REFACS

Sociodemographic profile, reported morbidities, well-being, and paid work of women: a population-based study*

Perfil sociodemográfico, morbidades referidas, bem-estar e trabalho remunerado de mulheres: estudo populacional

Perfil sociodemográfico, morbilidades referidas, bienestar y trabajo remunerado de mujeres: estudio poblacional

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Cross-section population-based study carried out in 2014, aiming to verify the associations between the sociodemographic profile, referred morbidities, wellbeing indexes, and paid work, analyzing data from the Women's Health Inquiry from the city of Uberaba/MG. Sociodemographic characteristics were self-reported. The morbidities referred were evaluated through self-reports, from a list based on the questionnaire Index of Work Capacity, and the wellbeing indexes were assessed through some questions from the WHOQOL-bref, the Scale of Population Depression Screening, and the Self-Report Questionnaire. 1,483 women participated (533 had paying jobs, and 950 did not). From those with no paid work, 41.9% were 60 years old or more, and 51.26% were in stable unions. Their mean educational level was 7.76 (±5.23), and their mean per capita income was 815.98 (±1082.75) reais (Brazilian currency). Most of those who did work paying jobs (54.6%) were from 35 to 59 years of age and 303 (56.85%) were not in a stable union. They had a mean educational level of 9.17 (±4.90) years old and a mean per capita income of 788.55(±766.69) reais. There were significant differences between the groups, indicating that women with no stable unions and with higher educational levels had paying jobs. The most commonly reported morbidities by all women were respiratory, endocrine/metabolic, and genitourinary. Those who had paid work were significantly satisfied/very satisfied with their performance of daily-life activities, and reported nothing/very little impairment in carrying out their activities due to pain. Houseworkers were more affected by feelings of nervousness/tension/preoccupation, tired more easily, and required more efforts to carry out daily activities.
Descriptors: Womens; Health surveys; Musculoskeletal system; Noncommunicable diseases; Health status.

Estudo transversal de base populacional realizado em 2014, cujo objetivo foi verificar as associações entre o perfil sociodemográfico, morbidades referidas, indicadores de bem-estar e trabalho remunerado, analisando dados do Inquérito de Saúde da Mulher da cidade de Uberaba/MG. As características sociodemográficas foram autorrelatadas. As morbidades referidas foram avaliadas por meio de autorrelato, a partir de uma lista baseada no questionário Índice de Capacidade para o Trabalho, e os indicadores de bem-estar por meio de algumas questões do Questionário WHOQOL-bref, da Escala de Rastreamento Populacional de Depressão e do Self-Report Questionnaire. Participaram 1.483 mulheres (533 com e 950 sem trabalho remunerado). Das mulheres que não exerciam trabalho remunerado, 41,9% estavam na faixa etária de 60 anos ou mais e 51,26% em união estável, apresentaram média de escolaridade de 7,76 (±5,23) anos e de renda per capita de 815,98 (±1082,75) reais. A maioria das que exerciam trabalho remunerado (54,6%) estava na faixa etária de 35-59 anos e 303 (56,85%) não estavam em união estável, com média de escolaridade de 9,17(±4,90) anos e renda per capita de 788,55 (±766,69) reais. Houve diferenças significativas entre os grupos, indicando que mulheres sem união estável e com maior escolaridade exercem trabalho remunerado. As morbidades mais relatadas por todas as mulheres foram as respiratórias, endócrinas/metabólicas e genitourinárias. As que exerciam trabalho remunerado estavam significativamente satisfeitas/muito satisfeitas com o desempenho das atividades do dia a dia e relataram nada/muito pouco impedimento para realizar atividades devido à dor. Houve maior comprometimento para as donas de casa com relação a sentir-se nervosa/tensa/preocupada, cansar com facilidade e apresentar esforço para realizar tarefas habituais.
Descritores: Mulheres; Inquéritos epidemiológicos; Sistema musculoesquelético; Doenças não transmissíveis; Nível de saúde.

Estudio transversal de base poblacional realizado en 2014, cuyo objetivo fue verificar las asociaciones entre el perfil sociodemográfico, morbilidades referidas, indicadores de bienestar y trabajo remunerado, analizando datos de la Encuesta de Salud de la Mujer de la ciudad de Uberaba/MG, Brasil. Las características sociodemográficas fueron auto relatadas. Las morbilidades referidas fueron evaluadas por medio de auto relato, a partir de una lista basada en el cuestionario Índice de Capacidad para el Trabajo, y los indicadores de bienestar por medio de algunas preguntas del Cuestionario WHOQOL-bref, de la Escala de Escala de Rastreo Poblacional de Depresión y del Self-Report Questionnaire. Participaron 1.483 mujeres (533 con y 950 sin trabajo remunerado). De las mujeres que no ejercían trabajo remunerado, 41,9% estaban en el grupo etario de 60 años o más y 51,26% en unión estable, presentaron promedio de escolaridad de 7,76 (±5,23) años y de ingreso per capita de 815,98 (±1082,75) reales. La mayoría de las que ejercían trabajo remunerado (54,6%) estaba en el grupo etario de 35-59 años y 303 (56,85%) no estaban en unión estable, con promedio de escolaridad de 9,17(±4,90) años e ingreso per capita de 788,55 (±766,69) reales. Hubo diferencias significativas entre los grupos, indicando que mujeres sin unión estable y con mayor escolaridad ejercían trabajo remunerado. Las morbilidades más relatadas por todas las mujeres fueron las respiratorias, endocrinas/metabólicas y genitourinarias. Las que ejercían trabajo para realizar actividades debido al dolor. Hubo mayor comprometimiento para las amas de casa con relación a sentirse nerviosa/tensa/preocupada remunerado estaban significativamente satisfechas/muy satisfechas con el desempeño de las actividades del día a día y relataron nada/muy poco impedimento, cansar con facilidad y presentar esfuerzo para realizar tareas habituales.
Descriptores: Mujeres; Encuestas epidemiológicas; Sistema musculoesquelético; Enfermedades non transmisibles; Estado de salud.

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INTRODUCTION

Work is directly linked to the stage in which human beings tarted changing nature and the space in which they lived to create materials and instruments to satisfy their basic human needs. However, in the past, women were supposed to stay in their homes, caring for the children, living for their children and their husbands. Starting from the second half of the XX century, the number of women in paid works has been growing[1]. They have been increasingly achieving their place in society and, as a consequence, in the work market.

Considering the fact that house chores were exclusively performed by women who did not take part in paid work, women started to be called "housewives", and despite their intense routine of domestic work that keeps them occupied, domestic chores are not counted as economic activities by official statistics in Brazil, although the length of this work journey is similar to that of a paid activity[2].

Domestic activities, supposedly, have more autonomy, less pressure with regards to deadlines, feelings of responsibility, and control over tasks. Also, they are not socially valued[3], and the isolation of the women in the house is associated to stagnation and disease in those who exclusively do these tasks[4].

Women inserted in the job market, on the other hand, can have an important role in the construction of their financial independence and in the perception of their competence and social value, increasing their self-esteem and consequently reflecting on their health and well-being[4]. On the other hand, researches carried out in different context[5-6] have been showing that paid work can lead to diseases.

Therefore, considering that both domestic and professional work can present risk and protective factors, influencing both physical and mental aspects of health, researches on the health of women should take into account the many roles they perform, while also assessing the different spaces of life in which they act. However, domestic work has still been the target of few studies with regards to its repercussions in the health of women, who are still the main responsible for it. Most investigations do not included it in their approaches of female work. In Brazil, few population-based researches are dedicated to analyzing the state of health with regards to female work, especially comparing paid workers and housewives[2]. Therefore, studies that evaluate reported morbidities (RM) and wellbeing indexes (WI) in these two segments can contribute to broaden the knowledge of this profile in the population, offering subsidies for the planning of actions of health promotion and being characterized as a tool for health surveillance.

In this context, population-based health inquiries are essential to get to know the health profile, the distribution of risk factors and their tendencies, in addition to health inequalities. The information periodically collected make it possible to monitor health actions and programs in different population subgroups, thus subsidizing the planning and management of collective health interventions, in addition t allowing for an estimate of the severity of the situation[5].

The objective of this study was verifying the associations between the sociodemographic profile, the reported morbidities, wellbeing indexes, and paid work, analyzing data from the Women's Health Inquiry from the city of Uberaba/MG.

METHOD

Cross-sectional study with a quantitative approach, part of a project called Women's Health Inquiry (ISA MULHER), carried out in residences in the urban zone of the city of Uberaba - MG in 2014, after the approval of the Research Ethics Committee from the Universidade Federal do Triângulo Mineiro (UFTM), under certificate 1 No. 1826. Participants were women selected from a probabilistic sample in multiple stages. Sample calculation was carried out and

considered ideal with 1530 women. Additional information can be obtained from materials already published[7].

Sociodemographic characteristics were self-reported and indicated by age (classified in the categories: 18 to 34 years old, 35 to 59 years old, and 60 years old or more), years of formal education, per capita income (calculated according to the division of monthly family income by the number of people who lived in the house), marital status (classified as "in a union": married or in a stable union, or "not in a union": single, separated, or widower), and exercising paid work (Yes or No).

The RMs were evaluated through self-reports, from a list based on the questionnaire Index of Capacity for Work[8], with the addition of some questions elaborated by the authors, presenting morbidities with regards to the many systems: Cardiac system (arterial hypertension, coronary disease, chest pain when exercising, myocardial infarction, coronary thrombosis, heart failure, cardiomegaly, Chagas's disease, other cardiovascular diseases); Respiratory system (acute infections of the respiratory tract - tonsillitis, acute sinusitis, acute bronchitis, chronic bronchitis, chronic sinusitis, asthma, emphysema, pulmonary tuberculosis, other respiratory diseases); Emotional system (severe or mild emotional disturbances); Neurological system (problems or reduction of hearing, disease or lesions in vision, neurological diseases - strokes, neuralgia, migraine, epilepsy, convulsions, other neurological disease or disease from the sense organs; Digestive system (gallstones or gallbladder diseases, pancreas or liver diseases, gastric or duodenal ulcers, gastric of duodenal irritation, colitis or duodenal irritation, other digestive disease); Genitourinary system (urinary tract infection, diarrhea, constipation, gas, kidney diseases, genital and reproductive organ diseases, other genitourinary disease); Tumors (benign tumor, malign tumor); and Endocrine/Metabolic (obesity, diabetes, varicose veins, high cholesterol, goiter or another thyroid disease, hypothyroidism, hyperthyroidism, another endocrine or metabolic disease). The women was considered compromised in a certain system when she had one or more morbidities in it.

To evaluate the WI, this study used some questions from the WHOQOL-Bref questionnaire6, from the Scale of Population Depression Screening (CES-D - Center for Epidemiological Studies-Depression), validated for use in Brazil[9] and the Self-Report Questionnaire (SRQ-20), for the screening of non-psychotic mental disorders, developed by World Health Organization. The questions asked to the participants, including their respective response options, are as follow: "How would you evaluate your quality of life" (Very bad/Bad, Not bad nor good, Good, Very good); "How satisfied are you with your health" (Very satisfied/satisfied, Not satisfied nor dissatisfied, Satisfied/very satisfied); "How satisfied are you with your capacity to perform daily routine activities (Very satisfied/satisfied, Not satisfied nor dissatisfied, Satisfied/very satisfied); "Do you think your (physical) pain prevents you from doing what you need" (No/Very little, More or less, Very much/Extremely); "Do you feel nervous, tense, or worried (Yes or No); "Do you feel tired all the time" (Yes or No); "Do you feel that your daily-life activities require an effort to be done" (Yes/No); "Do you get tired easily" (Yes or No); "How satisfied are you with your sleep" (Very satisfied/satisfied, Not satisfied nor dissatisfied, Satisfied/very satisfied); and "Do you sleep badly" (Yes or No).

Data were initially stored in the EpiData software, version 3.1, and later transferred to a spreadsheet in the software Microsoft Office Excel® 2007, which was used to validate data and verify their consistency. Later, the database was imported to the IBM software Statistical Package for the Social Sciences (SPSS), version 24.0, to carry out the statistical analyses.

The normality of data was evaluated using the Kolmogorov-Smirnov test, which indicated that distribution was not normal. For the univariate analysis, measures such as frequency and percentage were used, as well as variability measures, such as means and standard deviations. Later, a bivariate analysis was carried out, with a statistical significance of 5%, in which Mann-Whitney's test and Pearson's Chi-squared were used. The associations found were evaluated using the test of adjusted residuals.

RESULTS

The participants of this study were 1,483 women. Most of them (950 - 64.06%) did not perform any paid work. From these, 398 (41.90%) were in the age group of 60 years old or older, most (487 - 51,.6%) were in a stable union, with a mean of 7.76 (±5.23) years of formal education and a per capita income of 815.98 (±1082.75) reais.

The number of women with paid jobs was 533 (35.94%). From these, most (291 - 54.60%) were from 35 to 59 years old, and 303 (56.85%) were not in stable unions. They had a mean 9.17(±4.90) years of formal education and a mean per capita income of 788.55 (±766.69) reais.

There were significant differences between the two segments (p<0.05) for all variables, with the exception of per capita income, according to Table 1, suggesting that women with no stable unions, with lower per capita incomes and lower educational levels exercise paid work.

Table 1. Sociodemographic characterization of the population. ISA-Mulher, Uberaba, 2014.

Variables	Exercises paid work Frequency (%)		
	YES	**NO**	**p**
Age			
18 – 34	167 (31.33)	204 (21.47)	**0.001***
35 – 59	291 (54.60)	348 (36.63)	
≥ 60	75 (14.07)	398 (41.90)	
Marital Status			
In a stable union	230 (43.15)	487 (51.26)	**0.003***
Not in a stable union	303 (56.85)	463 (48.74)	
		Mean (SD)	
Per capita income	788.55 (766.69)	815.98 (1082.75)	0.423
Years of formal education	9.17 (4.90)	7.76 (5.23)	**0.001****

Caption: SD=Standard Deviation; *p<0.05 - Pearson's Chi-squared with adjusted standardized statistically significant resides; ** p<0.05 - <Mann-Whitney's.

Table 2 presents the prevalence of RMs. The most commonly related in women with paid work were respiratory (48.41%), endocrine/metabolic (40.90%) and genitourinary (37.71%). For housekeepers, the most common diseases were respiratory (51.05%), genitourinary (44.53%), and endocrine/metabolic (39.47%). Most housekeepers had RMs in the digestive (p=0.005) and genitourinary (p=0.011) tracts.

Table 2. Prevalence of reported morbidities. ISA-Mulher, Uberaba, 2014.

Reported morbidities		Frequency (%) Paid work		
		YES	**NO**	**p**
Cardiac	Yes	139 (26.08)	264 (27.79)	0.477
Respiratory	Yes	258 (48.41)	485 (51.05)	0.328
Emotional	Yes	131 (24.58)	231 (24.32)	0.910
Neurological	Yes	125 (23.45)	236 (24.84)	0.550
Digestive	Yes	140(26.27)	316 (33.26)	**0.005***
Genitourinary	Yes	201(37.71)	423 (44.53)	**0.011***
Tumors	Yes	33(6.19)	80 (8.42)	0.120
Endocrine/Metabolic	Yes	218 (40.90)	375 (39.47)	0.590

Caption: *p<0.05 - Pearson's Chi-square test.

The results referring to the WI are presented in Table 3. It was found that most women (both housekeepers and paid workers) considered their quality of life to be Good/Very good, were Satisfied/Very satisfied with their health and their performance of daily routine activities, and reported that pain represented No/Very little impediment for their execution of said activities. They felt nervous/tense/worried, did not feel tired, did not get easily tired, did not demand effort to carry out daily life activities, were Satisfied/very satisfied with their sleep, and did not sleep badly.

However, higher (positive) values of the adjusted residues indicate a strong association of being Satisfied/Very satisfied with daily life activities and paid work (p<0.040) and No/Very little impediment to carry out activities due to pain (p=0.013). Also, housekeepers felt more nervous/tense/worried (p=0.009), got more easily tired (0.004) and had to make efforts to carry out daily routine activities (p=0.009).

Table 3. Wellbeing indexes. ISA-Mulher, Uberaba, 2014.

Wellbeing indexes	Paid work Frequency (%)		
	YES	NO	*p*
Quality of life evaluation			
Very bad/Bad	26 (4.88)	52 (5.47)	0.082
Neither Good/Nor Bad	110 (20.64)	242 (25.48)	
Good/Very Good	397 (74.48)	656 (69.05)	
Satisfaction with health			
Very Dissatisfied/Dissatisfied	85 (15.95)	166 (17.47)	0.074
Neither Dissatisfied/Nor Satisfied	77 (14.45)	175 (18.42)	
Satisfied/Very Satisfied	371 (69.60)	609 (64.11)	
Satisfaction with the performance of daily routine activities			
Very Dissatisfied/Dissatisfied	50 (9.38)	99 (10.42)	**0.040**
Neither Dissatisfied/Nor Satisfied	61 (11.45)	151 (15.89)	
Satisfied/Very Satisfied	422 (79.17)	700 (73.69)	
Feeling prevented from carrying out activities due to pain			
No/Very little	367 (68.86)	582 (61.26)	**0.013***
More or less	80 (15.00)	183 (19.27)	
Very Much/Extremely	86 (16.14)	185 (19.47)	
Feeling nervous, tense, preoccupied			
Yes	306 (57.41)	611 (64.32)	**0.009***
No	227 (42.59)	339 (35.68)	
Tired			
Yes	112 (21.01)	240 (25.26)	0.057
No	421 (78.99)	710 (74.74)	
Gets easily tired			
Yes	149 (27.95)	335 (35.26)	**0.004***
No	384 (72.05)	615 (64.74)	
Effort carrying out daily life activities			
Yes	94 (17.64)	223 (23.47)	**0.009***
No	439 (82.36)	727 (76.53)	
Satisfaction with sleep			
Very Dissatisfied/Dissatisfied	176 (33.02)	306 (32.22)	0.883
Neither Dissatisfied/Nor Satisfied	132 (24.77)	246 (25.89)	
Satisfied/Very Satisfied	225 (42.21)	398 (41.89)	
Sleeps badly			
Yes	181(33.96)	353 (37.16)	0.237
No	352(66.04)	597 (62.84)	

Caption: *p<0.05 - Independence Chi-square.

DISCUSSION

The number of women with paid jobs was 533 (35.94%). This number is lower than the mean in the general Brazilian population, since IBGE data from 2014 suggested that, in Brazil, from 77,771 women older than 18 years of age, 39,431 (50.70%) had an occupation. This rate is of 42.91% for the Southeast region, where the city of Uberaba is located[11].

The results suggest that women who did not exercise any paid work were older (p<0.001). 398 (41.90%) were 60 years old or older, while most women with paid jobs were from 35 to 59 years of age (54.60%), the age of the economically active population. Data regarding the age group of those who did not have a paid job may be related to retirement, which may have taken

place with a part of them. In Brazil, according to data from the Statistical Yearbook of Social Security from 2014, 621,515 people received retirement pensions in 2012, 654,523 in 2013, and 645,687 in 2014[11]. For Minas Gerais, these benefits were 31,763 in 2012, 35,222 in 2013, and 37,377 in 2014[11].

For women, retirement meant a definitive removal from the work market. Often, this had already taken place due to marriage and pregnancy. In 1998, most removed themselves from work 10.1 years before starting to receive a pension. In 2008, that difference was cut down to 7.3 years[12].

However, it is important to have in mind that one of the consequences of the global aging process is an increase in the proportion of elders in the active population. That means that factors associated to their permanence in the job market has been widely studied, and researchers conducted in high-income countries have shown that health conditions are one of the main determinants for the permanence of elders in the job market, as it is for their return to work after retiring[13].

The fact that most women inserted in the job market is in the 35-39 age group, meaning they are more active than those from 18 to 34 years of age, could suggest that many of the younger ones prefer to dedicate exclusively to school, delaying their entrance in the work market. Another explanation to this result is associated to the fact that female participation in the job market is closely related to the age of their children, since younger children are more dependent and require more care. Since this care is almost exclusively attributed to the mothers, their insertion or continuity in the work market becomes more difficult.

The presence of children from 6 to 10 years old, and especially that of pre-school children, stand out as obstacles that prevent the entrance of women in the job market. Children older than these age groups, however, seem to not interfere in the decision of women to enter in the job market[14]. Additionally, the peak of probability of female participation takes place in the age group from 30 to 39 years of age, followed by the next age group, from 40 to 50, reflecting to some extent the cycle of fecundity and marriage.

Most women who did not have a paid job were in a stable union, a total of 51.26%, against 43.15% among those who did ($p<0.003$). A study[15] showed that being married, with or without children, diminish the likelihood for a woman to have a job, when compared to single women with no children. That calls the attention to the fact that married women were significantly less likely to work, suggesting that women tend to diminish their participation in the job market after marriage.

The mean educational level was not significantly ($P<0.001$) different between women who did not have a paid job (7.76±5.23 years) and those who did (9.17±4.90 years). A higher educational level shows a positive effect on female job opportunities, since it is associated to the occupational status and offer the opportunity exercise more qualified jobs, with better earnings, more autonomy and prestige[14], in addition to better life conditions, higher level of satisfaction of necessities, easier acquisition of knowledge, not to mention the influence that this have on the attitudes and behaviors that produce positive health effects, particularly in mental health[16].

On the other hand, women who did not have paid jobs and had lower educational levels show lower quality of life related to health and higher prevalence for non-transmissible chronic diseases, mental disorders, and depression[2]. The intellectual potential contributed in the promotion of healthy behaviors in more educated women, while lower health conditions, evaluated by many indicators, were more common among those with lower educational levels[17].

There was no significant difference between the segments related to per capita income, which suggests that having a paid job did not increase the purchasing power of these families. In this regard, a study[14] raised evidence to suggest that families that are considered to be potentially poor are more likely to have a women in the workforce. The phenomena according

to which women must work to pay for their livelihood and that of their family is known as "feminization of poverty", which can be justified by the way in which women work in the work market by the following reasons: working part-time or temporary jobs; wage discrimination; higher presence in works that require lower qualification qualification and offer lower salaries; and participation in the lower levels of the informal economy[18].

The RM have been assessed as good measures of health conditions, since they are close to the information obtained through clinical exams[19]. They are important targets of national and international policies[20,21] because the are, currently, the main cause for mortality. They are also responsible for higher rates of morbidity, disabilities, and costs associated with health, and are useful not only to know the demands for services, but also to evaluate health policies and help with new public health proposals.

A study[22] indicated that paid workers have lower prevalences of chronic diseases and of limitations provoked by diseases and mental disorders, in addition to lower mortality rates with regards to housekeepers. However, in this study, the RM most reported by women, with or without paid work, were those related to the respiratory system (48.41% and 51.05%, respectively). There were no significant differences between the segments. Another research[23], when comparing women with and without paid work in the city of São Paulo and their morbidities, found that they had a higher prevalence of respiratory diseases. However, in this study, these diseases were more prevalent among women who exercise paid work.

Despite the fact that respiratory diseases are among the most commonly related, a research[24] found that morbidity and mortality rates from this group of diseases in hospitals decreased both for asthma and for chronic obstructive lung disease, interpreting as possible causes of this diminution the improved access to health care and the diminution of smoking. However, this study did not evaluate these parameters.

For the RM in the genitourinary and digestive systems, the differences between the groups were significant (p=0.011 and p=0.005), being that women with no paid work were more affected.

Regarding the genitourinary system, this result could be related to a reserach[25] that indicated that younger women (40 to 50 years of age), with a social and professional activity, take the initiative to seek treatment, while housekeepers and retired women above 50 years of age resist to report their symptoms and find it difficult to adapt to treatment.

For the digestive system, an observational study on national scale[26] shows that gastrointestinal symptoms are present in the daily lives of two third of Brazilian women, regardless of social class, in all regions of the country, significantly affecting their quality of life. The same study shows that the main gastrointestinal symptoms reported were functional, and the causes attributed to the women were those related to their lifestyles and eating habits.

The digestive system manifestations are noticed and measured by the person who feels them. They include clinical signs and symptoms that suggest possible infections and/or gastric diseases, meaning that the assistance to people with these manifestations must be investigated, and sociodemographic factors, such as sex, age, educational level, among others, are grouped in individual profiles and are related to environmental factors, such as eating habits, which include habits associated to the consumption and preparing of foods; working conditions, such as physical and mental demands of the job, as well as the time spent on it; the accumulation of labor activities and frustration in their execution; and the use of pesticides in farming[27].

An investigation[28] found that women with a lower educational level were more likely to report obesity and an inadequate consumption of fruit and vegetables. Most women evaluated in a study reported that their gastrointestinal symptoms affected their quality of life, especially their mood, capacity to focus, and sex life[26].

The intestine, due to its strong connection to the brain, is an important catalyst of emotions. It can negatively modulate the behavior of women, leading to a vicious cycle that starts with negative feelings, such as low self-esteem, stress, anguish, anger and anxiety, and

triggers intestinal discomfort, which in turn leads to an internal unbalance in the female body[26,28]. These considerations could explain, at least partially, the fact that women with no paid work are more likely to be affected by these conditions.

The perception of the individual about their own health is important, whether they have a disease or not. The feeling of wellbeing transcends the presence of problems, despite having well-established relations to the clinical conditions and to the morbidity and mortality indicators19. Therefore, wellbeing should be constantly monitored, since it tends to be substantially prejudiced by chronic diseases and emotional problems. Regarding these indicators, evaluated in this study, it was found that most women (with or without paid work) consider their quality of life to be Good/Very good and were Satisfied/Very satisfied with their health and their sleep, and did not sleep badly. There was no statistical difference between the groups. Conversely, another research[17] that compared the health-related quality of life of working women to that of housekeepers found that those with paid work had better scores.

Most women (with or without paid work) also were Satisfied/Very satisfied with their performance in daily-life activities, and reported nothing/very little impairment in carrying out their activities due to pain. They did not tire easily and did not require effort to carry out daily-life activities. However, housekeepers were more compromised with regards to these indicators ($p=0.040$; $p=0.013$; $p=0.004$; e $p=0.009$, respectively).

As it can be observed, the WI so far presented indicated that participants were not very compromised, which prompts us to think about why that is so. One of the reasons could be the fear of being away from their usual activities. During situations of crisis, people with common mental health disorders can be put on leave from work or even lose the right to carry out domestic work in their own houses[29]. On the other hand, the fact that women with no paid work had more impairments could be related to the fact that professional work can bring, to women, new experiences, more opportunities to socialize, and can be, in addition, a way to escape the confines of domestic space[30].

Disagreeing with the results that indicated little impairment in the WI presented, most women (with or without paid work) felt nervous/tense/worried. Those with no paid work were more impaired by this ($p=0.009$). The monotony of domestic routine, associated to few opportunities to change, is frustrating to women who seek professional fulfillment and do not seek the object of their desire, be it because of their children or due to the pressure of their husbands. It also stands out that the formalization of paid work is important, since it implies better social protection, the support of laws for workers that guarantee sick-leave pensions, maternity-leave pensions, work-accident pensions, and retirement pensions[31].

The feeling of safety at work is related to a better health[32], and paid work can bring contradictory results that balance positive and negative factors, such as an increase in the stress on one hand, accompanied by improvements in self-esteem and social support on the other. In general, there is a long-running debate about which women are happier and healthier, those with or those without paid work. The results found from international data about women from 28 countries showed that housekeepers were a bit happier than full-time workers, but not happier than part-time workers[33].

However, it should be highlighted that the benefits provided by paid work depend, among other issues, on the position and the socioeconomic level of the woman. Jobs of low psychosocial quality, which include low levels of control over one's job, little demand and complexity, lack of job security, unfair wages, and lack of health benefits, which is not true for high-quality jobs[34].

There is an expressive number of women who presented health impairments and there are difficulties in offering integral healthcare to women, due to structural issues that compromise the quality and availability of health services. That, considering the National Policy for Integral Women's Health Care, which aims to reach women in all periods of life, shows that there are still many challenges to be faced before women are guaranteed a proper healthcare[35].

CONCLUSION

Most women do not have a paid work. Regarding the WI, most consider their qualities of life to be Good/Very good and were Satisfied/Very satisfied with their health and their sleep, and do not sleep badly. There were no significant differences between the different groups of women for these variables.

As for the RM in the genitourinary and digestive systems, the performance of daily activities, the impairment in the performance of activities due to pain, getting tired easily, the necessity of making efforts to carry out daily-life tasks, and feelings of nervousness/tension/preoccupation, the differences between the groups were significant, and women with no paid work were more impaired.

It should be noted that these results are limited by the fact that they were self-reported, which is limiting especially with regards to the morbidities. However, health inquiries carried out in many countries have shown that data found on the prevalence of chronic diseases have presented good reliability when compared to medical records or clinical examinations.

The results presented are extremely important to get to know the profile of working women, offering subsidies for public health policies to invest and develop preventive and curative strategies for this population.

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CONTRIBUTIONS
Isabel Aparecida Porcatti de Walsh acted in design, analysis and interpretation of data, writing and review. **Marina Mendonça Emílio** and **Jéssica Carvalho Lima** contributed in the analysis and interpretation of data, writing and review. **Vitoria Helena Maciel Coelho** and **Lislei Jorge Patrizzi Martins** participated in the interpretation of data, writing and review.

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