least stressful one. The women who rated the mother's role to be least stressful mostly belonged to the low income group. Working women of this group said that they got immense support from their children, who did most of their household chores while they worked outside. However, women of the high and middle income group found mother's role to be most the most stressful one, as their children were highly demanding.

Hence, the least stressful role for most women in the sample population was that of a neighbour. This can be attributed to the minimal interaction among the neighbour's in the colony, which creates less chances for any quarrel and subsequent stress.

Hence, the findings in this section shows that most of the working women of the sample population suffered from mild or severe role stress and most of them found the role of mother and daughter in law to be most stressful and that of a neighbor and community member as least stressful. Housewives on the other hand, suffered from minimum amount of stress. Most of them found daughter-in-law's role to be the most stressful one and the neighbor's role to be the least stressful one. The rest of the chapter would now explore the factors that help working women to cope up with the stress generated from multiple roles. Besides it also tries to explore the factors that causes or prevents stress among housewives.

II. FACTORS LEADING TO ROLE STRESS AND ROLE ENHANCEMENT

2.1. Factor 1--------Demographic Factors

i) Age of women and Stress

The trend in table 6.5 shows a decrease in the stress levels with the increase in age especially among the working women. The maximum percentage of working women having severe stress (41.9%) belongs to the age of 25-35 years, 36.8% women in the age of 36-45 years have severe stress and none of the women in the age of 46 years and above have severe stress. The percentage of working women (66.7%) having mild stress and no stress (33.3%) is maximum in the age of 46 years and above. Hence, among working women stress decreases with the increase in age. This can mainly be because working

women in the age group of 25-35 years had small children managing whom was a tedious task, especially along with a full time job. However, the older women had grown up children and hence they were more or less free from the task of child rearing. However, these women reported of facing severe stress when their children were young. Besides, women of the younger age group who were recently married even felt stressed out coping with newly acquired roles of a wife and daughter-in law, while older women had got so much used to these roles that they hardly created stress for them.

Table 6.5: Association between Age and Role Stress

Age of the Respondents (in years)	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	No Stress		Mild Stress		Severe Stress			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
25-35	7(22.6)	29(69)	11(35.5)	10(23.8)	13(41.9)	3(7.1)	31(100)	42(100)
36-45	11(28.9)	14(60.9)	13(34.2)	7(30.4)	14(36.8)	2(8.7)	3(100)	23(100)
46 & above	2(33.3)	5(50)	4(66.7)	3(30)	0(0)	2(20)	6(100)	10(100)
Total	20(26.7)	48(64)	28(37.3)	20(26.7)	27(36)	7(9.3)	75(100)	75(100)

Among housewives as it is the stress levels were very low and age wasn't found to play a significant role in influencing the levels of stress. Still a significantly higher percentage of housewives belonging to the age of 25-35 years had severe stress (42.9%).

Hence, it can be concluded that role stress decreases with increase in age more so among the working women. This is mainly because older women have lesser family responsibilities as they have grown up kids.

ii) ***Number of children & Stress***

The trend in table 6.6 shows that working women as it is are stressed out irrespective of the number of children. A far greater percentage (64%) of housewives are stress free in comparison to the working women (26%). Both row and column analysis doesn't show a clear association between the number of children and stress. Hence, the number of

children may not be a very significant indicator of stress for women but it is the employed status that puts pressure on them.

Table 6.6: Number of children and Role Stress

No. of Children	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	No Stress		Mild Stress		Severe Stress			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
0	2(20) (10*)	5(55.6) (10.4*)	4(40) (14.3*)	2(22.2) (10*)	4(40) (14.8*)	2(22.2) (28.6)*	10(100)	9(100)
1	12(36.4) (60*)	15(55.6) (31.3*)	9(27.3) (32.1*)	9(33.3) (45*)	12(36.4) (44.4*)	3(11.1) (42.9*)	33(100)	27(100)
2	4(15.4) (20*)	23(76.7) (48*)	15(57.7) (53.6*)	6(20) (30*)	7(26.9) (25.9*)	1(3.3) (14.3*)	26(100)	30(100)
3 & above	2(33.3) (10*)	5(55.6) (10.4*)	--	3(33.3) (15*)	4(66.6) (14.8*)	1(11.1) (14.3*)	6(100)	9(100)
Total	20(26.7) (100*)	48(64.0) (100*)	28(37.3) (100*)	20(26.7) (100*)	27(36) (100*)	7(9.3) (100*)	75(100)	75(100)

*** Percentage across the column**

Among working women the maximum percentage (66.6%) of women having severe stress were the ones with more than 3 children. A significantly high percentage of childless working women were also found to have severe stress (40%). Mild stress was prevalent most among working women with 2 children(57.7%).Among housewives though the maximum percentage of childless women were stress free but a good percentage of women were also found to have severe and mild stress. It's interesting to note here that though most women reported mother's role to be the most stressful one[1], the ones who didn't have children also reported of stress. Hence, child rearing is no doubt a tough job which brings stress to women but the absence of child is equally stressful for them. This can be attributed to the societal values which considers that a woman is complete only if she becomes a mother. Another reason can be the emotional vacuum faced by a childless woman. Hence, data here shows working women with no and more than 3 children were more stressed out.

[1] Refer table 6.3

Among housewives a similar trend was seen as a significantly high percentage of women (48%*) having two children were stress free and the minimum percentage of women with no (10.4%*) and more than 3 children(10.4%*) were found to have severe stress. However, the same trend didn't repeat in case of severe stress. Hence, a very clear association couldn't be found between the number of children and stress.

iii) Age of Children & Stress

Table 6.7: Age of children and Role Stress

Age Of Children	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	No Stress		Mild Stress		Severe Stress			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Below 5 years	6(27.2*)	14(21.2*)	6(14.63*)	7(24.1*)	6(15*)	1(10*)	18	22
Between 6-10 years	5(22.7*)	22(33.3*)	15(36.6*)	10(34.4*)	12(30*)	3(30*)	32	35
Between 11-15 years	4(18.2*)	19(28.8*)	12(29.2*)	5(17.2*)	11(27.5*)	3(30*)	27	27
15 years & above	7(31.8*)	11(16.6*)	8(19.5*)	7(24.1*)	11(27.5*)	3(30*)	26	21
Total	22(100*)	66(100*)	41(100*)	29(100*)	40(100*)	10(100*)	103	105

***Percentage across columns**

Table 6.7 clearly shows that the percentage of working women having mild and severe stress exceeds that of housewives irrespective of the age of the child. This shows that for working women child rearing in itself is a tough job. In contrast a far greater percentage of housewives irrespective of the age of their children don't have stress in comparison to the working women. This shows that age of children is not a very significant indicator of stress for women but it is the employed status that puts pressure on them.

When stress levels are compared among working women across groups, maximum percentage of women with children in the age group of 6-10 years have mild (36.6%) and severe stress (30%) and a comparatively lower percentage (22.7%) of women don't have any stress. Hence, working women with children in the age of 6-10 years are most stressed out. This is mainly because children in this age group are very active and

naughty. It is also in this age that they start school and hence require more help in studies as well. High levels of stress are also seen among women with children in the age of 11-15 years as 29.2% of women in this group reported of mild stress and 27.5% of women reported of severe stress. However, maximum percentage (31.8%) of women having children above 15 years of age reported of not having any stress. This is mainly because older children can manage themselves on their own and the mothers of older children are more or less free of the task of child rearing. However, among housewives a clear association between stress and child's age could not be seen. Hence, it can be concluded that the age of children isn't a significant variable affecting role stress.

iv)Roles performed within the family & stress.

Table 6.8: Multiple Roles performed in the family and Stress

No. of Roles performed	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	No Stress		Mild Stress		Severe Stress			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
1 role	1(50)	1(100)	0(0)	0(0)	1(50)	0(0)	2(100)	1(100)
2 roles	15(27.3)	43(67.2)	22(40)	17(26.6)	18(32.7)	4(6.3)	55(100)	64(100)
3 roles	4(22.2)	2(25.0)	6(33.3)	3(37.5)	8(44.4)	3(37.5)	18(100)	8(100)
4 roles	0(0)	2(100)	0(0)	0(0)	0(0)	0(0)	0(0)	2(100)
Total	20(26.7)	48(64.0)	28(37.3)	20(26.7)	27(36)	7(9.3)	75(100)	75(100)

As seen in table 6.8 more number of working women perform three roles in their homes in comparison to housewives. It is again seen here that a significantly higher percentage of housewives (64%) don't have any stress in comparison to the working women (26.7%). Greater percentage of working women have mild (37.3%) and severe stress (36%) in comparison to housewives (26.7%) and (9.3%) respectively.

The table trend shows an increase in the levels of role stress among both the categories of women with the increase in the number of roles performed at home. Among working a marginal difference is seen between the percentage of working women performing 2 roles (32.7%) and 3 roles (44.4%) and having severe stress. However, among housewives a significantly high percentage of women performing three roles (37.5%) reported of

having severe stress in comparison to those performing two roles (6.3%). Besides, among working women it was also observed that when they are performing one role then the percentage of women having role stress is equal to the percentage not having any stress (50%).When they are performing 2 roles then the maximum percentage (40%) of women have mild stress and when they are performing 3 roles then the maximum percentage of women had severe role stress (44.4%). Among housewives performing one role and two roles at home no woman had role stress, where as among housewives performing three roles maximum percentage of women had severe role stress. This shows that a positive correlation exists between role stress and the number of roles that one performs, the higher the number of roles performed the greater is the role stress. This is mainly because increase in the number of roles performed at home means an increase in the work load for women. Among housewives no doubt the stress levels increased with the increase in the number of roles but the stress levels were lower in comparison to the working women. This shows that an increase in familial roles is more stressful for working women in comparison to the housewives. Working women as it is find it extremely difficult to fulfill the demands of multiple roles associated with work and home, so an increase in a role means a further increase in their work loads which brings an increase in the levels of stress as well, but for housewives this isn't the case mainly due to the absence of the demanding role of an employee.

2.2 Factor 2----------Socio Economic Factors

i) Education and Stress

Table 6.11 shows a decrease in the levels of stress with the increase in the educational level of the respondent. Among working women severe stress is maximum (52.6%) among women who are illiterate and minimum among the women who are postgraduate (19%). Among women who are educated up to graduation maximum percentage (41.6%) of women face mild stress, 37.9% face severe stress and 20.7% do not face any stress. However, among the post graduate working women the percentage of women facing mild stress is even more (47.6%). The same trend is seen among housewives as well where the maximum percentage of women who are educated up to post graduation (77.8%)don't

face any stress and the minimum percentage of women not facing stress belongs to the illiterate category(50%).

Table 6.9: Association between Education and Role Stress

Education Of the Respondents	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	No Stress		Mild Stress		Severe Stress			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Illiterate	5(26.3)	2(50)	4(21.1)	2(50)	10(52.6)	0(0)	19(100)	4(100)
Upto10	2(33.3)	10(55.6)	2(33.3)	4(22.2)	2(33.3)	4(22.2)	6(100)	18(100)
Upto Graduate	6(20.7)	22(62.9)	12(41.4)	10(28.6)	11(37.9)	3(8.6)	29(100)	35(100)
Post graduate & above	7(33.3)	14(77.8)	10(47.6)	4(22.2)	4(19)	0(0)	21(100)	18(100) .0%
Total	20(26.7)	48(64)	28(37.3)	20(26.7)	27(36)	7(9.3)	75(100)	75(100)

Hence data here clearly shows that stress decreases with increase in the education level. So, it can be concluded that better education helps a woman cope up better with stress. Considering a direct relation between role stress and better health better educated women should have better health.[2] This is in alignment with the studies which show strong link between mother's education and the child health and thus survival. These studies indicate that women tend to have greater autonomy, decision making authority, and knowledge about their health and that of their children if they are educated (Thapan Meenakshi, 1997).

ii) Income and Stress

Table 6.10 shows a direct relationship between income and stress as the women of the low income group have more stress in comparison to the women of the high income group.

Among working women of the low income group maximum percentage of women (48%) have severe stress, 28% don't have any stress and 24% have mild stress. Similarly in the middle income group maximum percentage of working women (58.8%) have severe

[2] This is seen in section 3 of the chapter.

stress, 23.5% don't have any stress and 17.6% have mild stress. However, in the high income group minimum percentage (15.2%) of working women face severe stress and the highest percentage of women in this group face mild stress (57.6%).

Table 6.10: Association between Income and Role Stress

Total Family Income	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	No Stress		Mild Stress		Severe Stress			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Rs.1500-10000	7(28)	15(62.5)	6(24)	8(33.3)	12(48)	1(4.2)	25(100)	24(100)
Rs.10001-20000	4(23.5)	15(57.7)	3(17.6)	6(23.1)	10(58.8)	5(19.2)	17(100)	26(100)
Rs. 20001& above	9(27.3)	18(72)	19(57.6)	6(24)	5(15.2)	1(4)	33(100)	25(100)
Total	20(26.7)	48(64)	28(37.3)	20(26.7)	27(36)	7(9.3)	75(100)	75(100)

Similar trend is seen among housewives as well, where a significantly high percentage (52%) of women in the high income group don't face any stress and a significantly low percentage (4%) of women face severe stress.

Hence, data here shows a decline in stress levels with increase in the income. The stress levels are highest among working women of the low income group and lowest among working women of the high income group. Similarly, stress levels are lowest among housewives of the high income group. This is mainly because women in this group are economically well off due to which they can afford to buy modern domestic gadgets like washing machine, vacuum cleaner etc. which makes household work easier for them. Also they can employ domestic maids who shares most of the domestic responsibilities. Husbands of women in this group were also found to be the most supportive ones who helped them in most of the domestic work. It is mainly because of these factors that women in this income group were less stressed out and some even reported of having a role enhancement, compared to women in the low income group who had to do most of the domestic work on their own, without the help of modern gadgets, domestic maids or husbands help. Besides, the constant tension of making ends meet was another important

factor leading to stress among women in the low income. Considering a direct relationship between role stress and poor health (which is established in the next section of this chapter) women of the high income group should have much better health than women in the low income group, but the findings in chapter 5 depicts a completely opposite trend where women in the high income group reported of more illness in comparison to the women in the middle and low income group. One explanation to this can be the fact that women in the low income group have poorer health seeking behavior in comparison to women in the high income group, hence illnesses of women in the high income group are reported, but that of the women in the low income group are not reported even if they are suffering from the same. So, it might be the case that women in the low income group are unhealthier as they have more of role stress but this didn't come out in the study mainly because most of the illnesses among women in this income group went unreported. However, women in the high income group perceived their health to be better than women in the low income group. Hence a clear association exists between income, role stress and self perceived health status. Women of the low income group have more role stress and hence perceive their health to be poor which means that they are actually unhealthy.

Working women are usually more stressed out than housewives mainly because they have many job related stressors .Two such stressors are the level of job satisfaction and traveling time. The effect of these on stress levels of the working women can be seen from the tables below:

iv) Job Satisfaction and Role Stress

As seen in table 6.11, job satisfaction acts as an important factor influencing the levels of role stress among working women. A significantly higher percentage of working women (50%) who are not satisfied with their jobs have severe stress in comparison to the one's who are satisfied with their jobs (33.3%). The presence of severe role stress among women who are satisfied with their jobs might be attributed to the stressors in the home front. Among women who are partly satisfied with their job none of have severe stress. Similarly among women who are satisfied with their jobs a comparatively higher

percentage of women (29.3%) didn't have any stress in comparison to the women who were satisfied with their jobs (16.7%). Hence, job satisfaction does have an effect on the stress levels of working women as women who are satisfied with their jobs have less role stress in comparison to women who are not satisfied with their jobs.

Table 6.11: Association between Job Satisfaction and Role Stress among Working Women

Job satisfaction	Stress generated by the multiple roles (Percentages in parenthesis)			Total
	No Stress	Mild Stress	Severe Stress	
Not satisfied	2(16.7)	4(33.3)	6(50)	12(100)
Satisfied	17(29.3)	20(34.5)	21(36.2)	58(100)
Partly satisfied	1(20)	4(80)	--	5(100)
Total	20(26.7)	28(37.3)	27(36)	75(100)

V) Traveling Time & Stress

Table 6.12: Association between traveling time to office and Role Stress among Working Women

Travel Time	Stress generated by the multiple roles (Percentages in parenthesis)			Total
	No Stress	Mild Stress	Severe Stress	
Upto 60 mins	11(33.3)	14(42.4)	8(24.2)	33(100)
61-100 mins	1(9.1)	5(45.5)	5(45.5)	11(100)
More than 101 mins	8(25.8)	9(29)	14(45.2)	31(100)
Total	20(26.7)	28(37.3)	27(36)	75(100)

Table 6.12 shows that the time taken to travel to work place also plays a very important role in influencing the levels of stress among working women. A significantly higher percentage of women who took 61-100 minutes and more than 101 minutes to travel to their work place reported of having severe role stress (45.5%) in comparison to the women who took up to 60 minutes to travel (24.2%). Similarly the percentage of women who don't have any stress is much more among women who take upto 60 minutes to travel to work place in comparison to women who take longer time to travel. Hence, women who took less time to travel to work place reported of having lesser levels of

stress in comparison to women who took more time to travel. This is mainly because traveling in Mumbai is a highly stressful activity as it involves changing of a series of local trains.

2.3 Factor 3----------Help in Domestic work

i) Presence of Domestic Maid and Stress

Table 6.13: Association between the presence of domestic maid & Role stress

Domestic Maid	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	No Stress		Mild Stress		Severe Stress			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Present	9(26.5)	25(78.1)	15(44.1)	6(18.8)	10(29.4)	1(3.1)	34(100)	32(100)
Absent	11(26.8)	23(53.5)	13(31.7)	14(32.6)	17(41.5)	6(14)	41(100)	43(100)
Total	20(26.7)	48(64)	28(37.3)	20(26.7)	27(36)	7(9.3)	75(100)	75(100)

Table 6.13 shows that 34 working and 32 housewives have a domestic maid to help them in domestic chores of washing clothes, cleaning utensils, cleaning home, cooking etc. Some of these women had employed domestic maids for all these activities and some had employed for selective activities. Most women having domestic maids belonged to the high income group, few belonged to the middle income group as well.

The table clearly shows that stress levels are higher among women who don't have a maid in comparison to the ones who have. Among working women significantly higher percentage of women (41.5%) not having a maid faces severe stress in comparison to the ones who have a maid (29.4%). Among women who don't have maid the maximum percentage (41.5%) of working woman have severe stress, and the minimum percentage of women (26.8%) don't have any stress at all, where as among women having a maid maximum percentage (44.1%) of women have mild stress.

Similar trend is also seen among housewives where 14% of women not having a maid faces severe stress in comparison to 3.1% women who have a maid. Similarly while

78.1% housewives having a domestic maid don't have any stress, only 53.25 % housewives who don't have a domestic maid are stress free.

Hence data here shows that much more number of women having a domestic maid are stress free in comparison to women who don't have a maid. Hence, it can be inferred that the presence of domestic maid who helps a woman in her household chores helps to buffer stress to some extent.

iii) Number of family members helping in domestic work & Role Stress

Table 6.14: Household members helping in domestic work & Role stress

Number of members helping in domestic work	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	No Stress		Mild Stress		Severe Stress			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
0 members	3(25)	5(62.5)	3(25)	3(37.5)	6(50)	0(0)	12(100)	8(100)
1 member	12(27.3)	27(60)	16(36.4)	13(28.9)	16(36.4)	5(11.1)	44(100)	45(100)
2 members	4(23.5)	12(66.7)	9(52.9)	4(22.2)	4(23.5)	2(11.1)	17(100)	18(100)
3 members	1(50)	4(100)	1(50)	0(0)	0(0)	-0(0)	2(100)	4(100)
Total	20(26.7)	48(64)	29(38.6)	20(26.7)	26(34.6)	7(9.3)	75(100)	75(100)

Table 6.14 shows a decrease in stress levels with increase in the number of family members helping in domestic work. Among working women the percentage of women with severe stress decreases with increase in family members helping in domestic work. 50% of the working women not having help of any family member in domestic work face severe stress, 36.4% and 23.5% of women with one and two family members helping in domestic work respectively face severe stress and none of the women having three members helping in domestic work face severe stress. In contrast to this, maximum percentage of working women not having stress (50%) are the ones who have three family members helping them in domestic work and the minimum percentage of women not having stress are the ones who don't have the help from any family member.

Similarly, mild stress is found most among women having more than two members helping in domestic work (52.9%).

Among housewives as usual the levels of stress are lower as most of the women are stress free and the help by family members doesn't seem to make significant difference to their stress levels. However, a significantly high percentage (66.7%) of women with two family members helping them in domestic work are stress free and all the women with more than three members helping in domestic work are stress free.

Also it is seen that in the first category of woman with no help from family members the percentage of women with severe stress is much more than that with mild stress. However, in the third category (with two members helping) the percentage of women with mild stress is more than that with severe stress. Hence, it can be inferred that for housewives help by other family members in domestic work isn't of much importance as they have enough time for household work but for working women even a little help by family members in domestic work plays a very important role in helping them cope up with stress.

Thus, data here clearly shows that working woman who has no or less number of family members helping them in domestic work are more stressed out in comparison to the ones who have a greater help in domestic work by the family members. Hence, it can be concluded that family support greatly helps a working woman in coping up with stress.

2.4 Factor 4--------Leisure & Rest

i) Leisure time & Role stress

Table 6.15 shows a direct relationship between leisure time and role stress. Among working women who have leisure time of up to 10 hours, most women (40%) have severe stress, and the least percentage (26.7%) don't have any stress. In contrast to this, maximum percentage of women (26.7%) having leisure time between 11-20 hours don't

have any stress, and as low as 3.3% women of this category have severe stress. None of the working women have more than 21 hours of leisure time per week.

Table 6.15: Leisure time and Role stress

Leisure Time	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	No stress		Mild stress		Severe stress			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Up to 10 hours	16(26.7) (80*)	3(42.9) (6.25*)	20(33.3) (71.4*)	2(28.6) (10*)	24(40) (88.8*)	2(28.6) (28.5*)	60(100)	7(100)
11-20 hours	4(26.7) (20*)	13(72.2) (27*)	8(3.3) (28.6*)	4(22.2) (20*)	3(20) (11.1*)	1(5.6) (14.3*)	15(100)	18(100)
More than 21 hours	0(0)	32(64) (66.6*)	0(0)	14(28) (70*)	0(0)	4(8) (57.1*)	0(0)	50(100)
Total	20(26.7) (100*)	48(64) (100*)	28(37.3) (100*)	20(26.7) (100*)	27(36) (100*)	7(9.3) (100*)	75(100)	75(100)

***Percentages across columns**

Housewives as it is are stress free but lesser percentage (42.9%)of women having leisure time upto 10 hours don't have any stress in comparison to 72.2% of women who were having leisure time between 11-20 hours.

Hence, stress levels go down with the increase in leisure time. Hence it can be interpreted that a major factor contributing to the high levels of stress among working women is the lack of leisure time due to which they find less time for themselves and for their family. Fulfillment of all the familial and work related tasks in the limited time creates major stress among working woman. If the stress levels are compared across the groups it is seen that the maximum number of women with severe role stress have leisure time of less than 10 hours and the minimum number of working women having severe stress are the ones having leisure time between 11-20 hours.

A clearer picture can be had by comparing the women across groups. Among housewives a significant difference is seen in the percentage of women having more than 21 hours of leisure time (66.6%) and not having stress in comparison to women with leisure time upto 10 hours (6.25%).Similarly, among working women the maximum percentage of

women (71.4%) with leisure time up to 10 hours have mild stress and the minimum percentage (28.6%) of women with leisure time more than 10 hours have mild stress.

Working women with leisure time of up to 10 hours mostly comprises of women with severe stress and women with leisure time of more than 10 hours have minimum percentage of women having severe stress have. Hence the cross column analysis also supports the earlier analysis which is: stress levels are higher among women with less leisure time and lower among women with more leisure time.

ii) Sleeping hours and Role Stress

Table 6.16: Sleeping Hours and Role stress

Sleeping Hours (daily	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	No stress		Mild stress		Severe stress			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Less than 7 hours	16(22.5)	40(65.6)	28(39.4)	15(24.6)	27(38)	6(9.8)	71(100)	61(100)
More than 7 hours	4(100)	8(57.1)	0 (0)	5(35.7)	0 (0)	1(7.1)	4(100)	14(100)
Total	20(26.7)	48(64)	28(37.3)	20(26.7)	27(36)	7(9.3)	75(100)	75(100)

Table 6.16 shows that 77% percent of working women who sleep for less than 7 hours have mild and severe stress. The very few working women who sleep for more than 7 hours are stress free. This shows that a direct relation exists between sleeping time and role stress, particularly in the case of working women. However among housewives, sleeping hours doesn't seem to make much difference on the stress levels as stress is minimal even among women who were sleeping for less than 7 hours.

Among working women stress levels decreases with the increase in the time of sleep. While 38% of working women who sleep for less than 7 hours have severe stress and 39.4 % have mild stress, none of the women sleeping for more than 7 hours had severe or mild stress. Difference in the stress levels across the two groups of women can also be seen by comparing the figures of women who don't have stress. While 22.5 % of working

women sleeping for less than 7 hours don't have stress, all the 4 working women who sleep for more than seven hours are stress free. More sleeping time leads to less stress mainly because sleeping hour is also a very good indicator of the amount of workload for a woman. If a woman can afford to sleep for more than 7 hours it means that she doesn't have humongous amount of work to do, for which she has to cut upon her sleeping hours. Majority of working women (around 71) were cutting their sleeping hours mainly to complete the household tasks before going to work. This is why only 4 working women out of a population of 75 could afford to sleep for more than 7 hours. Hence, the less amount of sleeping hours for working women indicates their heavy workload.

iii) Exercise and Role stress

Table 6.17: Physical Exercise and Role stress

Exercise	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	No, never		Yes, sometime		Yes, all the time			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Exercising	6(27.3) (30*)	27(64.3) (56.2*)	9(40.9) (32.1*)	11(26.2) (55*)	7(31.8) (25.9*)	4(9.5) (57.1*)	22(100)	42(100)
Not exercising	14(26.4) (70*)	21(63.6) (43.8*)	19(35.8) (67.8*)	9(27.3) (45*)	20(37.7) (74*)	3(9.1) (42.9*)	53(100)	33(100)
Total	20(26.7) (100*)	48(64) (100*)	28(37.3) (100*)	20(26.7) (100*)	27(36) (100*)	7(9.3) (100*)	75(100)	75(100)

*** Percentage across columns**

Table 6.17 shows that women who exercise have less role stress in comparison to those who don't. A greater number of housewives (42) exercise in comparison to working women (22). The maximum percentage (40.9%) of working women in this group have mild stress, 31.8% have severe stress and 27.3% don't have any stress at all. Among working women who don't exercise the maximum percentage of women(37.7%) have severe stress, a little lesser percentage (35.8%) have mild stress and 26.4% do not have any stress.

Among housewives as it is stress levels are quiet low, hence exercise doesn't contribute much to the decline in stress among them. However, a slightly greater percentage of

housewives who exercise is stress free (64.3%) in comparison to the ones who don't exercise (9.1%).

Thus it can be said that exercise greatly helps a working woman in coping up with Role Stress but among housewives it didn't do anything to reduce the stress. However, the very fact that majority of housewives are stress free can be attributed to the fact that they exercise.

Column wise analysis also shows a similar trend. Among working women the maximum percentage of women who have mild and severe stress are the ones who don't exercise and among housewives the maximum percentage of women who don't have any stress are the ones who exercise.

Hence from this section one can conclude that no doubt working women face more role stress than housewives. However, among working women the highly educated women belonging to the high income group, living in small families and performing lesser roles in the family, who are satisfied with their jobs, who takes less time to travel to work place, who has a domestic maid to help in household chores, has a supportive husband, has more of leisure time and practices more of health related behaviors like exercise, faces lesser stress than women who don't have the above supportive factors. Among housewives stress levels are as it is very low, maximum number of women in this group don't have any stress and a minimal amount has severe role stress. So these variables don't seem to make a significant difference to their stress levels.

III. EXPLORING THE RELATIONSHIP BETWEEN ROLE STRESS/ ROLE ENHANCEMENT AND HEALTH

The above two sections proves the first part of the Role stress hypothesis which is that Multiple roles most often leads to role stress among women as working women who performs an extra role of an employee is more stressed out than the housewives who doesn't have to perform this role. This section tries to test the second part of the

hypotheses which is whether role stress has negative repercussion on the health status of women.

3.1 Role Stress and Total Number of Illness

As seen in table 6.18 the number of housewives having less than 3 illnesses is more than working women. However, more working women have more than 4 illnesses in comparison to housewives. This is mainly because housewives have lesser amount of role stress than working women.

Table 6.18: Association between Role Stress and Total number of illness

Total Number of Illness	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	NoStress		Mild Stress		Severe Stress			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Less than 3 illness	15(46.9)	31(73.8)	10(31.3)	9(21.4)	7(21.9)	2(4.8)	32(100)	42(100)
4-6 illness	5(13.5)	16(55.2)	16(43.2)	9(31)	16(43.2)	4(13.8)	37(100)	29(100)
6 and above illness	0(0)	1(25)	2(33.3)	2(50)	4(66.7)	1(25)	6(100)	4(100)
Total	20(26.7)	48(64)	28(37.3)	20(26.7)	27(36)	7(9.3)	75(100)	75(100)

Among women with less than 3 illness the maximum percentage of working women(46.95) are stress free, 31.3% have mild stress and the least percentage of women (21.9%) have severe stress. Among women with 4-6 illness the maximum percentage of working women (43.2%) have mild role stress and the same percentage of women have severe role stress, only 13.5% of women don't have any stress. However among women with 6 and more illnesses the maximum percentage of working women have severe stress (66.7%), 33.3% have mild stress and none of the women are stress free.

A similar trend is seen among housewives as well with the maximum percentage of stress free women (73.8%) having 3 illness and 55.2% women having 4-6 illness are stress free. The maximum percentages of women having severe stress (25%) are the ones who have more than 6 illnesses.

The data above clearly shows that stress levels increases with increase in the number of illness and vice versa. So a direct relationship can be established between role stress and number of illness. Women with higher levels of role stress have poorer health than the women with lesser role stress. This gives a clear explanation as to why working women have poorer health than housewives. This finding also solves the dilemma which the researcher faced in assessing as to whether self reported morbidity or self perceived health status is a better indicator of health.[3] Women of the high income group reported of more illnesses but they perceived their health to be much better than the women of the low income group who hardly reported of any illness. Now, since the stress levels are high among women of the low income group and a direct correlation exists between stress and number of illness hence it is proved that women in the low income group have poorer health. Hence, it can be inferred that self perceived health status is a better indicator of health in comparison to self reported morbidity.

3.2. Role stress and Self Perceived Health Status

Table 6.19: Association between Role Stress and Self Perceived Health Status

Perception about ones own health	Stress Generated by Multiple Roles (Percentages in parenthesis)						Total	
	No Stress		Mild stress		Severe Stress			
	Emp	HW	Emp	HW	Emp	HW	Emp	HW
Poor	0(0)	0(0)	3(100)	0(0)	0(0)	0(0)	3(100)	0(0)
Fair	3(13)	5(38.5)	9(39.1)	4(30.8)	11(47.8)	4(30.8)	23(100)	13(100)
Good	8(26.7)	31(67.4)	8(26.7)	12(26.1)	14(46.7)	3(6.5)	30(100)	46(100)
Very Good	7(53.8)	7(63.6)	5(38.5)	4(36.4)	1(7.7)	0(0)	13(100)	11(100)
Excellent	2(33.3)	5(100)	3(50)	0(0)	1(16.7)	0(0)	6(100)	5(100)
Total	20(26.7)	48(64)	28(37.3)	20(26.7)	27(36)	7(9.3)	75(100)	75(100)

As seen in table 6.19 self perceived health status is directly related to role stress, the lower the stress levels the better is the self perceived health status. All the housewives

[3] Refer chapter 5

who never faced any role stress reported of having an excellent health. A significant percentage of working women (47.8%) who reported of having severe stress reported a fair health condition. However, a good percentage of working women inspite of having mild and severe stress reported their health to be good, very good and excellent. This shows that working women inspite of having role stress feel better and perceive themselves to be healthy. This indicates role enhancement which might be due to the satisfaction which the working women get in being engaged in a socially productive role or due to their active life style. Among housewives majority never faced role stress and reported their health to be good or very good and even excellent, which can be mainly attributed to the absence of role stress. However, a good percentage (38.5%) of women having mild stress reported of having good and very good health.

Three women who reported of having *poor* health were employed and had mild stress. Maximum number of women having *fair* health comprised of working women and most (46.7%) of them reported of having a severe stress, 26.7% had mild stress and the same percentage of women didn't have any stress. The maximum percentage (47.8%) of working women who reported their health to be good had severe stress, a little less (39.1%) had mild stress and the least percentage (26.7%) of women of this group didn't have any stress. In contrast to this, maximum percentage (53.8%) of women who reported their health to be very good didn't have any stress, 38.5% had mild stress and as low as 7.7% had severe stress. This shows that lower the stress levels the better is the self perceived health status of women.

Among housewives a similar trend was seen, a very high percentage (30.8%) of housewives who reported their health to be fair had mild and severe stress. A significant percentage (67.4%) of women who reported their health to be good didn't have any stress. However, none of the housewives who reported of having excellent health had mild or severe role stress.

Hence, data here clearly shows that a direct correlation exists between self perceived health status and role stress. Women having less of role stress reported their health to be

excellent and very good where as women who had more of role stress reported their health to be fair and good. This is the reason why working women of high income perceived their health to be better than women in the low income group. However, some exceptions were found among working women who reported of having good and very good health inspite of having mild and severe stress. These women can be considered of having role enhancement.

Hence, this section shows that a direct relation exists between role stress and health. Both morbidity and self perceived health status is dependent on Role Stress. Women having more role stress have more number of illnesses and hence report of having a poorer health. In contrast women having role enhancement or no stress usually enjoyed a better health as they reported of lesser number of illness and perceived their health as good, very good and excellent.

Hence, the better health status of housewives can be attributed to the absence or minimal presence of role stress. As most working women are victimized with severe or mild role stress so they have a poorer health in comparison to housewives who are mostly free of any form of role Stress. Similarly the better health status of working women of the high income group can be attributed to the absence of role stress or presence of role enhancement.

IV. SOME CASE STUDIES TO DEPICT THE EFFECT OF ROLE STRESS AND ROLE ENHANCEMENT ON THE HEALTH & WELL BEING OF WOMEN.

The case studies quoted below illustrates the facts which have been empirically proved in the above three sections. These cases show the varying degrees of role stress present among working women and housewives and it also shows the relationship of these with health.

Case study 1-Working women (severe Role stress)

Preeti (Pseudonym) a high income group working woman is victimized by the lack of family support due to which she has ended up facing severe role stress. Preeti's husband, a scientist at BARC doesn't help her in housework. He doesn't want their child to be sent to a crèche so she also had to employ a baby sitter besides the regular maid and cook. Preeti's husband doesn't pay these domestic helps and expects her to pay for them as they are doing work which ideally should be done by her. Hence, Preeti ends up spending 1/ 4^{th} of her salary in paying these domestic helps. She cannot give enough time to her child which makes her feel guilty most of the times.

Besides the unsupportive family environment she has an equally difficult work situation. Her office which is in Church gate requires her to travel daily for around four hours, besides her working hours are very long. To top it all, she is not even being paid properly.

Due to the stressful work and home environment, Preeti is having stress related problems and disorders due to pollution and traveling (cough, congestion).Her husband doesn't understand her agony and says that if 90% of women in Mumbai can work and still manage their home, then why cant u?? He also tells her to leave the job ,if she can't manage the same, but doesn't show any inclination in helping her in the domestic front so that she can continue working..

Inspite of these difficulies Preeti hasn't given up. She is an ambitious woman who doesn't want to leave her job at any cost, also she doesn't want her professional degree of MBA to go waste...She already had breaks in her career due to lack of family support and now she is not willing to go in for any compromise...However, she admits that her job is taking a very heavy toll on her health and family life.

This is yet another of the many cases of working women of the study population who faced role stress due to the inability to perform the multiple roles. This case study depicts that for a working woman the situation becomes all the more difficult when she is not

satisfied with her job and when she has an unsupportive family. Hence as seen in the above section, family support and job satisfaction are extremely essential for a working woman to cope up with the stress generated out of the multiple roles.

Case Study 2- Working Woman (Mild Role Stress)

Shaheena (Pseudonym) a 32 year old young woman having two daughters (of 1 and a half and 6years of age) and belonging to the high income group, is not satisfied with her job of a scientific officer in BARC. She feels that it is too monotonous and hierarchical in nature, where she as a junior doesn't have the freedom and flexibility. This dissatisfaction with the job in turn gets manifested in terms of irritation towards her family members, as a result of which she has a troubled relationship with her husband...Shaheena wants to leave her job and migrate to the United States along with her family. But, her husband who is also a BARC employee is completely at ease with his job and is not agreeing to this proposal of hers...This situation has further deteriorated the already strained relationship between the couple.

Stuck in between a troubled work environment and an equally troubled domestic front Shaheena is not able to give her best to any work that she does on a daily basis. She can't finish her domestic chores on time despite the assistance of a maid who does most of the work including cooking. Shaheena also feels guilty for leaving her one and a half year old daughter in crèche and not giving her the time that she needs...The dissatisfaction at work front clubbed with the lack of an understanding partner makes it difficult for her to perform the multiple roles of a wife, mother and an employee..As a result of all this Shaheena constantly feels fatigued and stressed out and complaints of frequent headache, tension, irritation and absent mindedness...

The strong effect of work on Shaheena's well being was observed by the researcher in one of instances when the researcher had gone to meet her during a period when Shaheena had taken leave from the office for a week, as she had some extra leaves left at the year end. At this point of time Shaheena appeared to be much relaxed and chirpy, her face didn't carry the stressful look which the researcher had seen in the previous

meetings...The researcher could also observe her sharing a better relationship with her husband which she had noticed to be pretty strained in the earlier occasions...This particular incident made the researcher believe that Shaheena remains stressed out mainly because of her job which she doesn't enjoy.

From this case it can be inferred that if a person is not satisfied with one's job then it becomes all the more difficult for her (in this case) to manage the multiple tasks associated with each of the roles and this creates troubles for her family life as well. Shaheena's job dissatisfaction is mainly because of her high aspirations. She apparently seemed to be happy in the period when she had taken leave from the job but can she permanently leave her job and stay happy, will her husband allow her to do the same? These are some of the unresolved dilemmas which the researcher had after studying this particular case.

However, not every working woman of the study population was victimized by severe or mild role stress[4], there were few who didn't have any role stress, infact these women were facing a Role enhancement. However, such examples of role enhancement were very rare among working women and the few women experiencing this mostly belonged to the high income group. This can mainly be because of the fact that women of the high income were able to combine their multiple roles effectively as they could afford to keep a domestic maid who would do all their household tasks. They also had high tech household appliances which would make their household task easier. Their husbands are educated and well aware and hence are more supportive than the husbands of women belonging to the middle and low income group. Women of this group were well aware and more conscious about their health. So, obviously working women in this group were healthier and happier than the rest of the working women. Infact they were even better than the housewives because due to their work and money they were more empowered, had confidence and their work also provided them with a whole lot of social network. One such lady's case is described below

[4] Refer table 6.1

Case Study 3- Working Woman (Role Enhancement)

Krishna Dixit (Pseudonym) a degree holder in Engineering and working in BARC as a scientist is an ideal example of a working woman of the high income group facing Role Enhancement. Besides performing the regular roles of that of a mother, wife, employee, neighbor, community member Krishna is also a member of various academic groups like the Board of Research Studies, Somaiyya College. Besides, she is involved in Social work and is teaching poor children of the neighborhood. Krishna says that she is efficiently fulfilling each of these roles and believes in the philosophy of "Where there Is a will there is a way." According to her, planning and defining ones priorities is the best way to manage the multiple roles. Besides her own grit, determination and sincerity in performing each of the roles helps her in meeting the demands of each of the roles that she performs. Besides, Krishna gives a whole lot of credit to her supportive family without which she wouldn't have been able to perform any of the roles. Krishna's husband and her two children help her a lot in all the household chores and are extremely understanding and non demanding. The proximity of the work place is another reason which Krishna gives, for her ease in handling the roles. Except for back–ache,Krishna is not having any other health problem. She doesn't find time to exercise but she makes it a point that she walks down to the office once in a while.

Hence, this case study again depicts the importance of family support in helping a woman cope up with her multiple roles. This woman is facing a Role enhancement mainly because of her supportive family who helps her in the household chores. The short distance of the work place and most of all her own will and determination are the other factors.

Its not that working women alone were stressed out, few housewives in the sample population who were equally stressed out. Below is the case of one such woman:

Case Study 4- Housewife (Role Stress)

Sheila (Pseudonym) a housewife belonging to low income group is stuck in a bad marriage. Her husband who works as a helper in BARC is an alcoholic who comes drunk everyday and beats her. She stays in a joint family and has to take care of her young children and in-laws. The family income is too less to run such a huge family.

Besides a victim of domestic violence, Sheila also has to face the verbal abuses of her in-laws who taunt her for not bringing enough dowry.

Sheila regrets for not having done any professional degree and hence not working. Sheila feels that had she been working her family members wouldn't have treated her this way. Also she would have been able to take steps of leaving her husband. But now she is trapped.

Due to her troubled domestic front Sheila remains extremely tensed and depressed all the time.

Hence, this case shows the empowering effects of work. Had this lady been economically independent she would have been able to break the shackles of the troubled household. Hence, no doubt job has its own related stressors but it has advantages as well, which housewives trapped in a bad marriage can very well experience. Hence, it can be said that housewives can be happy only if they have a reasonably happy family life. They find it very difficult to cope with a slight problem in the domestic front as they keep brooding about it all the time and don't have any means to divert their mind. Working women on the other hand can cope up with a troubled domestic front much more easily as going out for work deviates their mind for some time. Most of the housewives facing role stress belonged to the low income group.

The above case studies have thus tried to capture the experiences of working women of the study population who were highly stressed mainly because of their inability to juggle the roles of a wife, mother, daughter-in-law and employee and thus ended up having several health problems like backache, chronic diseases like arthritis, diabetes etc, stress

related disorders like insomnia, head ache and irritation. It also shows that women who were successfully able to combine their various roles and were having a Role enhancement were able to do this mainly because of a good socio-economic background, supportive family, satisfying job, proximity of the work place and help from the domestic maid. These women were also free from health problems and reported of enjoying an excellent health. They formed the so called genre of "Super Woman" who could do anything and everything. However, their numbers were very few.

Housewives on the other hand were mostly stress free as they had a whole lot of time for themselves and their families. They were able to successfully fulfill their primary responsibility of a homemaker and hence were happy and healthy. The ones who faced stress among this group were usually the ones who belonged to the low socio-economic background, were not quite satisfied with their personal lives or the ones who were highly qualified and were not working. Their plights have also been depicted in the above section on case studies.

Conclusion

The major findings observed in this chapter can be put under the following points:

- In comparison to housewives working women faced more Role stress.
- Mother's role was rated as the most stressful one by maximum respondents.
- The next most stressful role rated by women was that of a daughter in law, a little lesser percentage of women found the employee's role to be the most stressful one and the least number of women found wives role to be most stressful.
- Neighbor's role was rated as the least stressful one by the maximum respondents.
- A direct relationship exists between Role Stress and the number of roles performed by the women within their families. The greater the number of roles the greater is the role stress.
- Domestic maid greatly helps a woman in fighting with role stress. Women having a domestic maid had lesser Role stress in comparison to women who don't.
- Help by family members in domestic work greatly helps a working woman in coping stress. Working women with more number of members helping in

domestic work had lesser stress. However, among housewives no such difference in stress levels was seen with the increase in the help by family members.

- An inverse relationship is found between role stress and age as role stress decreases with increase in age.
- The number of children and their ages wasn't found to make any significant contribution to the levels of stress.
- An inverse relationship was found between education level and stress. Stress levels decrease with the increase in the levels of education. This is true both in case of working women and housewives.
- Inverse relation was found between income and stress. Role stress decreases with the increase in income. Stress levels are more among women in the low income group and least among women in the high income group.
- Most of the working women faced role stress and the ones who faced role enhancement were the ones belonging to the high income group. On the other hand housewives in general faced role enhancement and the ones who faced role stress were the ones belonging to the low income group.
- Direct relationship exists between job satisfaction and stress. Working women who are satisfied with their job have less stress, where as women who are not satisfied with their job have more stress.
- Working women who take less time to travel to their work place have less role stress in comparison to the one's who take more time to travel.
- Direct relationship exists between role stress and leisure time. Women with more leisure time have less stress and women with less of leisure time have more stress. Since housewives have more of leisure time hence stress levels among them is very less in comparison to working women who have lesser leisure time.
- Sleeping hours make a significant difference for stress levels among working women as working women who sleep less have more stress. However, among housewives it wasn't found to make any significant difference.
- Exercise helps in reducing stress. Stress levels are low among women who exercise in comparison to the ones who don't.

- Direct relation was found between role stress and number of illness. Women with more number of illnesses have lesser stress in comparison to women who have less number of illnesses.
- Self perceived health status is also dependent upon role stress. Women having less of role stress reported their health to be excellent and very good where as women who had more of role stress reported their health to be fair, good and poor. Some working women inspite of having role stress feel better and perceive themselves to be healthy.

On the basis of the above findings one can conclude that working women have poorer health than housewives mainly because of the role stress that they face in managing the familial and occupational roles. Housewives on the other hand who just have to perform the familial roles were happier and healthier. However, some exceptional cases were found in these two groups. For example some working women in the high income group who faced Role Enhancement and the highly educated housewives of the high income group who were working before and who now faced a strain mainly because of not utilizing their talents and hence not working, or some housewives of the low income group facing a severe crisis in their home front. Besides, this chapter also throws light on some factors like better socio-economic background, small family size, family support, presence of domestic maid, job satisfaction etc. which helps a working women in coping with stress.

CHAPTER VII

CONCLUSION AND SUGGESTIONS

The present study has tried to see the effect of multiple roles on the health and well being of women by comparing the health of housewives who has to perform the multiple roles of a wife, mother, daughter, daughter-in-law, with that of a working woman, who besides these roles has to perform an additional role of an employee. For the purpose a set of 150 respondents comprising of 75 housewives and 75 working women belonging to diverse socio-economic backgrounds were purposively selected from the residential colony of BARC employees, also known as Anushakti Nagar, in Mumbai. The respondents were then interviewed by using a structured interview schedule, in depth interviews and case studies were also used.

The study has been based on Role analysis framework which is guided by two competing models of Role stress/strain or overload hypothesis and Role enhancement or accumulation or expansion hypothesis. According to the first hypotheses multiple roles, in this case employment and household work, leads to Role stress which in turn has negative repercussions on the health and well being of women and according to the second hypotheses multiple roles leads to Role enhancement, which in turn has a positive effect on the health and well being of women. Hence, the study tries to test the applicability of these two hypothesis within the study population. Besides, the factors contributing to these two, and it's impact on the health and well being of the sample population has also been studied in great details. Under health, parameters like health status, health-seeking behaviour and health related behaviour have been considered. Health status has been measured by using self reported morbidity and self perceived health status of the respondents. To fulfill the objectives of the study variables like age, education, income, family size, number of children and their ages, family support, role stress, role enhancement, morbidity, source of treatment, health related behaviours, leisure time, leisure activities etc. have been studied in great detail. The present chapter summarizes the major findings of the study and attempts to provide some suggestions to solve the problem universally faced by working women across income groups. Besides, it also attempts to provide suggestions for further research in the area.

A. MAJOR FINDINGS:

The respondents of the study comprised of working women and housewives belonging to the three income groups of high, middle and low. These women were married and cohabiting with their husbands, some were also widowed and divorcee. Husbands of almost all the respondents were employees of BARC except for the working women of the low income group which comprised of domestic maids and sweepers, who were residing outside the colony. Working women of the high income group comprised of engineers, MBA's and other professionals who were mostly employed in higher managerial jobs, where as women of the middle income group were mostly employed as clerks, school teachers or nurses. The major findings of the study can be clubbed under three broad headings of Health Status, Health seeking and Health related behaviours and Role Stress, Role Enhancement and factor's influencing the same.

1.Health status

The health status of the respondents was measured by asking them to report the major and minor illnesses that they suffered in the recent past (Self reported morbidity). Besides women were also asked to report about the perception about their own health (self perceived health status).

The findings of the study show that housewives enjoy better health than working women. This is mainly, because housewives have more leisure time to practice health related behaviors like exercise, meditation, yoga etc. Also, because of the abundance of time housewives can socialize and engage in other activities for entertainment, which makes them enjoy a better sense of well being. The better health seeking behaviour of the housewives, in terms of the time of seeking treatment, is another contributing factor for their better health status. Hence the abundance of leisure time, which enables them to practice more of health related behaviours and have better health seeking behaviour acts as a major factor responsible for the better health status of housewives.

The other very important contributory factor for the better health status of housewives as found in the study was the absence of Role Stress among them. The findings of the study showed an inverse relationship between role stress and health status. Hence,

working women who were found to be under immense Role stress due to the pressures of combining their occupational and familial roles, reported poorer health status in comparison to the housewives, who were found to be much more relaxed and happy, as they were successfully able to fulfill the role of a homemaker, which according to them was their primary role. Hence, the findings of the study are in compliance with the Role Stress hypotheses-according to which, the multiplicity of roles have a negative influence on the health and well being of women. This happens mainly because one is not able to combine the demands of these roles. This finding also goes at par with the few Indian studies done in the area (Madhiwalla and Jessani, 1997; Mukhopadhyay S, 1997). However, they are quite different from the findings of the western studies, most of which shows that working women have better health than housewives, and are based on the Role Enhancement hypotheses (Nathanson, 1975; Nathanson, 1980; Verbugge, 1983; Waldron and Jacobs, 1988; Annandale & Hunt, 2000; Sorenson and Verbugge,1987; Khlat et.al.2000). This discrepancy in the results between the western and Indian studies can be attributed mainly to the difference in the social structure of the two regions. In western countries women enjoy a comparatively better position and have been able to break the shackles of patriarchy to some extent. However, in a country like India where domestic work is still considered to be the primary responsibility of women and where participation of men in the household activities is quiet low, working women find it extremely difficult to perform this dual role of a professional and a homemaker. This leads to Role stress among them, which in turn has negative repercussions on their health. A working woman who is not able to give much time to her children or manage her home well feels guilty and hence ends up facing a whole lot of stress. Housewives, on the other hand feels proud of the fact that they are able to manage their primary responsibility of that of a wife and mother quiet well and hence derive a sense of satisfaction out of it. However, few educated housewives of the study population, especially the ones who were earlier working, expressed their frustrations of not utilizing their talents and not contributing much to the family income.

Another reason responsible for the role enhancement and the subsequent better health of working women in the west is their easy and comfortable life style. In western countries, due to the advanced technology office environments are quiet congenial, housework can be easily done with the help of sophisticated gadgets, traveling to the

work place is not a problem as roads and transport are quite efficient, besides better child care facilities are also available. Hence, for working women in these countries balancing work and home is not much of a problem and hence for them work usually provides benefits in terms of enhanced self esteem , more social contacts and more economic independence. Hence, they usually face role enhancement in contrast to their non working counterparts who are confined to home and are deprived of the above mentioned benefits of employment. Indian women on the other hand, don't have the same facilities as that of the women in the west and hence for them the balancing act becomes far too difficult. Employment for them brings more harms than benefits, as it greatly increases their work burden. Hence, for most Indian women the beneficial effects of employment are overpowered with the detrimental effects and this leads to Role Stress. Hence, one can conclude that employment can have beneficial impact on women only when the other factors are present to make her home and work conditions congenial.

Chronic ailments like arthritis, migraine, asthma, diabetes etc. and communicable diseases were common among working women. Similarly tension & related disorders like irritation, fatigue, insomnia, forgetfulness and backaches were more common among working women than housewives. While tension and related disorders was uniformly present among the working women across income groups, chronic ailments, headache and backache were most common among working women of the high income group. Communicable diseases were prevalent more among working women of the low income group.

The self perceived health status of housewives was better than that of the working women. However, it's interesting to note that working women perceived their health to be much better than what they actually enjoyed (as shown by the self reported morbidity). This can be attributed to the high levels of self esteem, accomplishment and confidence which a working woman experiences just because of the mere fact of doing something productive. Besides the social contacts and money which employment offers, provides them with greater sense of wellbeing, which housewives are not able to enjoy.

In terms of the health status of women across income groups, women of the high income group reported of suffering from more number of illness in comparison to those in the low and middle income group. However, they perceived their health to be better than those in the other two income groups. At this point the researcher was stuck in the dilemma as to which of the two groups have a better health- women of the high income group who reported of more illness but who perceived their health as excellent, very good and good or the women of the low income group who reported of less illness but who perceived their health as poor and fair. However, when the researcher found that the health seeking behaviour and health related behavior which were found to be directly related to better health outcomes was better for women in the high income group, she felt that women in this income group might be having a better health status but they report of more morbidity mainly because of their better health seeking behavior. Women in this group were more conscious about their health, went to the doctor immediately after falling ill, got cured immediately and hence perceived their health as good, excellent and very good. However, women in the low income group hardly went to the doctor and hence were unaware of the illnesses even when they were actually suffering from the same. This made them feel weak due to which they had a poor sense of well being and hence perceived their health as poor and fair. This assumption was further validated when role stress was measured among the women across income levels and it's correlation was seen with the health status. Women in the low income group reported of having more role stress in comparison to those in the high income group and since a direct relationship was found between role stress and health, so it was further confirmed that women in the high income group have better health than those in the low income group. Hence, this study proves that self perceived health status is a better indicator of health than the self reported morbidity. However, these findings need further validation by studies using clinical tests of measuring morbidity. More studies using these three measures would further indicate as to which one of the two is a better indicator of morbidity.

2. Health seeking and Health related behaviours

For, major illnesses the health seeking behaviour of working women was better than that of housewives. This is mainly because housewives suffered from less number of major illnesses than working women. However, almost the same number of working women and housewives suffered from minor illnesses, but the health seeking behavior

of housewives for these illnesses is much better than the working women. This might be because these illnesses don't interfere much with the day to day functioning, and a working woman who is always running short of time delay seeking treatment for the same, while housewives who have enough time, immediately seek treatment from the CGHS dispensary of BARC, which provides them treatment free of cost. Hence, it can be concluded that the housewives have a better health seeking behaviour than working women.

Working women spent much more money on their health and well being in comparison to the housewives[1].This is mainly because working women suffered from more illnesses than the housewives. Another reason to this, can be the fact that working women had their own money, while housewives had to depend on the money of their husbands. Inspite of this, working women had poorer health in comparison to the housewives. Hence, it can be concluded that the money spent on health and well being is in no way related to better health status.

Across income groups, women of the high income group had better health seeking behaviour as they spent more money on their health in comparison to those in the low income group. Women in the low income group had difficulties even in managing the small sums of money that they spent on health and had to take loans on high rates of interest for the same, which further made their lives miserable. Working women of the high income group were found to spend the maximum money on their health and well being.

Both housewives and working women preferred services of the CGHS dispensary which provided treatment free of cost to the employees of BARC. However, a substantial chunk of working women seeked treatment from the private sector as well, as most of the times they were not satisfied by the quality of services provided by this dispensary. Besides, they could not afford to spend lot of time standing in the queue outside the CGHS dispensary. Housewives, on the other hand, were highly satisfied with the services of the CGHS dispensary and didn't feel the need to go the private sector. This can be attributed to the lower awareness of the housewives which made

[1] Money spent on health refers to money spent on medical care and money spent on well being refers to money spent on beauty parlours, fitness, diet etc.

them consider the same services as god which housewives considered as bad. The difference in the preference of source of treatment by women of the two groups can also be attributed to the timings of the CGHS dispensary. While housewives could find time in the day time to go to this dispensary which is open only in the day time, working women usually didn't have the time to go to this dispensary in the day time and hence preferred the private clinics which are usually open in the night time too. The working women's dissatisfaction from the public sector both due to quality and time constraints made them explore alternate sources like homeopathic, ayurvedic etc. Also more number of working women preferred home remedies and self medication for minor illnesses as they delayed seeking care and wanted to get well without going to the doctor.

Across income groups, more women in the high income group preferred private sector and alternate sources of medicine. This can be attributed to the dissatisfaction of this group by the public sector and also to the high cost of these services which only women in the high income group could afford. However, women in the low income group were found to be using these two sources more than those in the middle income group as they had no options but to use these sources, since they were not covered under the free CGHS scheme. Because of the poor socio-economic conditions and the unavailability of free health care most women in this income group delayed seeking treatment, infact they have learnt to live in a morbid state and most of their illnesses goes unreported.

Housewives practiced greater number of health related behaviors in comparison to the working women, mainly because of the greater amount of leisure time that they had. A significantly high percentage of housewives exercised in comparison to the working women. However, in case of the other health related behaviours like meditation, eating of balanced diet, following sanitary measures, this difference between the two groups is marginal. This shows that except exercise which requires time, the other health related behaviours were equally practiced by both working women and housewives. Hence, it can be said that both the categories of women were equally aware and conscious about their health. Working women realized the importance of exercise and wanted to do it, but couldn't mainly because of the paucity of time. Similarly, because of the comparatively greater amount of leisure time that

housewives enjoyed they practised more leisure time activities in comparison to the working women. Watching TV and taking rest were the most popular leisure time activities among women of the two groups.

Women in the high income group practiced more health related behaviours than those in the low income group. Housewives in the high income group were found to practice the maximum number of health related behaviours. Similarly women of the high income group that too housewives engaged themselves in the maximum number of leisure time activities, this can be attributed to the ample time and money that they had. Activities like listening to music, going to theatre, out door activities like shopping, creative activities like going for dance and music classes and fitness related activities were most common among this income group.

3. Role Stress, Role Enhancement and factors influencing the same

Much more working women were found to have Role stress in comparison to the housewives mainly because of the presence of an extra role of an employee which consumed a substantial amount of their time and energy. Most women found mothers role to be the most stressful one. The next most stressful role was that of a daughter-in-law. Neighbor's role was found to be the least stressful one by most women.

Though majority of working women reported of mild and severe stress due to their employed status and reported to have more frequent episodes of major and minor illness in comparison to the housewives. But among the employed, the economic status of the family played a significant role. More number of employed women from the lower socio-economic status perceived their health to be poor or just fair. However, from upper income group some employed women having a conducive social, familial environment even had role enhancement. For eg. working women of the high income group, who were more educated, who had smaller families, had lesser number of children, had a satisfying job, who didn't have to travel for long distances to work, had a supportive husband who helped them in the household chores, had modern household gadgets, had a domestic maid to do the majority of routine work, could find reasonable amount of leisure time, in which they got involved in fitness related activities, faced less of role stress, sometimes even role enhancement, and apparently enjoyed better health than the ones who didn't have some or all of these

factors. It is these women who form the modern generation of the so-called Super Woman, who can do anything and everything. They do face role stress but the degree to which they face it is somewhat less than the women belonging to middle and low income groups who are involved in physically demanding work, have larger and less supportive families, have to manage most of their household work on their own and who also have to be victimized by domestic violence or an alcoholic abusive husband. Hence the findings of the study shows that supportive socio-economic, familial and environmental factors like high socio-economic background, small and supportive family, presence of a domestic maid, job satisfaction, more leisure time etc. greatly helps a working woman cope up with the demands of multiple roles. This findings is in compliance with the view of social psychologist Brehm S (1992) who felt that "whether multiple roles increase or reduce stress may depend on such factors as the quality of one's job, one's commitment to working, and the social support provided by partners and other members of one's social network" (Brehm S,1992). This finding is also similar to the findings of some studies mentioned in the literature review. Eg. Madhiwalla and Jessani's (1997) study, which showed that the association of work and health depends upon the totality of life factors like the resources available to the household, the expected number of children that the women bear and raise, the number of dependents and the sex wise and age wise division of work within the household (Madhiwalla and Jessani's, 1997). Similarly, Artazcoz et.al's study (2001) showed that married women who perceived their health as good were usually the ones who had a domestic maid to help them in household chores. Education, job satisfaction, help by family members are some other factors which are seen to have a positive influence on the health of working women by various studies (Nathanson C.,1980; Borrel C. et.al.,2004)

The study further explored the relationship between role stress and health. Each of the two was seen to affect the other. Role stress leads to ill health and ill health leads to role stress. However, the study only focused to see the impact of role stress on health and well being of women. The study showed an inverse relationship between role stress and health as women with more of role stress reported of the presence of more number of illness and perceived their health as poor in comparison to the women with mild stress. Women with no stress hardly reported of any illness and mostly perceived their health as excellent. This explains as to why working women have poorer health

than housewives and also the poorer health of the women in the low income group than those in the high income group.

Hence, the findings of the study throws some light on the problems faced by most working women in fulfilling the demands of multiple roles associated with the Public (work) and private (home) spheres. The study shows that the dual burden of work most often leads to role stress among working women, which inturn has a very bad repercussion on their health and wellbeing. However, the levels of stress and it's subsequent impact on health varies among class, with women of the high income group having less role stress than those in the middle and low income group. Very few working women reported of experiencing Role enhancement and most of these belonged to the high income group. Besides, the study also brings into light the various demographic, familial and work factors which helps working women cope up with the demands of multiple roles. Hence the findings of the study contests the Dual System Perspective, propounded by Liberal feminists, according to which the private and public spheres are totally distinct from one another and hence women shouldn't face any problem in balancing the two.

A. SUGGESTIONS

1. Solutions to the Problem

Broadly, the study has been successful in bringing out the problems which a working woman faces in balancing the occupational and familial roles in her everyday life, and it's resulting impact on their health and wellbeing. Most often a working woman has to choose from either of the two. If she wants to become a successful career woman, she has to make some compromises on the home front, and if she wants to become a good mother and wife she has to make compromises on her career front. Rarely is she able to strike a balance between the two fronts, even if she does she ends up compromising upon her health and well being. Both these situation have dangerous repercussions. The first can bring immense loss to the family and society and the second to the economy. Below are mentioned some suggestions which can help a woman solve this problem of dual burden of work, which can help in relieving her stress and inturn improve her health.

As mentioned in the literature review, the main reason for a woman's dual burden of work is the gender division of labour, due to which the familial roles are still considered to be the primary one, on which she can't compromise even if she is performing the role of a wage earner. Hence the best solution to improve the plight of working women is a change in the gender division of labour. If women can step out of the private sphere and participate in the activities of the public sphere along with men, even men should step in to the private sphere and equally participate with women in the domestic chores of looking after the children, cooking, cleaning etc. Only then can the burden of work on women can reduce. This might seem to be an ideal solution but not a very plausible one. The gender division of labour is deeply rooted in our society and most men feel that taking on the female roles of looking after the household and caring, would mean a threat to their gender identity. As viewed by radical feminist's men's reluctance of taking on to the domestic chores is a means of maintaining their patriarchal power. Hence, changes in the men's behaviour would require a change in the patriarchal order; it requires men to subsume from the dominating role, to the role of an equal partner in marital relationship. This can't happen in a day or two and would require a longer time. Hence, a more immediate solution to the problem is needed.

The feminist solution to the problem is paying wages for housework. According to the Marxists and Socialist feminists, if housewives are paid for the work that they do in the household, then they would not require to go out to work, and hence would not have to face the dual burden of balancing the home as well as work front. However, the researcher doesn't completely agree with this view point, as job doesn't mean only the economic empowerment of women, but it also provides them with feelings of self esteem, accomplishment and provides them with a social network. Hence, if housewives are paid and are confined to their homes, they would be denied of the other benefits of employment which are very much needed for the over all development of women. Again here it is not clear as to who would pay the woman, the state or her husband. If a woman is paid by her husband then it would further increase her dependency on him as now he would also become her employer and hence would get another reason to control her. Moreover, this would further make housework an activity exclusively for women. Hence, paying women for housework

is not at all feasible in helping women overcome the dual burden of work. A more practical solution to the problem is possible only with institutional support.

The working hours of women should be made flexible and they should be allowed to work from home as and when needed. Some private companies are coming with such flexi time-women friendly policies to take care of pregnant mothers and help them combine job and work responsibilities. For eg. The mother friendly scheme launched by HLL (Mumbai) is one of the first schemes of its kind. The company allows the young mothers to take break for a couple of years, while keeping in lien on their jobs. It also allows women to take work home and earn a percentage of their salaries. Many HLL mothers have wide range of options of working full time with a long lunch break or working alternate days or weeks. The flexi-time option not only helps the working mothers, but also the company. Inspired by HLL, even NIIT has offered a similar scheme of family friendly working policy, which allows mother's to rush back to children as and when required. Besides, it also allows mother's to work part-time, for half pay, till the baby is a year old. ORG-MARG has also come up with a similar flexi-time scheme. However, the number of corporates offering such women friendly scheme is limited. But here, at least the process has begun, in comparison to the govt. sector which is far more rigid to introduce any scheme of this kind. The only such scheme that exists in the govt. sector is the age old maternity benefit scheme, which too has flaws as three months is too less a period for leave. Hence, more corporates, govt. and non govt. enterprises should take ideas from the above mentioned examples and come up with flexible working schemes to help women balance family and work.

Besides such schemes, the work place should also have crèches near or at the workplace, to keep the young children in the day time. Most working women have extremely tough time in making arrangements for the care of the young kids when they are away for work. Crèches at the work place can help women keep an eye on their young ones even while they are working.

Community parenting is another new alternative which is widely being suggested by some feminist literature to tackle this problem. Collective responsibility for caring can be met through informal community and friendship networks, and through the development of more fluid and open family forms which do not see children as the

property or exclusive responsibility of their parents. Eg. In Kibbutz communities in Israel the bachelors volunteers to help the parents in taking care of their young children and thus contribute to the state's economy.

Hence, some of the above measures with a little support from the family and work front can greatly help women balance the dual roles of wage earner and home-maker.

2. Avenues for further research

The entry of women in the labour force has brought several positive outcomes to themselves and the economy. However, it has led to some serious problems as well. Patriarchy has been carried in the work front as well, where women are discriminated in terms of the wages and work status. Besides, it has also led to an immense increase in the work loads for women, as she now has to work in two fronts-home and office. Though some Indian studies have tried to bring out the problems which a woman faces in balancing the roles of a homemaker and a wage earner, none have tried to look into the repercussions of these on the health and well being of women, using the Role Analysis framework (Role Stress and Role Enhancement), as used by studies in the west. The present study is one of the first of this kind, which tries to see whether employment leads to role stress or role enhancement for the working women and how this impacts upon the health and well being. More researches in the area are needed to validate the findings of this study and to further bring about the magnitude of the problem. Studies trying to measure the mental and physical health by clinical measures would also help in validating the findings of this study. Besides, the present study was not able to measure the mental health and concentrated more on the physical health. Future, studies should also try to measure mental health of women by using the various scales of mental health, as role stress can have damaging repercussions on the mental health of women as well. Also it would be easier to understand the two phenomena of role stress and enhancement if a scale is developed for measuring the same.

The present study has also explored the effect of variable like age, income, family size, family support, presence of domestic maid, job satisfaction etc., which helps a woman in coping up with the stress associated with the multiple roles. However, some factors which play a very important role in helping a woman fight with stress could

also have been considered. One such factor is the woman's personality type and their attitude. An efficient lady with a sharp mind, good time management skills and a strong will can very well manage the multiple roles and it's associated tasks. However, a woman, not having the above qualities might find it difficult. Hence, further studies in the area should also try to assess the women's personality type and it's relationship with the role stress or enhancement. Similarly, family support has been measured only in terms of the help provided by family members in the domestic chores. The emotional component derived from the family has not been assessed. It's quite possible that a woman with strong emotional support from the family will have less role stress than those who don't have the same. Future studies should also try to bring in this component.

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ANNEXURE - I

Interview Schedule for Housewives and Working Women

A. SOCIO- ECONOMIC PROFILE

1. Name
2. Age
3. Religion
4. Education (in terms of years of schooling)

5. Are you professionally qualified?
   a) Yes
   b) No

6. If yes, then:
   a) Degree
   b) Diploma

7. Which stream/area?
   a) Engineering
   b) Medical
   c) MBA
   d) Others
   e) No Professional Education

8. Details of family members (family type &Roles)

Serial No/Members	Relationship to the respondent	Age	Sex	Work status/occupation	Education level attained

B. Work Details (if you are a housewife then go to q no. 19)

9. Work

A.STATUS:
   a) Employed
   b) Housewife

B. If employed then, specify sector?
   a) Government/public
   b) Non- govt./Private
   c) Quasi govt.
   d) Self-employed
   e) Other(s) (specify aided by govt. Ngo or Ingo)

10. Type of occupation:
   a) Housemaid/Labour

b) Clerical
c) Administrative
d) Teaching
e)Scientist
f) Executive
g)Entrepreneur
h) Others

11. Nature of Occupation-
    a) Unskilled [eg.domestic help, labourer]
    b) Semi-skilled [eg. small shop/phone booth]
    c) Skilled [eg.has undergone some training]

12. Years of service
13. Income
14. Working Hours.
15. Travel:
    a)Time taken to travel to work place(in minutes)
    b) Mode of travel used
        1-Train
        2-Bus
        3-Auto
        4-Walk
        5-Car
        6-Multiple
    c) Cost incurred in traveling

16. What were your reasons for taking the job?
    a) Economic.
    b) For social status.
    c) For better career.
    d) To utilize time.
    e) Others

    Prioritize them as 1, 2,3 and so on if more than ONE reasons.

17. A. Are you satisfied with your job?
    a) Satisfied
    b) Partly satisfied
    c) Not Satisfied

B. If A, then why?
    a) It's according to my interest/ I enjoy it.
    b) It gives me money, self confidence and a sense of worth.
    c) It's less demanding.
    d) Others.

C. If b & c, then why?
    a) It's monotonous.

b) I don't have my freedom.
c) It's too strenuous.
d) Others

C. MARITAL DETAILS.

18. Marital Status:
    a) Married
    b) Widow
    c) Divorcee
    d) Separated

19. Number of years of marriage:

Details of husband=

20. A. Educational level (years)
    B. Whether husband is professionally educated or not-
        a)Yes
        b)No

    C. If yes then specify the stream?
        a) Engineering
        b) Medical
        c) MBA
        d) Others
        e) No professional education

21. In which sector is your husband employed?
    a) Government/public
    b) Non- govt./Private
    c) Quasi govt.
    d) Self-employed
    e) Other(s) (specify aided by govt., Ngo or Ingo)

22. What is your husband's occupation?
    a) Labour
    b) Clerical
    c) Administrative
    d) Teaching
    e) Scientist
    f) Executive
    g) Entrepreneur
    h) Others-

23. What is his income?

24. What is your total family income?

D. SOCIAL ROLES & SOCIAL SUPPORT

Lead- as women we have to perform many roles.(wife, mother, daughter-in-law, daughter, employee etc.)

25. What are the roles that you perform outside the family
    a) Neighbourhood
    b) Community
    c) Workplace
    d) Any other (specify)

26. A. Are you able to manage all these roles familial and indicated in Q28 efficiently?
    a)Yes
    b) No
    c) Sometimes cant

B. If a, then why?
    a) My family is satisfied.
    b) I am satisfied.
    c) I am able to manage time well.
    d) Others

C. If b& c, then why?
    a) My family is not satisfied.
    b) I am not satisfied.
    a) I am not able to manage time.
    b) Others

27. A. Do u feel stressed out in managing these roles?
    a) No, Never
    b) Yes, all the time
    c) Yes, sometimes

B. If b & c, which role you find to be most and least stressful? Arrange/label them in ascending order of stress generated by these roles.(refer Q no.28)
    a) Wife
    b) Mother
    c) Daughter in law.
    d) Daughter.
    e) Employee/employer
    f) Community member
    g) Neighbour

28. Do other family members help you in your housework?
    a) Yes
    b) No

29- If yes specify
    a) Husband.

b) Son/daughter
c) Daughter in law.
d) Mother in law.
f) Others

30. In what activities do they help you?
a) Cooking.
b) Shopping.
c) Washing clothes.
d) Cleaning.
e) Looking after the children.
f) Others.

31. A. Do you have a domestic maid?
a) Yes
b) No

B. If yes, then what job does she do?
a) Washing clothes.
b) Cleaning.
c) Washing dishes.
d) Cooking
e) Others.

C. How much do you pay her?

D. Who pays her?
a) You
b) Your Husband
c) Both

E. HEALTH AND HEALTH BEHAVIOURS

32. How do you consider your health to be?
a) Excellent
b) Very good
c) Good
d) Fair
e) Poor

33. How do you perceive the health of others (if housewife then that of working women and
if working women then that of housewife)?
a) It's better than ours
b) It's worse than ours
c) It's like ours
d) Can't say

34. What are the major illnesses that you suffered in the past three years?

a) Intestinal.
b) Communicable diseases.
c) Chronic diseases- Arthritis/Asthma/Migraine/Diabetes
d) Heart related
e) Reproductive
f) Others-Anaemia, Skin diseases etc.

NOTE- If the respondent doesn't suffer from any of these then skip to Q 36

35. Where did you seek treatment for it?

a)Private

1) Practitioner
2) Clinic/dispensary
3) Nursing home
4) Hospital.

b)Public

1) Practitioner
2) Clinic/dispensary
3) Nursing home
4) Hospital

c) Alternate system of medicine.
d) Home remedies.
e) Any other

36. What are the minor illnesses that you suffered from in the past three months?

a) Cold,
b) Cough,
c) Back ache
d) Head ache
e) Fever.
f) Injury/accident.
g) Tension/irritation/any other illness related to stress.
h) Others.

NOTE- If the respondent doesn't suffer from any of these, then skip to Q 38

37. Where did you seek treatment for this?

a) Private

1) Practitioner
2) Clinic/dispensary
3) Nursing home
4) Hospital.

b) Public

1) Practitioner
2) Clinic/dispensary
3) Nursing home

4) Hospital

c) Alternate system of medicine.
d) Home remedies.
e) Self medication

38. In case of illness, when and at what time point, do you go for treatment?
    a) After trying home remedy
    b) After self-medication, when the medicine appears (perceived as) to be ineffective
    c) Immediately
    d) As a routine check up

39. Cost incurred in medical care (in Rs) -
    a) Routine (per month)
    b) Individual episodes (Approx. total)

40. What do you do to remain healthy?
    a) Exercise.
    b) Meditate.
    c) Eat balanced diet.
    d) Follow sanitary measures/ Cleanliness regime.
    e) Others.

41. How much money do you spend on your well-being?
    a) Yoga (per month/one time)
    b) Gym/Exercise (per month/one time
    c) Meditation (per month/one time
    d) Reiki (per month/one time)
    e) Cosmetics and toiletries.(per month)
    f) Any special health diet (per month/one time
    g) Parlour (per month)
    h) Others (per month/one time

42. How much leisure time you get/week?
43. What do you do in this time?
    a) Entertainment-
        1) Music
        2) TV
        3) Theatre
        4) Outdoor activity
        5) Gardening etc.
    b) Creative activity
    c) Health/ Fitness related act.
    d) Reading.
    e) Socializing/talking on phone
    f) Rest
    g) Others.

44. How many hours do you sleep?