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An Overview of Working Women Health Consciousness in India

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Abstract-This paper titled, “An overview of working women health consciousness in India”. Health is an important component of human development. With the rapid changes brought about through globalization and the resultant new economic order, there is an increase in the need for academic studies to be focused on the area of women’s health. If health is defined ‘as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’, it follows that existence is a necessary condition for aspiring for health. The health of Indian women is intrinsically linked to their status in society. Research on women’s status has found that the contributions Indian women make to families often are overlooked, and instead they are viewed as economic burdens. Poor health has repercussions not only for women but also their families. Women in poor health are more likely to give birth to low weight infants. They also are less likely to be able to provide food and adequate care for their children. Finally, a woman’s health affects the household economic well-being, as a woman in poor health will be less productive in the labor force. While women in India face many serious health concerns, this profile focuses on only five key issues: reproductive health, violence against women, nutritional status, unequal treatment of girls and boys.

Index Terms: Violence, unequal treatment, diseases

INTRODUCTION

The health of Indian women is intrinsically linked to their status in society. Research on women’s status has found that the contributions Indian women make to families often are overlooked, and instead they are viewed as economic burdens. There is a strong son preference in India, as sons are expected to care for parents as they age. This son preference, along with high dowry costs for daughters, sometimes results in the Mistreatment of daughters. Further, Indian women have low levels of both education and formal labor force participation. They typically have little autonomy, living under the control of first their fathers, then their husbands, and finally their sons. All of these factors exert a negative impact on the health status of Indian women. Poor health has repercussions not only for women but also their families. Women in poor health are more likely to give birth to low weight infants. They also are less likely to be able to provide food and adequate care for their children. Finally, a woman’s health affects the household economic well-being, as a Woman in poor health will be less productive in the labor force. While women in India face many serious health concerns, this profile focuses on only five key issues: reproductive health, violence against women, nutritional status, unequal treatment of girls and boys, and HIV/AIDS. Because of the wide variation in cultures, religions, and levels of development among India’s 25 states and 7 union territories, it is not surprising that women’s health also varies greatly from state to state.

WOMEN HEALTH IN INDIA

Health is complex and dependent on a host of factors. The dynamic interplay of social and environmental factors have profound and multifaceted implications on health. Women’s lived experiences as gendered beings result in multiple and, significantly, interrelated health needs. But gender identities are played out from various location positions like caste and class. The multiple burdens of ‘production and reproduction’ borne from a position of disadvantage has telling consequences on women’s well-being. The present section on women’s health in India systematizes existing evidence on the topic. Different aspects of women’s health are thematically presented as a matter of presentation and the themes are not to be construed as mutually exclusive and water tight compartments.
OCCUPATIONAL STRESS IN WOMEN

Occupational stress is stress involving work. Work and family are the two most important aspects in women’s lives. Balancing work and family roles has become a key personal and family issue for many societies. There are many facets in working mother’s lives that subject to stresses. They deal with home and family issues as well as job stress on a daily basis.

REASONS OF OCCUPATIONAL STRESS

Imbalance between work and family leads to occupational stress. Imbalance between work and family life arises due to a number of factors. Various factors are following.

1. Mental harassment
2. Sexual harassment
3. Discrimination at Workplace
4. No Safety of Working Women While Traveling
5. Lack of Family Support
6. Insufficient Maternity Leaves
7. Job insecurity

Women have specific health concerns. With the rise in the number of working women in this age of globalization, new health problems are surfacing that the seminar proposes to deliberate upon. Health problems of working women have received inadequate attention. Stress of work coupled with domestic responsibilities, pregnancy related problems has taken a toll not only on women’s physical health, but their mental health too, with large number of women being afflicted by common mental disorders including depression. Faced with gender based discrimination at different stages of their lives many find it difficult to cope with the stress they are subjected to.

Another area relating to their health is the new reproductive technologies like IVF and surrogacy that promises hope for millions of childless couples. Commercial surrogacy has become a growing business. It is exploiting poor women in a country like India. There is urgent need for government to enact laws to regulate surrogacy and protect the interests of the couples involved. Questions of ethics and religion too need to be tackled along with the legal issues involved.

WOMEN AND WORK

The multiple burdens of paid work, childcare and household responsibilities that women shoulder and the manifold effects (health and otherwise) it engenders has been a leitmotif in feminist literature on women and work. However, as an area of enquiry in health research, the field of occupational health occupies an enclave of its own, with limited dialogue with other areas. Historically, much of the body of evidence focuses on the (male) worker in an industrial setting. Sex differentials in occupational injuries and deaths may be obscured because of non-presentation of such data. For example, labour statistics do not carry sex disaggregated data on fatal and non fatal injuries in factories, mines, railways and ports (Government of India, 2003). Further in India, within the body of work on occupational health of women, a disproportionate share is claimed by enquiries into women’s occupational health in low paying, low skilled (and often un organized) sector.

RISK FACTORS IN WOMEN’S LIVES

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

Women’s empowerment is hindered by limited autonomy in many areas that has a strong bearing on development. Their institutionalized incapacity owing to low levels of literacy, limited exposure to mass media and access to money and restricted mobility results in limited areas of competence and control (for instance, cooking). The family is the primary, if not the only locus for them. However, even in the household domain, women’s participation is highly gendered. Nationally, about half the women (51.6%) are involved in decision making on their healthcare. Women’s widespread ignorance about matters related to their health poses a serious impediment to their well-being. The NFHS-2, for example, reports that out of the total births where no antenatal care was sought during pregnancy, in 60 percent of the cases women felt it was ‘not necessary’. And, at a time when AIDS is believed to have assumed pandemic proportions in the country, 60 percent of the ever married women have never heard of the disease. Women’s inferior status thus has deleterious effects on their health and limits their access to healthcare.

REFERENCES

