Summer Training at
United Nations Children Fund (UNICEF),
Rajasthan
(April - June, 2013)

DETERMINANTS THAT INFLUENCE THE DECISION MAKING POWER OF WOMEN AT HOUSEHOLD LEVEL IN JASOL, RAJASTHAN

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CERTIFICATE

This is to certify that **Dr. Keerti Jain** student of the 17th batch of the Post Graduate Diploma in Health and Hospital Management (PGDHM) at Institute of Health Management and Research, Jaipur underwent the summer **internship at United Nations Children Fund (UNICEF)** from April 6th to June 8th 2013 and performed study on

Determinants that influence the decision making power of women at household level in Jasol, Rajasthan

The candidate successfully carried out the study assigned to her during summer training and her approach to the study was sincere, scientific and analytical.

We wish her success in all her future endeavours.

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IIHMR, JAIPUR

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Acknowledgement

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Acknowledgment

The Success of any task would be incomplete without the expression of gratitude to the people who made it possible. Although words fall short to express sincere gratitude towards everyone who helped directly or indirectly in my endeavor. It is a pleasant aspect that, I now have opportunity to express my gratitude for all of them.

This is two months summer training report from 6 April to 8 June, 2013 in UNICEF Rajasthan. This training would not have been completed without substantial support from great number of people. At the onset of my report I would like to acknowledge my sincere thanks to our institute, Institute of Health Management Research, Jaipur for providing us platform to gain enough knowledge and skills in different aspects of health Management. With full gratitude I express my indebtness to Dr. S. D. Gupta, Director of IIHMR and Dr. Ashok Kaushik , Dean , Health management for arranging our internship at UNICEF, Rajasthan.

I thank my mentor Monika Choudhary for guidance and support during this training.

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Thanking you

Keerti Jain

PGDHM 17 Batch

LIST OF ABBREVIATIONS

- ANM : Auxiliary Nurse Midwife
- ARI : Acute Respiratory Infections
- ASHA : Accredited Social Health Activist
- AWW : Anganwadi Worker
- IEC : Information, Education and Communication
- IPHS : Indian Public Health Standard
- MCH : Maternal and Child Health
- MO : Medical Officer
- NCD : Non- communicable Disease
- NIHFW : National Institute of Health & Family Welfare
- NRHM : National Rural Health Mission
- ORS : Oral Re-hydration Solution
- PHC : Primary Health Centre
- PHN : Public Health Nurse
- RCH : Reproductive and Child Health
- SBA : Skilled Birth Attendance
- SC : Sub-centre
- UNICEF : United Nation Children Funds
- WHO : World Health Organization

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Chapter 1

State profile

Mother India, the vast Subcontinent constituting the world's largest democracy, an intriguingly complex religious and cultural tapestry with her great mercantile classes, sprawling bureaucracies and exploding economy, remains one of the most visually memorable and bewitching journeys ever. Of all her states, Rajasthan is perhaps the most tribally diverse, artistically decorative, architecturally magnificent and regal in India.

Rajasthan known as "the land of kings", is the largest state of the Republic of India by area. It is located in the northwest of India. It comprises most of the area of the large, inhospitable Rajasthan has artistic and cultural traditions which reflect the ancient Indian way of life. Rajasthan- the land of royalty is a glittering jewel set in the golden sands of a barren deserts landscape. The light that reflects off the golden sands engulfs a land renowned for its vibrant colors, people in bright clothes and beautiful jewellery, living in cities dotted and dominated by towering forts and palace that rise from the sands like mirage

The brightness of its life, the legends of its heroism and romance are all captured in the vibrant and evocative music of this desert land. The richness and diversity of Rajasthani music comes from its old and undisturbed tradition. Music which is rich evocative heroic plaintive and joyful governs all aspects of Rajasthani lives. The voices both male and female are strong and powerful. The numerous songs sung by the women reflect the various feminine moods and strong family ties that govern their lives. Splendid monsoon of Rajasthan call for special songs without which no celebration is complete.

The incredible light, the austere and atmospheric landscapes of desert and ancient Aravali mountains, the romance of Rajasthan’s heritage and chivalry, the hospitality and humor of the people whether from regal lineage or simple, dignified desert-dwellers, and their arts and crafts.

From this same sandy tract the world heard the bangs of India’s nuclear test program – first during the regime of Mrs. Indira Gandhi and, quite recently when Mr. Atal Behari Vajpayee as Prime Minister. The nuclear blast that caused a world-hunting polarization of leading nations

was made in an insipid belt of Rajasthan known as Pokhran. Also famous for its painted mud Potteries, Pokhran has become the recent sanatorium if India associated with the pride of its people

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Badmer

Barmer is a district of western Rajasthan state, India. Barmer is the second largest district of Rajasthan. Barmer district is part of the Great Indian Desert or Thar Desert.

In 2006 the Ministry of Panchayati Raj named Barmer one of India's 250 most backward districts (out of a total of 640). In addition to economic challenges & the daily hardships imposed by a life in the desert, women and children in Barmer have limited access to quality health care and counselling services

Balotra is a city in Barmer District of Rajasthan state in India. It is about 100 km from Jodhpur. The town is famous for hand block printing and textile industry and for an annual desert and tribal fair at Tilwara. Apart from economic challenges & hardships imposed by life in desert, women & children in Barmer have limited access to quality healthcare.

Jasol profile

The historical village of Jasol, the capital of the former Malani area ruled by the fiercely independent Mahecha clan of the Rathore Rajputs, includes old Cenotaphs, the temple of Rani Bhatiyaniji, the horses of the indigenous Malani breed are still bred over there. The village was established by the Rathore rulers. The Rathores of Jasol, who are the descendents of Rawal Mallinath, are the eldest amongst all houses of Rathores in Rajasthan. Rawal Mallinath was the eldest son of Rawal Salkhaji, Salkhaji's other two son were Viramdeo and Jaitmal.
Jasol village population is 12,414 according to census 2001, where male population is 6,415 while female population is 5,999

Chapter 2

UNICEF

UNICEF has been working in India since 1949 advocating for the rights of children and young. The largest UN organization in the country **,**UNICEF is fully committed to working with the Government of India to ensure that each child born in this vast and complex country gets the best start in life, thrives and develops to his or her full potential.

The challenge is enormous but UNICEF is well placed to meet it. The organization uses quality research and data to understand issues, implements new and innovative interventions that address the situation of children, and works with partners to bring those

UNICEF uses its community-level knowledge to develop innovative interventions to ensure that women and children are able to access basic services such as clean water, health visitors and educational facilities, and that these services are of high quality. At the same time, UNICEF reaches out directly to families to help them to understand what they must do to ensure their children thrive.

UNICEF also wants them to feel a sense of ownership of these services. That same knowledge and interface with communities enables the organization to tackle issues that would otherwise be difficult to address: the complex factors that result in children working, or the growing threat that HIV/AIDS poses to children.

- ✓ **What makes UNICEF unique in India?**

Is its network of 13 state offices. These enable the organization to focus attention on the poorest and most disadvantaged communities, alongside its work at the national level.

UNICEF knows that key to addressing these challenges are its partnerships with sister UN agencies, voluntary organizations active at the community level, women's groups and donors.

The organization also works with an array of celebrities, including members of the Indian cricket team and leading actors from the Indian film industry, as well as hundreds of thousands of unnamed volunteers who tirelessly give their time and influence to ensure that, together, they are able to help every child realize his or her full potential.

Mission of UNICEF

UNICEF is mandated by the United Nations General Assembly to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential.

UNICEF is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behaviour towards children.

UNICEF insists that the survival, protection and development of children are universal development imperatives that are integral to human progress.

UNICEF mobilizes political will and material resources to help countries, particularly developing countries, ensure a "first call for children" and to build their capacity to form appropriate policies and deliver services for children and their families.

UNICEF is committed to ensuring special protection for the most disadvantaged children - victims of war, disasters, extreme poverty, all forms of violence and exploitation and those with disabilities.

UNICEF responds in emergencies to protect the rights of children. In coordination with United Nations partners and humanitarian agencies, UNICEF makes its unique facilities for rapid response available to its partners to relieve the suffering of children and those who provide their care.

UNICEF is non-partisan and its cooperation is free of discrimination. In everything it does, the most disadvantaged children and the countries in greatest need have priority.

UNICEF aims, through its country programmes, to promote the equal rights of women and girls and to support their full participation in the political, social, and economic development of their communities.

UNICEF works with all its partners towards the attainment of the sustainable human development goals adopted by the world community and the realization of the vision of peace and social progress enshrined in the Charter of the United Nations.

-ASHA project

Empowerment – Automated solution for health advocacy

Introduction

UNICEF travels deep inside Thar desert-Barmer on India's western border. Beyond endless sands is border with Pakistan. Coupled with economic challenges& hardships imposed by desert, women and children in Barmer have limited access to healthcare. The infant & maternal mortality is one of the highest in Rajasthan and it is highest in Badmer district. People in villages rely heavily on ASHA workers to provide counseling on pregnancy and newborn care.

This an integrated package to address many things like to improve quality of counseling at home and during outreach using audio visual videos .Timely identification of danger signs.

In the last month, these community health mobilizers of Barmer have seen a drastic transformation in their role. While the typical ASHA moves around with pen and paper collecting information Barmer's e-ASHA provides quality counseling with the help of fancy android tablets. Technology for Improving Survival and Development of Women & Children

Description

IIT Jodhpur with support of UNICEF has developed a software package for android platform which can provide solutions and can help in improving quality of home based antenatal counseling, postnatal Care, childhood care through integrating all these in one device weighing less than 400gms and easy and is also low cost which can be given ASHA/ANMs. It is envisaged that the package will be developed in such a way that the ANC, Natal and PNC modules are integrated and also data can be transferred automatically to a centralized server (if it is not connected to the internet, then it stores a local copy and waits to upload till it is connected to the data network, this is a useful feature for rural India, where in some cases data networks on

mobile networks may not be available) from where an SMS(Text Message) can be delivered two days prior to next schedule visit both to the mothers and to the frontline functionaries.

- ASHA jasol

Until a few months ago, ASHA Sahyoginis, the health workers of Jasol village in Rajasthan's border district Barmer could be seen lugging a bag full of registers. On their regular visit to track the health record of women in their public health centre area, they had to carry all types of registers. One for pregnant women, another for lactating mothers, newborns, immunization and so on.

Now the scene has changed. Now they walk in smartly with their new-found asset: a tablet PC, under a pilot project " -ASHA" of UNICEF under the guidance of Dr Anil Agarwal health officer UNICEF Rajasthan and the State Health Department. The ASHA Sahyoginis of Jasol village is the first ones in the country to go hi-tech.

The border district of Barmer was chosen for the initiative because a State-level analysis of data revealed a relatively higher infant and maternal mortality rates here. In addition, the adverse geographic and climatic conditions also pose a challenge for health services system in border areas. Funds have been provided by the Jasol PHC to buy 10 tablet PCs for the ASHA Sahyoginis.

The tablet PC has given a new confidence to the Asha Sahyoginis, who have been very quick in learning its use. About 25 health workers have been trained under the project for reporting the health status of women in the Jasol public health centre in Balotara block of Barmer.

The Indian Institute of Technology, Jodhpur two reaearch officer Vaibhav and vikas has contributed towards developing the software for the project. The initial results have been encouraging and hopefully it will be launched in the whole district in future. The health workers

feed all the health information about pregnant women and children in the software designed for the pilot project. When the health workers upload information, they automatically get tips on how to take care of the women. An instant video gives tips on the steps to the followed, or if the pregnant woman or the child needs to be referred to the hospital. When data is uploaded by the health workers, it gets stored in with the IIT and in due course the UNICEF and the Health Department will be able to track the project's success.

The district IEC (information, education, communication) coordinator Vinod Kumar Bishnoi says, "The software is fully equipped with all information on ante-natal and post-natal check-ups, all question-answers on newborns and immunization list. The health workers have to upload the data once, then both the pregnant women and ASHAs get reminders for follow-up, check-ups and vaccinations through SMS."

Sharing her experience with the device, 27-year-old Devaki says that it is a very useful tool. Earlier, they had to try very hard convincing women, mostly uneducated, about the need to have vaccines or the ill-effects of malnutrition on their babies. "Now it's much easier. Once we feed a woman's data, we quickly get detailed information on her health status. We show her the video and she can understand how her low haemoglobin count would affect her health and what should a lactating mother eat."

"It is a mutually educative experience," she adds. Though studied only till Class VIII, Devki can type at a modest speed, though in Hindi. Her elder sister Saraswati and other colleagues are also very happy to be associated with this project. They say: "It is easier to work on the PC than the paper formats. The best thing is when we feed info about a pregnant woman, she may not be able to read it, but can certainly understand the visuals."

Shayar Kanwar, also working at the Jasol PHC for the past eight years, says she is fully enjoying working on the tablet. "We have learnt a lot and the best part is earlier, women used to be reluctant to interact with us. Now they, too, have started taking interest. It is much easier for them to understand their health status. Even their family members can see that she needs better care," she adds.

Objective

To develop android based integral solution to provide services for collecting real time data.

Data is uploaded to a web application and acknowledges messages that are send to both beneficiaries and Accredited Social Health Activist (ASHA)

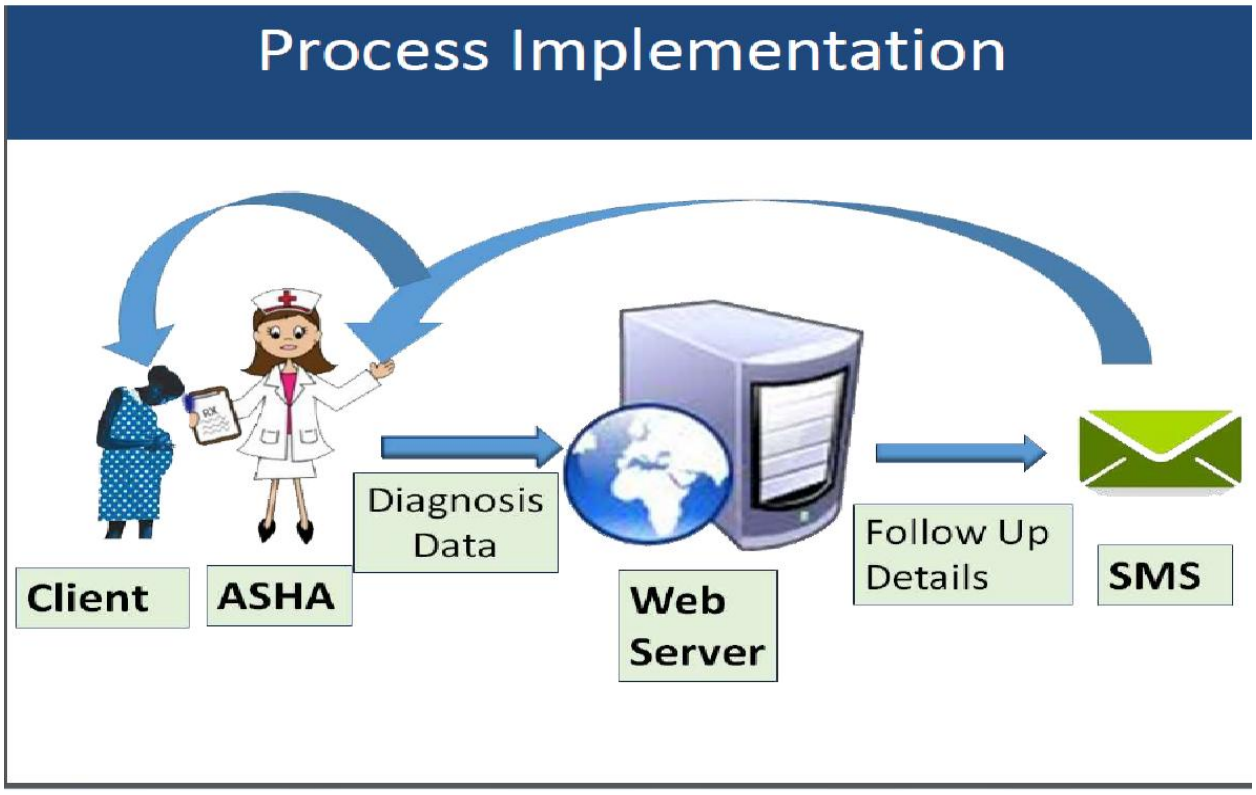
Process description

ASHA screens women and children using a simple tool on android based tablet

Spot counseling through videos and messages using tablet device

The same information also become a data collection tool and information is uploaded to the web server

Server application logs and feedback information to both the ASHA and client vis SMS



Results

- Use of simpler low cost technology which is man portable has improved the quality of counseling.
- Early action and responses can be taken by the help of real time data.
- Identification of high risk pregnancies and sick newborns.
- Direct server digitalization has eliminated human error and reduced overall man hours.
- Recall of messages by the beneficiaries incre

Chapter 3

Determinants that influence decision making power of a women in health issue at house hold level

Introduction and background

In the 21st century, women enjoy more freedom and power than ever before. However, they are still disadvantaged when compared to men in virtually all aspects of life. Women are deprived of equal access to education, health care, capital, and decision making powers in the political, social, and business sectors. Whereas men are credited with performing three quarters of all economic activities in developing countries, women actually perform 53 percent of the work, according to the United Nations. The 1995 UN Human Development Report, states that "an estimated $16 trillion in global output is currently 'invisible,' of which $11 trillion is estimated to be produced by women."

A woman is the nucleus of the family, particularly, in rural India. She not only collects water, fuelwood, fodder and food but also plays a significant role in preserving the culture, grooming the children and shaping their destiny. The status of women in India has been subject to many great changes over the past few millennia. From equal status with men in ancient times through the low points of the medieval period, to the promotion of equal rights by many reformers, the history of women in India has been eventful.[1]

Late Dr. Manibhai Desai always emphasized that although women represent only 50percentage of the total population, they contribute 75percentage to the development of our society while men contribute only 25percentage.

Unfortunately, in spite of their laudable and vulnerable roles, which cannot be substituted by machine or men, women have been neglected since generations. This is happening inspite of a woman being recognized by our ancient saints and culture as not merely a mother but as a superior scholarly Institution. It is said in Manu Samhita (Chapter II, Para 145) *Upadhyaayan-dasacarya acarryanam satam pita; Sahasram tu pitrnmata gauraveratiricyate*. "A Guru who

teaches Veda is 10 times superior to an ordinary teacher and the father is 100 times more than a teacher, but the Mother is 1000 times more superior to the father".

The position and status of women strongly influences their ability to make decisions to realize that potential. Women's position and status is formed around a series of cultural and economic factors such as resource use, ownership, control, legal and ideological structures, and education and information. The status and position of women is reflected by their ability to take decisions in the spending of household income, the quantity and quality of child care they are able to provide, and health-seeking behaviors (including family planning decisions)
Following marriage, a daughter-in-law is expected to perform domestic duties under the supervision of her mother-in-law, who is usually the primary decision maker in matters of child-rearing and care of the family. In addition, in India communities are patriarchal, and property is passed from father to son. Women lag far behind men in education, economic resources and nonagricultural employment.

In instances where women wish to make decisions regarding household consumption, expenditures, or health care, they may need help and agreement from other family members, particularly the husband or mother-in-law, in actually conducting these transactions.
In 1994, at the International Conference on Population and Development in Cairo, development organizations agreed that women's empowerment is necessary for important development outcomes: "the empowerment and autonomy of women, and the improvement of their political, social, economic and health status, constitute an important end in themselves and one that is essential for achieving sustainable development." Gender equality and women's empowerment is necessary for the improvement of women and men's well-being, for social justice, and for the achievement of development goals.
Women are traditionally less involved in decision making at all levels. Their important role is not recognized and, therefore, still not accepted in decision-making. The share of women in community decision-making structure is still very low.
Without the active participation of women and incorporation of women's perspectives at all levels of decision making, the goals of equality development and peace cannot be achieved. [3]
The World Bank (2002) defines empowerment as the "expansion of the assets and capabilities [of individuals] to participate in, negotiate with, influence, control and hold accountable

institutions that affect their lives."[4] Kabeer's (2001) popular definition adds a layer of complexity to the simple component of control and states that empowerment is "the expansion in people's ability to make strategic life choices in a context where the ability was previously denied to them."[5]

In the 21st century, women enjoy more freedom and power than ever before. However, they are still disadvantaged when compared to men in virtually all aspects of life. Women are deprived of equal access to education, health care, capital, and decision making powers in the political, social, and business sectors. Whereas men are credited with performing three quarters of all economic activities in developing countries, women actually perform 53 percent of the work, according to the United Nations. The 1995 UN Human Development Report, states that "an estimated $16 trillion in global output is currently 'invisible,' of which $11 trillion is estimated to be produced by women."

Chapter 4

Objective

The study is undertaken with following objectives:

To study the determinants that influence the decision making power of women in health issues

To assess women's control on their fertility.

To evaluate the level of decision making process among women in the matters concerning their children.

To observe women's empowerment through their decision making power.

Rationale of study

Women play a great role in over all development and progress of the nation. But their participation in different fields either directly or indirectly are still behind in many aspects. In most cases, women are considered inferior to men, and their life is restricted within the four walls of the house. For taking any decision, less power is given to women, as they have the right to take decisions regarding various items, as that of the men. So, in order to make women aware about their influence on society, nation and for attaining their respectable status within the family, the present study was undertaken.

Being a women mother in law has rights to take decision, but in the same family daughter in laws was not given rights. The study was undertaken to determine why this difference prevails in the society.

Chapter 5

Methodology

Study area

The study was conducted on Jasol, a small village situated in Pachpadra tehsil of Barmer district in Rajasthan. Jasol village population is12,414 according to census 2001, where male population is 6,415 while female population is 5,999.

Jasol has Primary health care centre and 6 sub centre.

Maternal Health care services are provided primarily by Primary Health Care Center & a by Community Health centre at Balotra through government program "Janani Sureksha Yojana" & other private hospital which are also providing Maternal Health services.

Study population

Males and females from different areas of Jasol were selected randomly who are married and have atleast one child.

Study design

This was cross sectional household survey, the study employed both quantitative and qualitative techniques of data collection.

Sampling Tools

Questionnaire was designed to assess the decision making power of women, it contains four parts. First part has questions regarding their demographic and socioeconomic information which include questions like age, sex, caste, marital status. Questions like age at marriage, number of children, economic status, education and occupation income related questions.

Second part has questions to judge their decision making power in daily household purchase, their responsibilities and their contribution to income and power to spend the money.

Third part of questionnaire has questions in relation to the health need of the women and children, their freedom to go to hospital, and choice of the delivery place and treatment given to their children. It also contains questions to know how much say a women had in her reproductive health and control over fertility.

Forth part has questions related to judge their say about social issues like equality of women in society, dowry, domestic violence, eve teasing and question related to preference of the baby.

Data collection

Key informants who include ASHA workers, ANMs, Ward sarpanch, famous astrologer and few old ladies were also interviewed to get qualitative data.

Subsequently 150 questionnaires were distributed and respondents were interviewed. The questionnaires where some of the questions were left unanswered were rendered incomplete and were excluded from the study. Thus the final sample as size accounted to 120 subjects (57 males, 63 females)

Data Compilation and Analysis

Collected data were consolidated on SPSS. The consolidated data was re-checked for completeness and accuracy. Data Analysis was done for the quantitative data. The ideas, opinions and attitudes that emerged were noted related to the objectives. Comparison and critical analysis of the ideas led to the findings and interpretations.

Chapter6

Key findings

Section 1

Socio demographic and economic factors of Respondents

Total 120 respondents were interviewed in which 48 percent are makes and 53 percent are females. Majority of the male respondent (32 percent) are in age group of 26-30, whereas majority of female respondent (41 percent) are from age group 21-25 years of age.

Out of all families 30 percent were nuclear families, and the rest are joint families with different number of total member in families.

Forty eight percent of total respondents are from general cast, 33 percent from other backward classes, and rest 18 percent are schedule caste and tribe.

Jasol is a small village therefore 58 percent of household were below poverty line card holder and rest 42 percent were above poverty line.

Ninety five percent of the male were employed and were engaged in occupation like labor, teacher etc, but contrary only 33 percent of females were working and engaged in occupation like labor, ASHA worker etc.

Thirty eight of families have total income below 5000 per month, 32 percent of families have total income of rupees 5000-8000. Only sixteen percent of families have income above 10000.

Only 3 percent of women contribute more than half of the family income. Majority 68 percent didn't contribute to the total family income.

Table 1.1 Socio-demographic and economic factors of respondents

SEX		
Males	47.5	
Females	52.5	
AGE (in years)	**PERCENTAGE (in percentage)**	
	Male*	**Female****
Below 20	0	25.4
21-25	4.9	41.3
26-30	31.6	23.8
Above 30	24.6	9.5
TYPE OF FAMILY		
Nuclear	30	
Joint	70	
CASTE		
General	48.3	
Other backward classes	33.3	
Schedule caste/ schedule tribe	18.3	
HOUSEHOLD STANDARD OF LIVING		
Below poverty line	58.3	
Above poverty line	41.7	
MALE EDUCATION*		
Uneducated	22.8	
till 5^{th}	19.3	
6th-10^{th}	26.3	
11-12^{th}	22.8	
higher than 12^{th}	8.8	
FEMALE EDUCATION**		
Uneducated	42.9	
till 5^{th}	14.3	
6th-10^{th}	33.3	
11-12^{th}	6.3	

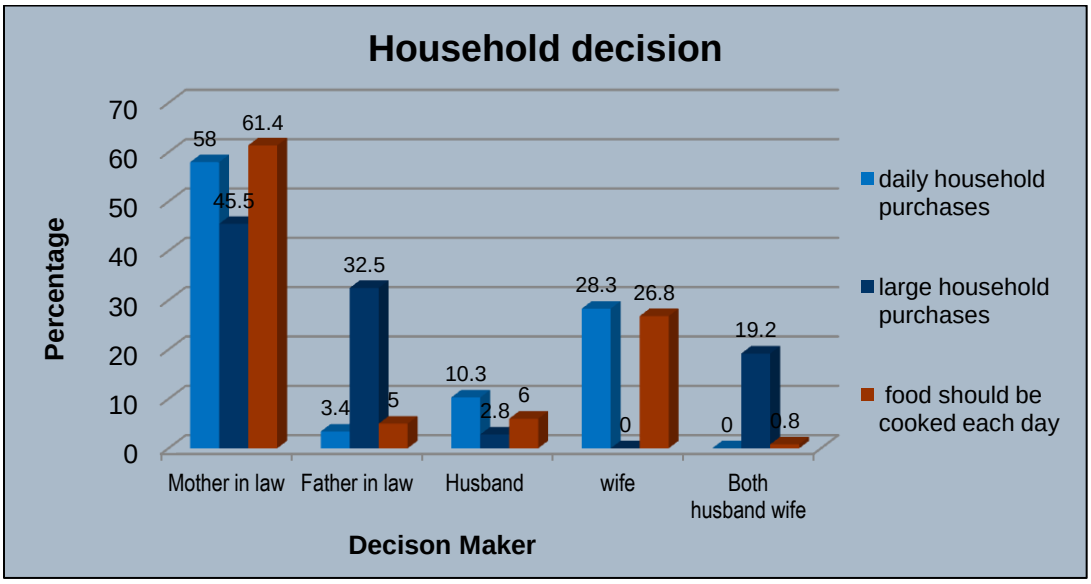
higher than 12th	3.2	
OCCUPATION		
	Male*	Female**
Working	94.7	33.3
Not working	5.3	66.7
FAMILY INCOME		
BELOW 5000	36.7	
5001-8000	31.7	
8001-10000	15.8	
10001-15000	8.3	
Above 15001	7.5	
CONTRIBUTION OF WOMEN TO TOTAL FAMILY INCOME		
None/ Not working	67.5	
Less than half	15.0	
About half	15.0	
More than Half	2.5	
n= 120.* n= 57,** n= 63		

Section 2

Decision taking power in relation to daily household needs

In India, there is a strong sense of family "togetherness" and individual identity is closely tied to the family, so decisions often involve complex negotiations. Measuring whether a woman is involved in the final decision making is therefore a more suitable measure than whether or not she is the sole decision maker. Table 1.2 depicts that when comes to take the decision regarding food to be cooked daily then about 30 percentage of women are sole decision maker, where as only 28percentage of women take decision regarding daily house hold purchases, where as not a single women is found who can take decision regarding large household purchases. But few household (13percentage) were there where all the family members were involved in the discussions and decision making process, where as mother in laws in the family seems to have more rights in decision making. In about half of the household she is a sole decision maker in daily household needs, but the percentage reduces to about 33percentage (only 17percentage) when it comes to take decision for the large purchases.

Figure 1.1 Depicting decision makers of daily household needs



n= 120

Figure 1.2 Effect of family type on women decision taking power

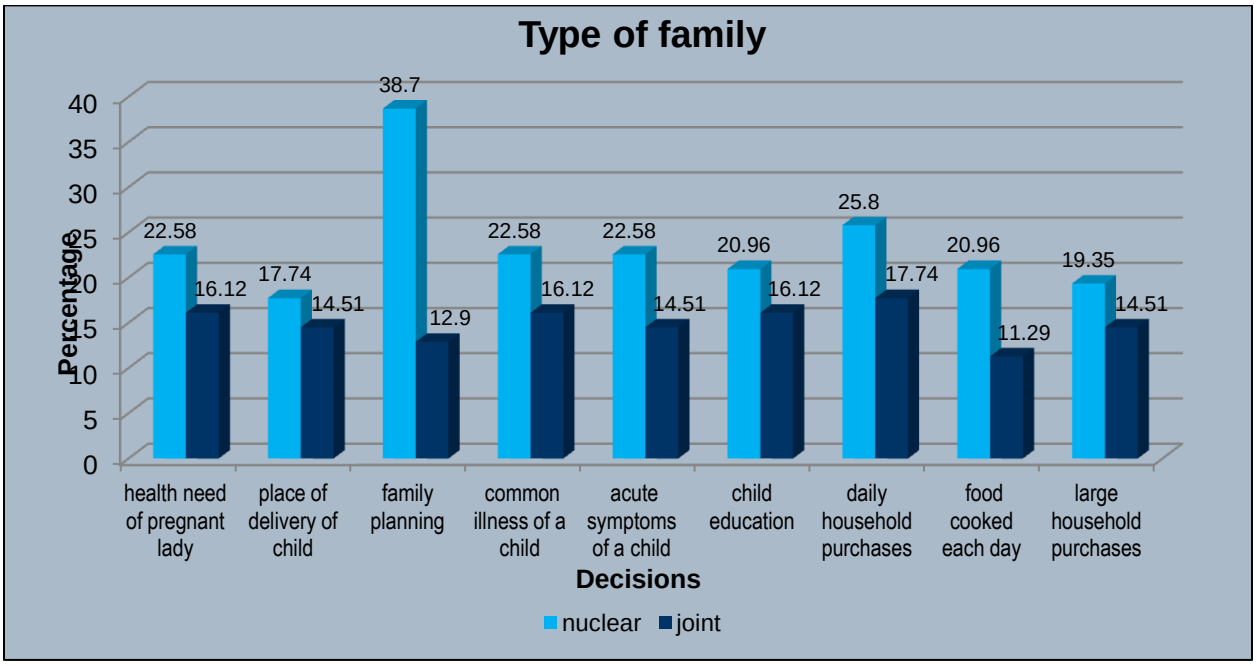


Figure 1.2 depicts clearly that women have very little say have a very little say in decision regarding daily household purchases when they are living in joint family with their elders. Decision making power is significantly high with the wives living in the nuclear family in all the prime decision regarding household level.

Section 3

Effect of economic empowerment on decision making power

Table 1.2 Table depicting percentage of women allowed keeping the money for themselves

Women allowed to keep money for themselves	Frequency	Percent
Yes	94	78.3
No	26	21.7
Total	120	100.0

For women, earning cash is not likely to be a sufficient condition for financial empowerment. Financial empowerment also requires control over the use of one's earnings. In addition, a married woman's ability to convert earnings into empowerment in her own household may also depend on the perceived relative importance of these earnings to the household. When the respondent were asked about the issues related to the financial quotient, like "in their families is it allowed for a women to keep money aside then 94percentage of respondent said yes. (Table 1.1)Among those when the reasons were asked only 26percentage said they can spend and keep money because they earn themselves, 85percentage responded that they have equal rights to keep the money because they are their wives.

Among 26percentage of households where women cannot keep money aside and spend it according to their wishes, 22percentage said females don't have proper knowledge in relation to money utilization and 65percentage respondents think that if there are elders in the family then they have all the right over money earned. Few people said their wives themselves don't want to keep the money etc.

But 97percentage of them said they can keep the money, but have to take permission from either husbands or elders in the family in prior. When women have access to resources, mainly earnings, their bargaining power within the household increases and they have a greater say in decisions related to their health, their children and other family matters.

Figure 1.3 Effect of employment on decision making power of women

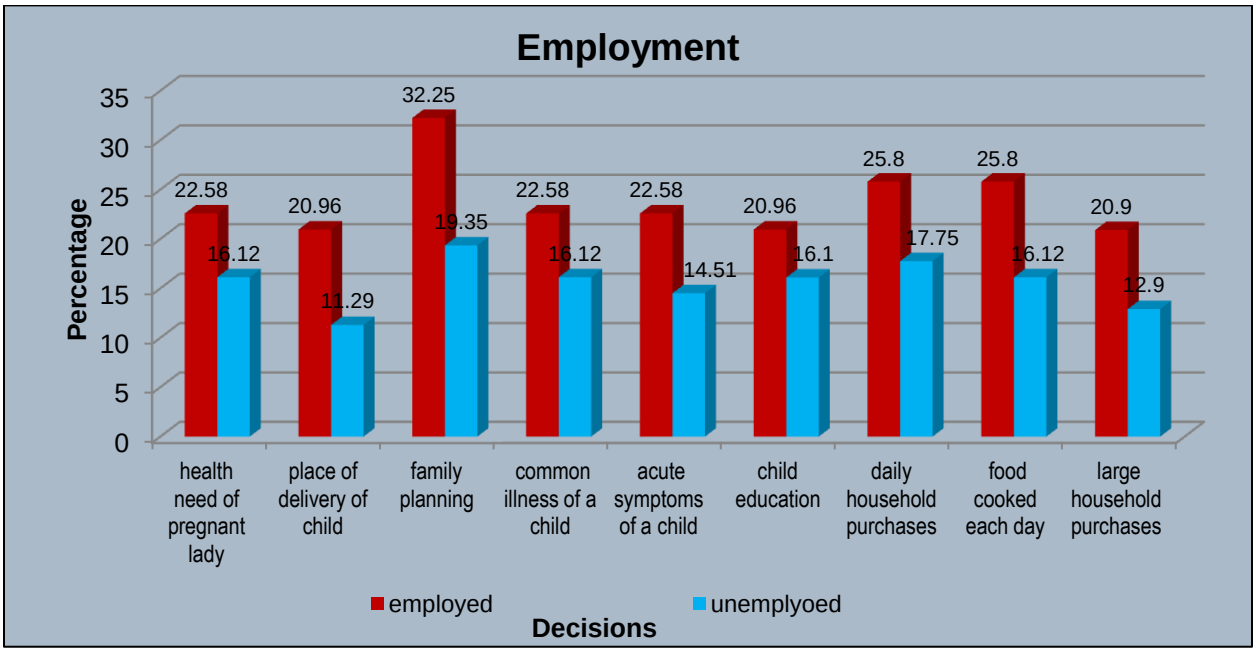


Figure 1.3 clearly shows that women who are employed posses more power of taking all the basic decision regarding household decisions.

Women who are employed have significantly more say in matters regarding family planning; decisions regarding their health issue .There are also a demarked difference in the say of large household purchases**.** Women were asked for their decision when they are employed and helping family economically.

Section 4

Effect of education on decision making power of women

Education is recognized as a major instrument in empowering women. Its help a woman gain a better understanding of her rights and responsibilities. Table 1.1 clearly shows that half of the female respondents are uneducated, 47.6percentage (14.3percentage, 33.3percentage) have completed 6^{th} – 10^{th} class, only few females have pursued higher education. When compared to males in which only 28 percentage are illiterate. When respondents were asked about their perception about women education after marriage than about 62percentage of them think it's good and one should study after marriage. But when it was asked whether you or your wife wanted to study only 28.3 percentage said yes, and only around 17percentage are still studying or had completed their studies.

Table 1.3 Effect of employment on decision making power of women

in percentage, *n = 120 *n ≠ 120(multiple responses)*

Sr no		Yes	No
1	What do you think about women education after marriage	61.7	38.3
2	Do you/ your wife want to continue study?	28.3	71.7
3	If yes then studying? or studied	16.7	83.3
	Reasons for yes*		
a	Education is necessary	44.2	55.8
b	Can help financially by doing job or service	30.0	70.0
c	Self dependent	55.8	44.2
	Reasons for no *		
a	Don't get time from household work and children	57.5	42.5
b	Don't want to study	48.3	51.7
c	No use of education to do household work	64.2	35.8
d	Don't get permission from in laws and husband	10.2	89.8

When reasons were asked for the same 44percentage said that education is necessary, and about 56percentage thinks education makes you self dependent and 30percentage of think it will help them financially and can lead to economic empowerment.

Reasons for not studying were like, 58percentage of respondent talked about the time constraint, they said it's very hard for them to get time from household and children responsibilities, so if they want also they cannot think of studies and school, 48percentage don't want to study because they have never went to school so now also if even facilities are provided they don't want to study. Ironically more than two-third of respondents think there is no use of education in doing house hold work, they can do it efficiently even they are not educated.

11percentage of respondent don't get the permission from either elders or from husband even they want to continue with their studies.

Figure 1.4 Effect of education on decision making power n= 63

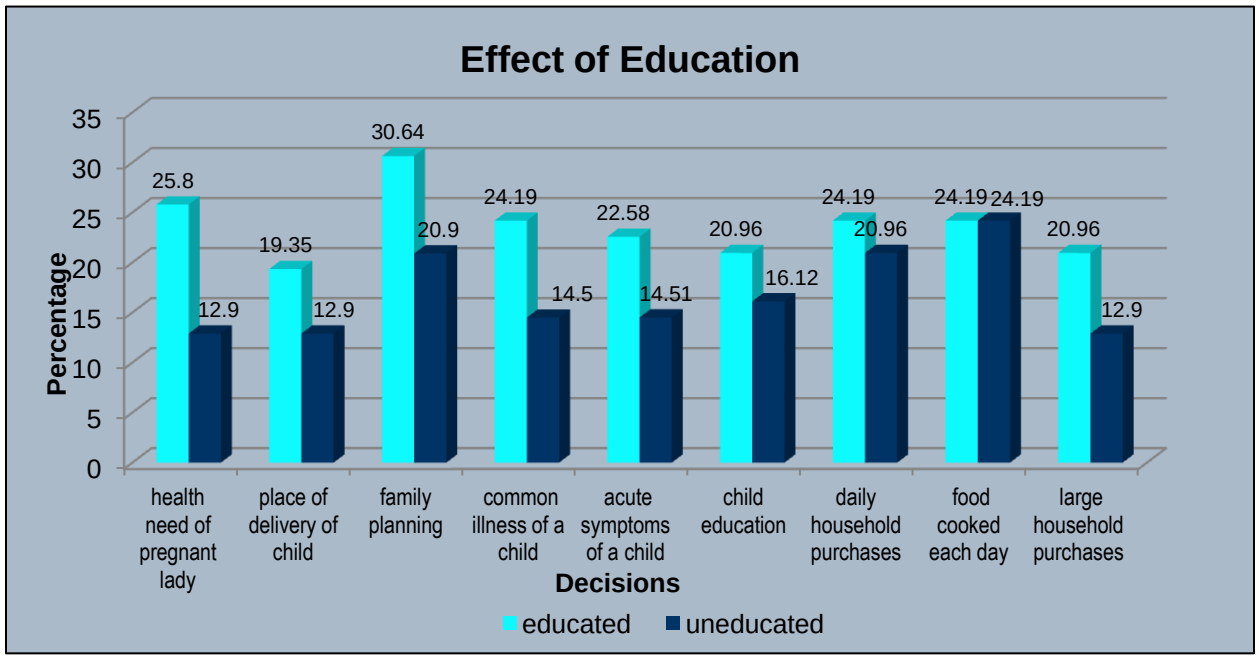


Figure 1.4 clearly shows that educated women has more say and have more power when compared to uneducated women, in relation to their health needs during pregnancy (26percentage) , place of pregnancy (19percentage) , family planning (31percentage), and decision regarding their child health and large household purchases. Whereas there is no

significant difference in decision making power regarding daily household purchases and food to be cooked daily.

Section 5

Decision regarding maternal health

Figure 1.5 Decision maker regarding maternal health

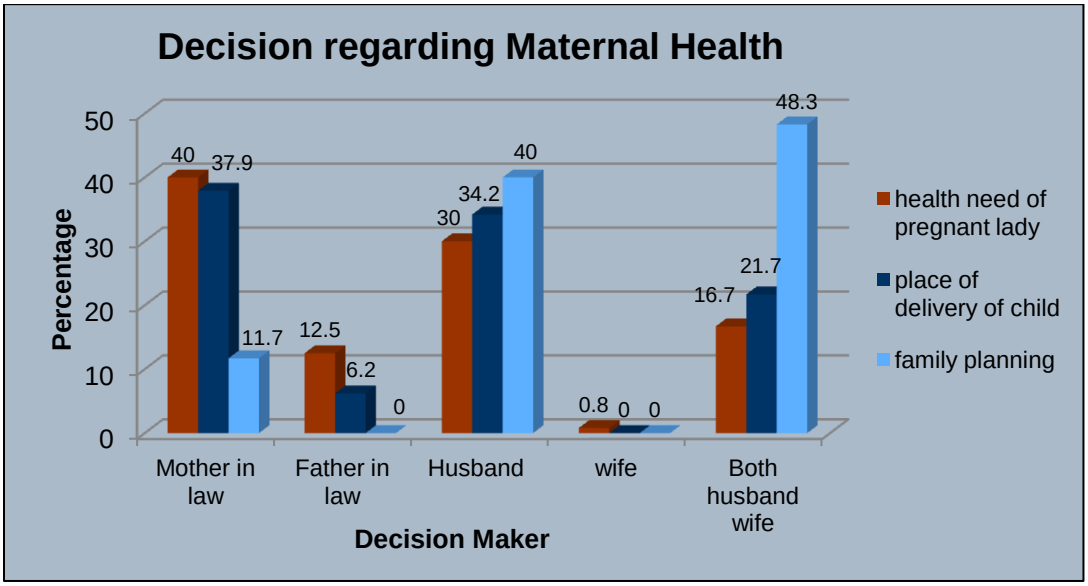


Figure 1.4 depicts that mother in law and husband is the key decision maker regarding health need of pregnant lady (40 percent, 30 percent respectively) and the delivery place of the child (38 percent, 34 percent). Whereas decision regarding family planning in mainly taken by husband (40 percent) or taken jointly by both (48 percent). Wife alone can take almost no decision regarding any maternal health need and family planning.

Figure 1.6 Decision maker regarding child health and education

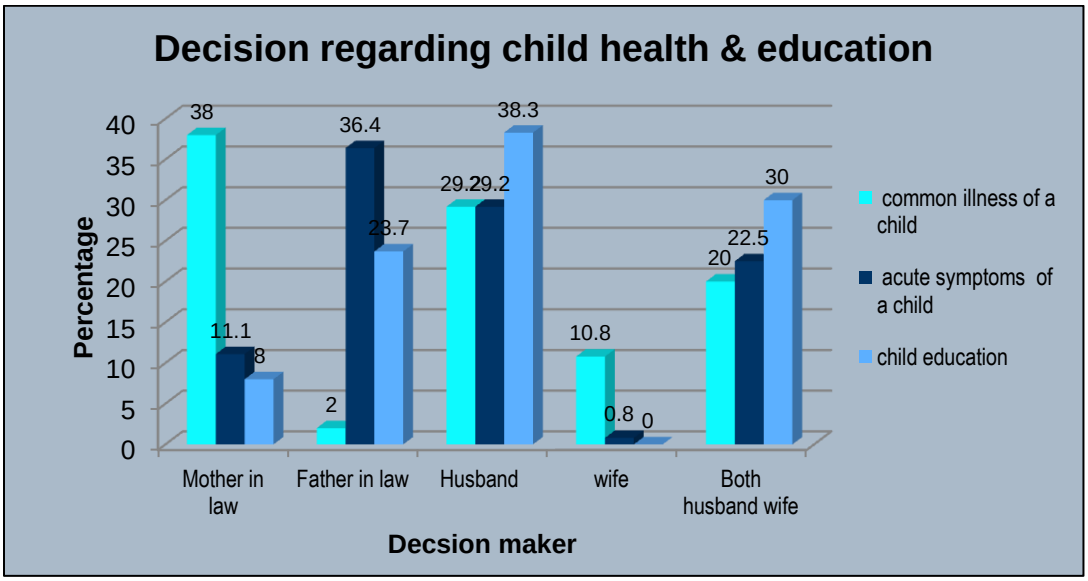


Figure 1.5 depicts the decision maker n relation to children heath and education. Again very few wife (10 percent) can alone take any decision even regarding common illness. Not even one percent of women alone can decide the treatment course in case of emergency acute symptoms, almost none of them can take decision regarding their child education.

Mother in law (38 percent) is again the key decision maker in regard to the treatment given to the child in case of common illness. Father in law takes the decision in the case of emergency conditions. Thirty eight percent of husband takes decision regarding child education.

Chapter 6

Discussion

The cultures of South Asia are largely gender stratified, characterized by patrilineal descent, patrilocal residence, inheritance and succession practices that exclude women, and hierarchical relations in which the patriarch or his relatives have authority over family members, resulting in women exploitation in one or the other way.

Patriarchal kinship and economic systems limit women's autonomy and as a result the health status of both women and children suffers.

Women are the prime targets of programmes that aim at improving maternal and child health and achieving other desired demographic goals. This is not surprising since women are the ones that bear children and are typically the primary caregivers in households. An understanding of the status and empowerment of women in society and within their households is thus critical to promoting change in reproductive attitudes and behaviour, especially in patriarchal societies.

Employment and education of women increases the likelihood of their participating in decision making only if they are employed for cash; in fact, women who are employed but do not earn cash are less likely than women not employed to participate in decision making.

Education is recognized as a major instrument in empowering women. Most of the literature on women's empowerment suggests that education empowers through indirect channels of employment and earnings. The intuition is that when women have access to resources, mainly earnings, their bargaining power within the household increases and they have a greater say in decisions related to their health, their children and other family matters.

Education may help a woman gain a better understanding of her rights and responsibilities, and make her more confident about her possibilities, including the possibility of a divorce, should the relationship with her husband and his relatives deteriorate as a result of her stance in family decisions.

There are important differences in the nature and determinants of women's ability to influence decision within the household based on whether the decisions are financial or social and organizational, and that women who control one of these aspects of family decisions do not necessarily control the other. Most intriguingly, they found that, while education plays an

important role in determining women's input in financial decisions, it is largely immaterial in determining household decisions related to social and organizational matters.

Heaton, Huntsman and Flake (2005), using data from Bolivia, Peru and Nicaragua, confirmed this multidimensionality of decisions within the household and the differences in the determinants of women's autonomy across these dimensions. They concluded that policies designed to change educational, economic, and familial characteristics of women will only have a modest impact on women's overall sense of autonomy.

Many studies have recognized the importance of economic empowerment in improving the status of impoverished women. A study conducted by Lennie (2002) states that "the most straightforward vehicle to 'empower' poor women is to increase their productivity in home and market production and the income they obtain from work." (Kishor *et al.,* 2004) has proposed various strategies to combat these problems, such as increasing women's access to land and other assets. Kabeer(2005) in addition argues that providing security of tenure will encourage more women to use their domestic space for income-generating activities. Other recommendations include investing in human capital such as training for productive employment, providing financial resources with a focus on credit, expanding wage employment opportunities, improving social protection for female workers and empowering women through greater organization.

A common assertion in the literature is that the status of women, low level of education among women, poverty and poor sanitary conditions, high level of fertility and teen age fertility, low level of contraceptive use and low level of utilization of reproductive and child health services are associated with high level of maternal mortality

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Chapter 7

Limitations and Recommendation

There are a number of limitations that must be kept in mind when interpreting the statistical results from this paper. First, there are a number of potential measurement problems. The decision variables are solely the perspective of the respondents and were not validated through interviews with other members of the family or through individual interviews. It is possible, for example, that the respondent says she makes decisions about visits to her family when she is being interviewed in front of her family members or her peers when in reality she has to receive approval of her husband for such decisions. Such behavior could make decision variables overestimates of what they really are. As a result, the decision variables are susceptible to response bias

The respondents used here look at each decision independently thus failing to account for the tradeoff or association each respondent almost certainly must consider as she makes her decision. For example, whether a respondent has some say in decisions related to family visits may in part be dependent on whether she has some say in decisions related to her own health.

Similarly, if a woman is consulted in decisions related to big household purchases, chances are that she is consulted in decisions related to small household purchases as well. A statement such as "two out of four decisions are associated with higher education", therefore, overlooks the complexity of decision making within the household. In a similar vein, the analysis here assesses the relationship between women's say in household decisions and other factors individually. In reality, whether a woman is asked for input on household decisions could be dependent on a complex combination of some or all of these factors.

Despite these limitations, however, this survey provides a useful empirical and statistical glimpse of the major determinants of women's autonomy within the household in Jasol, Rajasthan. Obviously, the government should not divert all its resources from primary and secondary education to higher education based on these findings alone, partly because primary and even secondary education seem to have the biggest impact on other social indicators

but also because poor people in Jasol like in many other developing countries, are the major beneficiaries of primary education and basic healthcare. However, these findings do suggest that the education system in the country may not be creating noticeable awareness about gender equality. The fact that husband's education does not have any statistically significant association

with the probability that his wife will have some say in decisions also testifies to the weakness of the curriculum and/or the pedagogical techniques in cultivating gender awareness among both boys and girls.

In economic empowerment, women's access to savings and credit through collective action gives them a greater economic role in decision making through participation in terms of optimizing their own and the households welfare.

With various women empowerment activities and training, there has been a significant increase in the confidence of women. They have developed mutual trust, social security, skills and access to technology and credit through their Self Help Groups and various People's Organisations. The women groups have motivated the entire community to take up hygiene, sanitation, family planning and health care activities with the community. Several groups have established their grain banks to ensure food security for their members. There has been increased awareness about education for children, particularly, girls. Prevention of child marriage has been an important agenda of many Self Help Groups which has been endorsed by the other sections of the community as well.

Conclusion

Indian rural women have come a long way regarding careers and social standing. Dyson and Moore (1983) have stated that autonomy represents the 'capacity to manipulate one's personal environment,' and that 'equality of autonomy between the sexes implies equal decision-making ability with regard to personal affairs."

For the smooth running of a family, it is very important that equal status and equal power should be given to the basic constituents of family, i.e., man and woman so that they can rear up their children in a better way, and solve their day to day problems for achieving their desired goals. Women possess low decision-making power in their families.

Subsequently, building of capabilities to create awareness, improve their skills, develop leadership and link with technologies, trade, financial institutions and local governments can empower them to take active part in socio-economic development at par with others. Such steps have led the community towards a literate and progressive society, directly benefiting every family and helped to bring the rural women as key players, into mainstream development

In economic empowerment, women's access to savings and credit through collective action gives them a greater economic role in decision making through participation in terms of optimizing their own and the households welfare.

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