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ROLE OF FAMILY LIFE EDUCATION ON DECISION-MAKING ASPECT OF RURAL WOMEN

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Abstract:-In rural areas the women are ignorant about the latest information on different domains of life, which may be due to poor literacy rate of female. One of the indicators of women in family is whether she is given a share in the decision making process. Women carry a disproportion and growing share of economic and domestic responsibility for the family. Inspite of this, they do not have the decision making power to determine when they start a family and at work intervals they have children. Assess to information and for enhancing their reproductive health and family planning choices has been demonstrated to be a major tool for the empowerment of women. In the recent past, there has been a remarkable upsurge of interest in the improvement of quality of family life of rural people. The present study highlights the women decision making power as per their family life aspects. To measures this, a set of questions were framed. Three categories were framed to depict the level of decision-making pattern by subtracting high, medium and low achievable scores. Knowledge on family life was further divided into seven sub-areas i.e. personal hygiene, nutrition and health, family planning, maternal and child care, HIV/ AIDS and physical and emotional health.

Keywords: Decision-making, Knowledge, Family life, Personal hygiene, Child care and Emotional health.

INTRODUCTION

Education is considered as one of the most potent instruments of peaceful social change and also a significant means to develop among individuals ability of self- actualization and self- realization. Women in the family play a pivotal role in improving the quality of family life, as they constitute one third of country economically active population. In the recent past, there has been a remarkable upsurge of interest in the improvement of quality of family life of rural people. Non availability of time due to involvement of women in agricultural sector is another hindering factor in implementation of the gained knowledge, giving no time for their self and family care (Mathu, 2001). Men are generally takes various decisions on family matters. Women are quite often not even consulted because of the feeling among men that women are incapable of expressing their decisions, due to illiteracy among them.

Along with poverty, illiteracy among women cannot be put aside which mean due to lack of education there is lack of awareness among women regarding health and nutrition. Today also, women are careless about their health, no matter whether they are literate or illiterate. Knowledge enables these women to evaluate the situation and make safe choice based on well developed sense of life. It is basically aims at providing information through training on psycho social competency to promote adjustment, decision- making, problem-solving, critical thinking and interpersonal relationship. Decision making helps to deal constructively with decision about our lives. Padmavati (2001) Reveled that fundamental decision making regarding vital issues such as education ,health care, expenditure of income on necessities, comforts and luxuries, marriage of children, investment for permanent assets, earning from the land are all taken by male. Therefore, the women is left with little or no resources except herself situation is worsened due to limited mobility, illiteracy, poor health -care comparatively poor nutrition, fewer opportunities to acquire skills for self improvement, lack of ownership of land, property and lack access to institutionalized credit .Many cultures maintain a traditional patriarchal system in which men are the primary

decision- making in the family and social relationship. The view that family, home and private life is the province of women's authority and concern restricts women's opportunities and subject them to control by men.

MATERIAL AND METHOD:

The study was carried out in rural area of Rohtak and Bhiwani district of Haryana state randomly selecting a total sample of 300 women in the age group of 20-30 years (fig-1).Two village from each district i.e. .Mehraa and Badeshra from Bhiwani and Kanni and Shangi villages from Rohtak district were selected randomly .From each village, 75 women were selected randomly. Assessment was done by self structured knowledge inventory on family life education. Frequency and percentages were calculated to have the level of knowledge on different aspects of family life education.

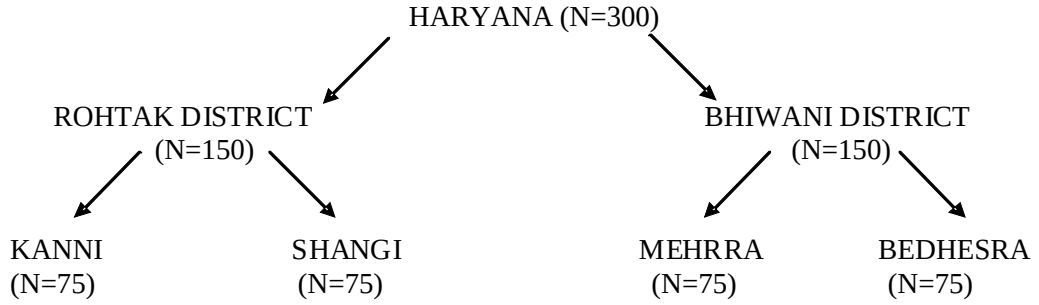

Figure 1. Distribution of samples.

The data were collected through personal visits. Rapport was established with the respondents before conducting the interview. The data were analyzed using the various statistical tools. It has been operational as the degree to which a respondent was involved in various decision related to family life such as, household activities, child care, shopping for children, bathing of children and education ,health care, expenditure of income on necessities, comforts and luxuries, marriage of children, investment for permanent assets other activities and various type of decision making pattern. To measures this, a set of questions were framed. Three categories were framed to depict the level of decision -making pattern by subtracting high medium and low achievable scores.

Development of Inventory for decision- making

Table 1:Inventory for Decision –Making

Categories	**Code**
Low (20-40)	1
Medium (41-60)	2
High (61-80)	3

Regarding the decision-making power, the table Indicates that almost equal percentage of respondent from both districts were involved in decision making followed by low, medium and high involvement.

RESULT AND DISCUSSION:

Respondents involvement in decision-making pattern.

Table 2 indicates that the district wise comparison shows that the respondents of Bhiwani district were slightly more involved in decision making pattern as there were 46 percent respondents who had low involvement followed by 28.67 percent and 25.33 percent with medium and high involvement respectively.

Table 2: Respondents involvement in decision-making pattern.

Variable / **Decision making**	Bhiwani N=150	Rohatk N=150	Total N=300
Low (20-40)	69(46.00)	72(48.00)	141 (47.00)
Medium (41-60)	43(28.67)	41(27.33)	84 (28.00)
High (61-80)	38(25.33)	37(24.67)	75 (25.00)

Figures in parentheses indicate percentages

Where as 48 percent respondent of Rohatk low involved followed by (27.33%) and (24.67%) involved On the whole it can be said that almost equal percentage of respondent from both the districts were involved in decision making pattern.

Family life education knowledge on the basis of Decision-making pattern

Perusal of the data in the table 3 gives the distribution of respondents for their knowledge on family life education the basis of decision making pattern. The table highlights that for personal hygiene aspect, the highest percentage (52.00) of respondents who was highly involved in decision making had low knowledge followed by moderate and high knowledge. Respondent of medium decision making category were better than the low decision making groups as their were approximately 70 percent respondents from the medium decision making power in moderate to high knowledge category against 53 percent from low decision making category.

Regarding the knowledge on nutrition and health the table shows that from low decision making power category there were 46.10 percent respondents in low knowledge category and equal percentage in moderate to high knowledge category (26.95 %). Further the distribution of respondents with medium decision making power, points out that 50.00 percent of respondents were in low knowledge in this aspect and 50.00 percent were in moderate to high knowledge categories of the respondents who were highly involved in decision making, 50 percent had moderate knowledge followed by low (38.67 %) and high knowledge (10.67 %).

Results on genders sensitivity indicate that almost all the groups had similar knowledge. There were approximately 54.00 percent respondents in moderate to high knowledge categories from low decision making pattern followed by 53.00 percent from medium and approximately 55.00 percent from high decision making category.

Table 3: Family life education knowledge on the basis of decision-making pattern

Aspect of knowledge	Decision-Making			Total N=300
	Low n=14	Medium n=84	High n=75	
Personal hygiene				
Low (12-20)	67(47.52)	25(29.76)	39(52.00)	131(43.63)
Moderate (21-28)	52(36.88)	31(36.90)	20(26.67)	103(34.33)
High (29-36)	22(15.60)	28(33.34)	16(21.33)	66(22.00)
Nutrition and Health				
Low (13-21)	65(46.10)	42(50.00)	29(38.67)	136(45.33)
Moderate (22-30)	38(26.95)	22(26.20)	38(50.67)	98(32.67)
High (31-39)	38(26.95)	20(23.80)	8(10.67)	66(22.00)
Gender sensitivity				
Low (10-16)	65(46.09)	40(47.62)	34(45.33)	139(46.33)
Moderate (17-23)	57(40.42)	30(35.71)	31(41.33)	118(39.33)
High (24-30)	19(13.47)	14(16.67)	10(13.33)	43(13.33)
Family planning				
Low (9-15)	70(49.65)	35(41.67)	32(42.67)	137(45.67)
Moderate (16-21)	54(38.29)	25(29.67)	36(48.00)	115(38.33)
High (22-27)	17(12.06)	24(28.67)	7(09.33)	48(16.00)
Maternal and Child care				
Low (23-38)	68(48.23)	33(39.28)	35(46.67)	135(45.00)
Moderate (39-54)	33(23.40)	44(52.38)	23(30.67)	101(33.67)
High (55-69)	40(28.37)	7(8.34)	17(22.67)	64(21.33)
HIV/AIDS				
Low (8-13)	53(37.59)	32(38.09)	39(52.00)	124(41.33)
Moderate (14-19)	53(37.59)	30(35.71)	18(24.00)	101(33.67)
High (20-24)	35(24.82)	22(26.20)	18(24.00)	75(25.00)
Physical and emotional health				
Low (8-13)	60(42.55)	43(57.20)	23(30.67)	126(42.00)
Moderate (14-19)	42(29.79)	23(27.38)	32(42.67)	97(32.33)
High (20-24)	39(27.66)	18(21.42)	20(26.67)	77(25.67)

Figures in parentheses indicate percentages

Regarding family planning knowledge, table 3 indicates that 49.65 percent respondents of low decision-making category were in low knowledge followed by 38.29 percent moderate and 12.06 percent in high knowledge categories. Almost equal number of respondents from medium and high decision making pattern categories had low knowledge. More percentage of respondents who were highly involved in decision making and moderate knowledge (48.00 %) as compared to those whose decision making pattern was medium (29.67 %). High knowledge was possessed by those who were in medium decision making category (28.57 %) in comparison to low and high decision making groups.

Regarding the knowledge on maternal and child care aspect, it was found that the respondents with medium level of decision-making power were better as there were 52.38 percent in moderate knowledge category followed by low and high knowledge. Data of high decision-making pattern highlights that there were 46.67 percent respondents in low knowledge category followed by moderate (30.67 %) and high knowledge categories (22.67 %). The distribution of respondents in low decision-making pattern pointed out that a high percentage (48.23 %) was in low knowledge category followed moderate and high.

Table further points out that the respondents with high decision-making power had poor knowledge about HIV/AIDS as there were 52.00 percent respondents in low knowledge category followed by equal percentage (24.00 %) in both moderate and high categories. The respondents of low and medium decision-making category were almost equally distributed in the three levels of knowledge. The results are also supported by national family health survey 3 (NFHS-3,2005-06) also show that young people poorly informed on issues related to HIV prevention only 28 percent of young women and 45 percent of young men in the age group 15 to 24 had comprehensive knowledge about HIV/AIDS. Another study by Rani and Rao (1995)

With regard to physical and emotional health knowledge, 42.55 percent respondents with low decision making power and low knowledge followed by moderate and high knowledge. Similarly, 57.20 percent respondents with medium decision making power had low knowledge followed by moderate and high knowledge. The trend was slightly different for respondents with high decision making power. The percentage of respondents from this category had moderate knowledge followed by low and high knowledge. Kaur and Goyal (2008) in their study showed a definite link between low status of women and deficiencies in knowledge and utilization of preventing health services.

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