WORK FAMILY BALANCE – A STUDY AMONG MUSLIM WOMEN MEDICAL PRACTITIONERS IN KERALA

Thesis Submitted to
Mahatma Gandhi University, Kerala
In partial fulfillment of the requirements for the award of the degree of
DOCTOR OF PHILOSOPHY

in

SOCIOLOGY

Under the faculty of Social Sciences

By

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ABSTRACT

Medical doctor is a high paid profession as well as a prestigious and status oriented position in any society. It is fulfillment of long cherished dreams and result of extreme hard work. Academic qualifications along with a number of related and supporting factors help one person to be competent in this field. A popular doctor is one who has the skill, practice and acceptance among his patients. It further enhances his/her responsibility and challenges the ability to maintain quality in such a competitive field. Muslim, a follower of Islam religion is comes under the strong structural and functional framework strongly directed in all spheres of life from personal to professional. The dual role of women as doctor by profession and powerhouse of the family is a herculean task. Both place different demands and expectations which contradict each other. The two fulltime roles of professional responsibilities and expected cultural behavior tend to open a situation of over burden which becomes a potential source of tension, inner conflict, and dilemma especially professions like medicine which require a lot of time, energy, attention, preparation and concentration. All these conditions added with religious and cultural spices lock the individual within a circle which sometimes burn or blast the system. In such a situation the personal achievements like education and employment may trouble the individual instead of empowering them. Change in status and recognition as contributing members does not guarantee them life satisfaction and may results low self-esteem. Imbalance in the work and family domains turn the conditions negative for the individual and it may reflect in wider society through his personal relations as a member of society and professional relations as a responsible doctor. For any women dual role performance becomes relaxed and develops self-esteem if supported by men and materials. Presence of a network of all the supporting factors equates her efforts with success. The family, especially husband is probably the strength and support by sharing worries and works. Such a situation is under question because male dominated pockets still existed in all sectors in our society.

Keywords: Work-family balance, empowerment, self-esteem, women medical practitioners, Muslim, dual role, support system, marital satisfaction.

Chapter I

INTRODUCTION

"Taking care of patients is not a job it is a calling"

"Woman is the full circle. Within her is the power to create, nurture and transform."-Diane Mariechild. Women constitute almost half the human race. Woman is the heart of human existence on this planet. She plays an important role in the society, but her importance and roles are underestimated all over the world. In the 21st century majority of poor women are home makers. The elementary reason for this suffering is illiteracy and this creates a hindrance for the women to earn their livelihood through dignified ways. Educational and social backwardness not only adds to the problem but makes it impossible for the women to work outside. According to all these views women are supposed to remain at home, where they get very little exposure. Women live in poor conditions, but there is a ray of hope in this fast changing world. It has been identified the necessity to educate the women for empowering them.

The rising cost of living, increasing expenses on education of children, increasing cost of housing and property force every family to look for ways and means of increasing the house hold income. As a result women in India who earlier were mostly home makers are forced to go for jobs and taken up careers. Education and employment are the two basic tools which could change the economic and social status of females in the present society as well as over a long time.

Women have been, for ages stick on stereotype roles which provide them comfort and less risk. These are mostly unorganized and unskilled in nature like clerks, receptionists, telephone operators etc. The categories of skilled jobs suitable for girls were teachers, typists and nurses. But the hike of education among women and their massive entry in to employment turned the nature of women's employment. Almost all fields of profession even labeled as masculine which involves high risk and challenge, started to enter by women. Now the movement of women from inside the house to outside world had taken the tangent as moving from low profile to high profile occupations.

Increased participation in nontraditional works created new complexities for women. Medicine is the most profitable and one of the oldest most prestigious professions for the upper class women in India. As the society moving towards complexity, this field also becomes more challenging. The complexities of modernity added the already existing risks like long hours of work, night duty etc. But it keeps attracting more and more women with its magnetic fame and appeal.

While women are expanding that their role in life to include a career, they still have to maintain their traditional role at home even if she receive good monetary benefit and social respect. Women remain the primary care takers of the family, and are also the primary caregivers for the elderly. She has to be a super woman to satisfy the needs of every member of the family.The role conflict is an important issue of working womenleading through new paths of complexity.

The key factor determining the status of women in the world's societies is their level of economic power. Where there women's power is high; theyare able to translate this power into relatively high status; conversely, where the economic power is low their overall social status is almost invariably low. In other words, enhanced female economic power is regarded as the prime factor in reducing gender inequality. Increased income and its control by women give themself-confidence, voice and veto in household decisions and control their life options. "Women's Economic Empowerment is the "magic portion" of the development" (Blumberg 2005). The possession of economic power by women means more than simply the capacity to translate this power into high status, positive regard and respect for them on the part of men; it means an overall capacity to manage their own lives in ways relatively free from male control.

Usually, when one tries to fulfill the responsibilities of roles in both domains meticulously, there arise conflicts. Limitations including time constraints, social perceptions and treatments, personal capabilities etc. are the most common reasons for such conflict.

Historical Perspective

The studies on women in India reveal that there were different phases of rise and fall in their status in the society and home. In Vedic period women enjoyed the status of equality with men in term of social freedom, education and other rights. But with the passage of time their condition deteriorated in a male chauvinistic society. In the present social and economic environment

women are not treated on equal parameters with the males especially regarding issues like having authority in the family, property rights, employment opportunities social and security aspects. A strong patriarchal society with deep rooted socio-culture values continues to affect gender equality and women's empowerment. With time Indian women have evolved under the British rule as well as in the independent economy due to various cultural and economic experiences. Now they participate fully in areas such as education, sports, politics, media, art and culture, service sectors, science and technology etc.

The dawn of the 21st century has been marked by a transformation in which knowledge has become the central focus and driving force of human development, and pushes the boundaries at a dramatic speed and across a board range of activities irrespective of sex. This trend transforming the industrial world towards knowledge based society at a rate far greater than that of the replacement of an agrarian with an industrial society in the late twentieth century. Women find space when knowledge assuming a greater role in the economy consequently when the demand for skilled labour has increased.

The transformation process into the information or the knowledge based society is the leading influence on innovation and development programmes for the future. It will effect human development in many ways such as intense global competition, liberty in decision making processes, the concepts of equality and diversity, increasing degree of freedom of choice by the individual. It is changeable over time and encompasses economic, social,

political and cultural attributes and opportunities associated with being women or men.

The absence of women in the "knowledge domain" of society will provoke existing gender inequalities and its socio-economic outcomes. Women's empowerment through science and technology has probable to enable them to realize their potential and shape their life in accordance with their aspirations.

Work Family Balance

Work-life balance is a concept, which mainly includes proper prioritizing the task between "Work" and "Family". It requires attainment of equilibrium between professional work and personal work. The issue of work-life balance was earlier raised in U K by the working women during the 1960s and 1970s. During the mid1980s, the issue was also taken into consideration by the US government, as result in1990; US confirmed the recognition of work-life balance as a main human resource management issue (Bird, 2006). Job satisfaction is an important component of life satisfaction can only fulfill if employees can accomplish stability in their work and family life.

Work-family balance is the lack of opposition emergesbetween work and other life roles. It is a state of equilibrium in which equal demands of personal, professional and family life. Work-family balance consists of flexible work arrangements that allow employees to carry out other life programs and practices.

In our society, balancing work and family life has become increasingly challenging, as more women assume the nontraditional 'breadwinner' role but at the same time are expected to retain their 'caregiver' or 'homemaker' roles.

Continued inflow of women into the labour market has significantly changed the profile of the labour force. It has result a modification in many women's responsibilities and priorities, as well as in acquiring new attitudes toward work and altering roles. Employers are also facing new challenges in their approach to people management to extract maximum output.

Having work family balance is the most challenging issue faced by employed women now a day. With the increase in work pressure and advancement in technology the nature of working needs have increase. On the other hand, personal life can also be demanding if have a kid or aging parent. Due to modern and complex changes, family demands more from women. Females in the workforce are growing now as a significant and ongoing pressure group.

Medicine is a competitive and demanding field that requires steady devotion and constant sacrifices. On the one hand, woman wants to be an excellent clinician she puts her patients first; on the other hand, she wants to be a mother she plays an active role nurturing her children. Although many women have navigated this territory, it remains challenging due to the tremendous pressure and time demands on women working in medicine, particularly in the competitive, male-dominated specialties like Surgery, Neurology, Anesthesia and Cardiology.

Balancing family and career is something most of the working mother struggles, regardless of what they do. Many physicians spend more than standard 40-hours work per week. Definition of what work time means is complex in modern medicine. Typical physician duties largely include patient contact, charting, teaching, meetings, administrative duties and community outreach activities. And with the addition of mobile technology, work time can easily creep into life time. Medical practitioners spend 60 hours at work or doing work at home. There is mandatory time for sleep, have food, hygiene, and exercise, leaving the remaining time for others depend on individual needs.

Work-family balance of married women medical practitioners is different from other married professional women. Many female physicians reduced their working hours to accommodate family matters (Frank et. al., 2000; Verlander, 2004). This is acute at the period of their mid-career, where family and caregiver responsibilities are greatest.

Higher percentage of female physicians, in the early and middle stages of their career, can be found in less risk areas like family medicine and general practice medicine. This flexible structure of the primary care practice allows female physicians to work reduced hours so as to accommodate their responsibilities in the home (Verlander, 2004). Workload efficacy, as well job, career and work-life satisfaction generally rises with career tenure and female physicians work fewer hours per week than their male counterparts. Perhaps the strategy of working fewer hours will allow them to better “manage " their workload and " balance " their work and home commitments (Verlander,

2004). At the middle career stage, female physicians report a much lower level of workload efficacy and satisfaction with their work-life balance compare to the early stage of their career.

The perception of success and its determinants are correlated with gender norms that prescribe responsibilities and obligations in the private domain to women and those in the public domain to men. Responsibility related to household is one of the main career obstacles faced by women (Heath, 2004). An American review underlined the importance of the family–work relationship and its impact on decisions about their personal and professional life (Verlander, 2004). It has been found that success of females is influenced by family factors and balance between family life and work life (Shollen, Bland, Finstad, & Taylor, 2009; Verlander, 2004), which have been identified as a great influencingforce in the perception of success by women than by men (Dyke & Murphy, 2006; Markus, 1990).

Decision Making

According to Opare (2005), decision making is "the ability if any group of people or representatives to participate in decisions not only affects their lives by contributing ideas, but also provides opportunity to reshape, redirect the outcome of certain activitieswhich are crucial in the future". The term women empowerment is defined by many scholars as their achievement of decision making power. Devi (1979) put forward four variables to assess the changes in status of employed women, such as the extent of power of decision-making in family, freedom inspending, help received in household

responsibilities and deviations from traditional customs. Employment contributes significantly to the social status of employed women. Empowering people means encouraging them to become more involved in the decisions and activities that affect their job (Smith 1996). Empowerment understood as taking responsibility, achieving self confidence and exercising decision making (Warren and Gielnck (1995).

Education, employment and economic freedom enable the women medical practitioners to participate actively in decision making process. It is a composite of access, capabilities and actions that shape whether women have influence over the decisions about their work and family matters. Employed women in general have the power in family decision making as an active economic contributor of the family. Women's lives are deeply embedded in the household and family and their position cannot be analysed outside of this primary social institution. Family is running according to a number of decisions taken by the members. A woman with due importance in family decision making can better be accepted by the society or she can convert her power in decision making into other spheres of life including profession. Economic decision making is an area alien to women till she entered into the scene as a contributor. Above all, the power to decide or control over her body and decisions on sexual matters are the achievements referred as turning point in this regard. This help her to develop self-esteem so that become more productive in her familial and professional roles

Muslim

A Muslim, also spelled Moslem is an adherent of Islam, monotheistic Abrahamic religion based on the Qur'an- which Muslims consider the verbatim word of God as revealed to prophet Muhammed. With lesser authority than the Qur'an, there is hadith, leadings and practices of Prophet Muhammed as recorded in traditional accounts. "Muslim" is an Arabic word meaning "one who submits to God". Muslim believes that there is only one true God who is referred to with the name Allah (Rizvi 1984).

The religion of Islam is the second largest religion in India, comprise 14.2% of the country's population (census 2011). Muslims in India are socially, economically and politically backward community. This backwardness is evident as widespread illiteracy, low income, irregular employment and under representation in higher employment categories, high incidence of poverty and so on with a low level of human development. Muslims were late to join social transition, especially in the attainment of education. This backwardness in education has a negative reflection on the standards of social and economic life, defined in terms of asset ownership, employment structure, marital status, assistance received from financial agencies etc. (Kareem, 1989).

Public perception about Muslim women are unequal and oppressed who needs to be identified, challenged and addressed both within the Muslim and wider communities. Muslim women can found the change to balance multitask and tackle the different challenges facing today. Hence, there is a need to empower and strengthen the leadership among Muslim women in different

levels of their life so that they can proactively support those who are vulnerable and use their power, knowledge and skills to support other women in the same community through individual and collective efforts (DCLG, 2008).

Muslims as the largest religious minority community in India is invariablyempowered to access the positives of development and the fundamental rights guaranteed in the constitution (Sachar Committee Report, 2007).Traditional conservative thinking and patriarchy of the society results low level of empowerment for the Muslim women. Further, better socio-economic statuses brought better empowerment of Muslim women.

In the twentieth century, the history of Muslim educational institutions in the State starts from the 15 annual meeting of the All India Muslim Educational Conference of 1901 held in Madras, presided over by Justice Badun. Even the emergence of Aligarh Muslim University was the result of many Educational Conferences, which were held in various parts of northern India. In the Madras Conference, a large number of socio-religious and educational activists actively participated in the meetings and visualized its visions. As a result of this, Muslim leaders of the South took the initiative to form an organization viz. South Indian Muhammadan Association to promote general education among the Muslims in Kerala (Kurup 2014). Similarly, many scholars from different parts of the State took various steps. It led to the foundation of a series of community organizations in the respective regions with the object of establishing educational institutions.

Kerala ShashtraSahityaParishat (KSSP) found 57.2 percent of home makers among Muslims in Kerala, a high rate compares to women in other religious backgrounds and districts. The finding points out the nature of work participation of women in the 'Developed State Kerala'. Previously, it can be noted from the study that Muslim women were limited their spheres within domestic and community, in comparison with the women from other religious backgrounds. Kerala is a socially progressive state with high rank in Human Development Index (HDI) than all. The Muslims in Kerala are estimated at around a fourth of the state's population, who are addressed as the well-educated Muslims in the country (Census, 2011). However, Muslim women have been largely silenced and sidelined from the national mainstream (Sachar, 2006).

The structural disabilities on Muslim women are present in the spheres of education, economy, social and political life. Present situation has been changing tremendously because of several factors. Women empowerment can be visible in girl's education, autonomy freedom of movement, to go to hospital needs, to purchase, to visit bank for cash transaction etc. are the noted achievements. All this happened in a short span of time due to gulf migration of their family members or husbands and the presence of Muslim reformist movements like NadwatulMujahideen and Jama' at-e-Islami which floated their own women's organizations that may targeted to new awareness and awakening among Muslim women. Major political party in Kerala, Indian Muslim League (IUML) launched its women's wing.

Women in Kerala enjoy a better socio-economic status compared with their counterparts living in the rest of the country. But it does not mean that there is a fair uniformity in socio-economic status of women among all religious groups. The socio-economic conditions of Muslim women in Kerala are generally in the path of progress when compared with women in other states. Recently, there are remarkable shifts in the educational aspirations and attainment in Malabar region especially in Kozhikode and Malappuram districts. The roles played by religious movements are instrumental in changing the outlook of the Muslims towards education and employment. The setting up of a number of institutions for providing education varies from primary to collegiate both in public and private sectors also changed the attitude of Muslims towards education.

There is a silent but remarkable demographic transition happening in the Muslim population in Kerala, and more significantly, among Muslim women, who are getting more and more empowered like women from other communities. (Thomas Isaac, 2013). Before fifty years the community had low social and health indicators, especially in many areas of Malabar region. But today things changed a lot in the community.

Islam encouraged education especially religious education among women. In a 2013 statement, the Organisation of Islamic Cooperation noted that there is a restriction of education in many Islamic member nations for girls. UNICEF observed that out of 24 total nations with less than 60% female primary enrollment rates, 17 were Islamic nations; more than half the adult

population is illiterate in several Islamic countries, and the proportion reaches 70% among women. Other scholars also claim thatIslamic nations show the world's highest gender gap in education. Muslim girls in particular have high dropout rates, especially after tenth and twelfth standards. Most Muslims families are just waiting for their girls to turn 18 before marrying them off due to pressure of early marriage norm.

The norms and customs were originally intended to protect women and even guarantee women autonomy; they have become instead instruments of exploitation. 'If everyone know the status of a muslim women in Islam even the men would want to be women' comment by Dr. Adeela Abdulla IAS, Collector Alapuzha. She also said that women can put extra effort to dilute or cool off core issues in the society. Even though we are under limited circumstances the fire of change could start from within us and need to spread out. Those who succeeded in their struggle to overcome the barriers come forth in cherishing their dreams are not at all empowered in their individual point of view but inspire many from the similar social and religious background to come forward to break the traditional and uprising shells of threats.

Educationally, Muslims are one of the most backward communities in the country. Muslim girls and women lag behind their male counterparts and women of all other communities. While more young Muslim women are enrolled in higher education than ever before and are apparently more successful inclearing board examination, undergraduation, post graduation including professional courses than Muslim men. Even a number of Muslim

women sign on for Ph.Ds. Education and employment prepare the Muslim women to be a change agent.

Muslim Women and Employment

Women are allowed to work in Islam. It is subject to certain conditions, such as if a woman is in financial need and her employment does not cause her to neglect her important role as a mother and wife. Islamic law however, permits women to work in Islamic conditions, such as the work not requiring the woman to violate Islamic law (e.g., serving alcohol), and that she maintain her modesty while she performs any work outside her home. Some scholars refer, Prophet Muhammad's first wifeKhadijah, a merchant before and after converting to Islam, as instances that Muslim women may undertake employment outside their homes. Traditional interpretations of Islam require a woman to leave the house and take up employment with her husband’s permission.

No doubt the Gulf boom changed Kerala, into a high-spending consumer State with low employment potential and fewer avenues for economic growth and welfare or development programs. As "Gulf mansions" mushroomed and land value went up, a strong middle class emerged on the one hand and those who were left out fell further into despair and poverty.

A plural community with distinct socio-economic conditions Indian Muslims differ from region to region and within a region from one social group to another. The participation of Muslims in salaried jobs, both in the public and the private sectors, is quite low. The presence of Muslims was found to be very

low in important positions as with only three per cent in the IAS, 1.8 per cent in the IFS and four per cent in the IPS. A large number of them engaged in small scale self employment activity though main reason behind this is lack of education (Sachar, 2006). India Human Development Report by India's Planning Commission in 2011 findings shows improvement on a few indicators like poverty, education, health, etc., as regards Muslims but the rate of growth much lower than for Scheduled Castes and Scheduled Tribes. The situation has improved little after the Sachar Committee Report. One-third of the Muslims in the country were living below the poverty line according to the 2011 report. Muslim women have the lowest Work Participation Rate (WPR) among the three major religious categories (Hindus, Muslims and Christians).Therefore, the emphasis should begiven with regard to women education to equip her multiple roles as citizen, housewife, mother, and contributor to family income, builders of new society and builder of the nation (Sonowal, 2013).

Muslims are far below in the national average of literacy rate in 2011. The literacy rate among Muslims in Kerala is 66.27 percent as per census 2011 .The Muslim female has a literacy rate of 78.9 per cent which is above their male counterparts (71.9 %). In Malabar region, among total population Kozhikode has highest Muslim literacy rate (81.02). Kannur district in Malabar region is in the next position (54.57 %) than the Thrissur district (54.48).Wayanad district secured the highest position for the male literacy rate among Muslims (49.87). Another important point is that Muslim femalesecured high literacy rate than the Muslim males in all districts of Malabar region of

Kerala (India Census Report 2011). Education as one of the significant social indicators has bearing on the achievement and the growth of individual as a whole. This is perceived as highly suitable for providing employment hence improving the level of human well-being, the quality of lifeand access to basic social services.

India and its growth in Health Sector

Health is regarded as an important indicator of economic development of any country. The level of health status of the people reflects the socio economic development of the country. It is shaped by a variety of factors such as level of education,income level,life style, health consciousness,personal hygiene, sanitation facility,housing facility, capacity and access to health care services.It is widely accepted that poor health status is the product of poor nutritional level in low income countries added with lack of drinking water supply, improper sanitation facility,housing conditions. The government of India has taken keen steps to improve the standard of health through spending more on public health. The advancement in science and technology has extended the life span of the people in general.

Since independence constant effort have been made to booster medical research and enhanced the accessibility of our health infrastructure. Comparing Indians with low income countries have unfavorably in terms of availability of health infrastructure and its utilization .The first landmark in official health policy of independent India was the acceptance of Bhore committee Recommendation of 1946, which laid the foundation of comprehensive rural

health services through the concept of primary health centers and the committee emphasized that health service should be easily available to all irrespective of their capacity to pay for it.(Rajasekhar, 2008). The WHO sponsored Alma Ata declaration in 1978 energised all governments to made remarkable change in the health sector.

With the passage of time, India is advancing in its health care and treatments facilities. The growth in this sector has lead to the application of new equipments, methods, facilities and well trained professionals including medical practitioners. India has vast progress in this sector and it offers some of the best treatments and medications as compared to other countries. (Alfred, 1998)

Health Care Sector in Kerala

Kerala has a distinctive and long history in the field of organized health care. Before the advent of European medicine, families of practitioners of indigenous system like Ayurveda handed the scene from generation to generation. Rather turning to self-treatment people were accustomed to approach caregivers when they were sick. When the colonial powers established their rule in the region, they brought their medical system here. (Ramankutty, 2000)

As per the direction of maharaja of Travancore, a hospital was started at Neyyatinkara, in 1900 which was considered as the first government hospital in Kerala. After this, many hospitals came up in the public health system in Travancore, central Travancore and Malabar regions. The public health system

of Kerala has long glorious traditions of hundred and seven years. But actually the public health system strengthened only after the formation of united Kerala after 1957. However during the last twenty five years there were some shortfalls in the sector. (Gangadharan, 2007)

Kerala's healthcare system with its very good facility has garnered international acclaim. The United Nations Children's Fund (UNICEF) and the World Health Organization desighnated Kerala because of its effective promotion of breastfeeding over formulas a Kerala the world's first "baby-friendly state". For example, in Kerala more than 95percentage of births are hospital-delivered. Aside from ayurveda (both elite and popular forms), siddha, and unani many endangered and endemic modes of traditional medicine, including kalari, marmachikitsa,andvishavaidyam, are present in Kerala's health sector. There is a fusion of both medical and supernatural treatments, and are partly responsible for drawing increasing numbers of medical tourists. Kerala with a steadily aging population (11.2percentage of Keralites are over age 60) and low birthrate (18 per 1,000) becomes one of the few regions of the Third World to have undergone the "demographic transition" characteristic in pace with developed nations as Canada, Japan, and Norway. In 1991, Kerala's total fertility rate (children born per women) was the lowest in India. However, in Kerala morbidity rate is higher than that of any other Indian state. (Prakash, 2003)

The southern State of Kerala placed on top of all other states in India, in its first ever Human Development Report published in 2002, because of easy

accessibility and coverage of medical care facilities. Kerala is an important state where private health sector, both indigenous and western systems of medicine, has played a crucial role. Missionary hospitals have contributed abundantly by even going into the interiors of the state. High level of education achieved especially by women and greater health consciousness of the people has played a key role in the attainment of good health standards in Kerala. Today with the mushrooming of private hospitals that offer quality services with high tech infrastructure providing international standards and with the tie up of the health care industry with the tourism sector, health care in Kerala is growing fastly. (Human Development Report, 2002).

The available health indicators provide evidence of a well followed health background to our people. Kerala has the highest per capita public health expenditure compared to other states. High health awareness of the Kerala people facilitate high health facility utilization rate in the state. (Guptha,1999). Mortality indicators also show that health status of Kerala secured advanced state than the rest of the country and are even keep comparable standard with developed countries. This outstanding acheivement of health status has no doubt been achieved through widespread growth of institutions in public, private, cooperative sectors. (Finch, 2002)

To a large extent, Kerala's remarkable achievements in health care were based on its vast network of public health institutions which equipped her to earn the fame of "Kerala Model of Health" worth emulating even by advanced countries. Low cost of health care, universal accessibility and availability to the

poor sections of the society were the hall mark of this model. This health model was designed by many socio -economic conditions like high female literacy rate in the state. Apart from these, the application of extensive network of medical institutions in modern medicine has also made this possible. Along with all these conditions, Kerala faces some major problems in the health sector at the beginning of the 21st century. Difficult access to health care has resulted in the impoverishment of a sizeable segment of the population. In the11th plan one of the major programme of the state focused to strengthen the public health system and provide universal health security. (Economic Review,2010)

Though Kerala had made remarkable achievements in health sector, the public health in the State was facing a number of challenges. In recent years, in spite of large-scale intervention, epidemics are increasing during the monsoon season are a regular feature. Among the communicable diseases, water-borne diseases becoming a major health concern such as dengue fever, chickungunya, malaria along with leptospirosis for the State. Along with this occasional outbreak of water-borne diseases such as diarrhea, hepatitis, and enteric fever are also creating problems. Due to better global connectivity of the State, many newer emerging diseases and its precautions are also a challenge for the State. Reports of re-emergence of vaccine preventable diseases and health issues due to large-scale interstate migration of labourers create new hurdles. In addition to the burden of communicable diseases, high prevalence life style and other diseases like hypertension, diabetes, heart disease, cancers, mental health

disorders, and elderly population and road accidents make the health situation in Kerala more complex. To address the issues faced by the sector on a long-term basis and in a sustainable manner coordination of various departments and their efforts are very important to address these challenges.

Rising affluence, increased stress, new food habits, and pesticide residues in food products, obesity and rising incidence of diabetes have all contributed in varying degrees to the health crisis. Growing dislike of malayalees' for physical labour, led to a steady stream of migrant labourers from other states into construction and other areas, may well have a role to play. High liquor consumption is a problem in the state along with junk food and obesity which cause liver diseases (Economics Times 2016).

The effective implementation of the public distribution of food played an important role in improving nutritional status. The Kerala moving towards the achievement of a health condition described as "good health based on social justice and equity".

The spread of epidemics is mostly due to failures in implementation of waste management, mosquito eradication and provision of safe drinking water. The incidence of suicides, death and disability due to road accidents are also high in the state. The problems are more severe formarginalized groups (like Adivasis and the fisherfolk) are greater than that faced by 'mainstream' society.

It is proved reality that the role of doctors in social construction is prominent not only by doing their part amongst the patients or in the health arena. We have many efficient doctors in our society engaged in various other

fields of social action indirectly related to their profession. Many as IAS officers, Political executives, teachers (not only in the medical institutions), successful business persons, scientists, writers, Human rights activists, environmentalists, social workers, engineers and so on. They contribute to policy making and execution, social engineering by motivational speeches, opening horizon of cosmetology and so on.

The doctors are there because they were more talented. A compassionate meticulous and talented doctor created as a result of continuous and tiresome hard work paid by each one of them and their family. It is a devotion, which includes sacrifices and pains and outcome of systematic and planned hard works. Mental and academic preparations starts from a younger age and work hard not only till get the admission but throughout the life. Doctors are going through continuous tough competition throughout their life like to win better ranks in the entrance examination to get admission, during the course and also while practicing after the studies. Innovations and rapid changes taken place in the field so they have to be equipped by updating and refreshing what they studied in their studentship.

The service horizon opened to the doctors from the patients who come in front of them for treatment to them whom sitting wherever they are and consult the doctor by using modern technology. Spatial limitation no longer exists that the skilled and busy surgeons can handle and control a surgery in an operation theatre which is far away by sitting in his place.

Most of the doctors who employed in private or government sectors are practicing after their duty over there, at the home or outside the home. Sometimes they are working in different places in alternative basis. Most of the busy doctor's morning OP duty extends till evening, and then have to continue the evening duty without much gap for rest. In between it is mandatory to go for in-patient examination, to attend emergency cases, operation theatre, casualty, dialysis centre etc. Many skip their food, sleepless and hardly find time for exercise, recreation and leisure time is too limited. Even after the duty time has a responsibility over the IP patients and should be there on a call if an emergency occurs.

Even though parallel medical services like ayurveda, homeo, yunanietc are present the significance of modern allopathic medicine still leading.

The difference in the attitude among those who selected the medical field as a passion and as a fashion is visible in their life. There is a common notion that parents of medical background nurture their children according to that and inject the spirit right from the childhood and direct them towards it. Normally the children who reared in such an atmosphere shows attachment towards this field, and work hard to get it. The passionate children without such background also strive to achieve it. Another category by considering only the social appeal, the glamour, monetary benefits also attracted to the field. Some parents are ready to invest a huge amount of money for getting a medical degree for their children. There is a marked difference between these two.

Membership in professional organizations and associations help them to protect their rights and so find time to attend its meetings and programmes even though they lack adequate time for its activities. They are putting extra efforts to be a part of it for the cause of entire practitioners.

Like any other service sector we can see a group of workaholic or work centered figures in the medical field too irrespective of sex. Highly professional doctors are competitive too and they prioritize jobs. Some doctors referred as "family doctor" by someone. They are so closed and trust their life in him. In such condition treatment is so easy. Sometimes just a meeting with the doctor itself helps for relaxation from the ailment. The new concept of doctor, for many, is not just to examine manually and prescribe medicine rather direct the patients for more tests and all.

The role of a doctor in one's life, from birth till death is not unavoidable today. A person may have to trust a doctor throughout his life during expected and unexpected situations. Important decisions taken in the life like marriage, having child, adoption etc. may be in advice of a doctor for special cases. A busy doctor has to sacrifice many of his personal likes. A doctor, who is referred by his patients as 'kaipunyamulla' doctor, is a certificate of merit given by a beneficiary to his/her doctor who stands close to his hearts. Unfortunately such a generation of doctors who have patience to hear his/her patients are comes down in this world where professionals are marketing their time like things by a businessman.

Prevention is cost effective than cure. The social responsibility of medical professionals is challenging by taking part in the immunization programmes of the government. Community health care services and disaster services are noteworthy in counting his/her role as responsible professional. Recently while Kerala face flood in its severe form than ever, the role of medical professionals in rebuild Kerala mission 2018 along with all governmental machinery need a special mention

The profession of doctor has an international appeal and has demand all over the world. Push and pull factors of migration for doctors are attractive and favourable. The opportunities of migration are greater among doctor couples to gulf countries. Lady Doctors are in great demand due to high preference among women patients in these countries. But cases reported from the countries like America, where people see Muslims as part of fascism and terrorism and other inhuman activities, even lady doctors from Islam with Islamic dress were rejected by the patients.

A trend of new modular fertility clinics with high tech facilities are on increase and more attractive packages and offers like designer babies came to be successful in the field. IVF clinics in Kerala have doubled over the past 5 years. Though an expensive option, it is now gaining acceptance among malayalis. Earlier fertility clinics were considered unnatural as well as financially and morally unacceptable. Infertility rising at an alarming rate in Kerala unlike past surrogated mothers is on the increase in our society. The

surrogate is carrying the fertilized egg of someone who is not her legal husband.

The specialized centers to treat physical problems like obesity, diabetics etc. are also emerging. Cosmetology like plastic surgery, hair fixing etc are also get momentum. Growing centers of physiotherapy, scan, high tech laboratory, diagnostic centres and related institutions are also seen today. The psychotherapy and counseling centers are also on increase. In general there is a mushroom growth in the medical, Para medical and related activities.

Today, as life demands need more and more specialization. Doctors like professionals in every field challenged by the technological knowledge to use machines of different series. Women's access to new technology is not a simple question. Whether there is a computer connected to the internet that women can use. As women make up nearly two thirds of the world's illiterate, and one out of every two women in developing countries is illiterate, women are more likely than men to lack basic literacy and computer skills, which would enable them to take advantage of the new global communication opportunities.

Even though the medical field is regarded as highly gentle and glorified, are not free from controversies. Various reports, they are not at all hopeful, make us fear and forced to rethink or redefine the ethics of this profession. Many say doctors are life givers but some of them are known as life takers. Medical practitioners are generally victimized by the medical companies by offering attractive incentives and emoluments like foreign trips, jewels,

vehicles etc. They become the part of lobbying of such profit motive companies and prescribe their medicines largely compromise quality in a high rate may lead the patients for more complications. Painful patients even the children are used as specimen for the new products of these companies. As we watch in the mass medias, the doctors may act as agents of big cosmetic companies to get what they want in a cheap rate by trapping poor patients. Illegal abortions and other unethical means are used in this field only looking for profit. Organ transplantations are another field of corruption needs more protective laws for the poor. Agents in this field for various purposes are a big area of corruption and bribe. Dialysis, an important part of kidney treatment also not free from the inhuman aspect of corruption in the form of receiving commission. So here comes the role of an ardent believer with strong religious background significant here. Major religions including Islam provide a guideline to its followers about how to be virtuous and truthful in life. Here comes the significance of women medical practitioner with more humanitarian concerns.

Women inMedical field

In India, there is a history of gender hidden curricular for the exclusion of women from the medical profession. It was only after 1880 the entry of women in medical profession took place. In 1885, the Counters of Duffer in Fund was established for providing medical education and scholarships to women. Between 1988 and 1997 registered a rapid increase of women doctors. At graduate level women's participation in medicine was around 50% in 2010,

but still a wide gender gap persists in post-graduation and doctoral level where the percentage of women doctors is around 1\3 of the male doctors. Still higher positions and leaderships in the academic and administrative are mostly occupied by men. Generally, women medical professionals prefer "soft" specialization, except a few, which suit to their family responsibility. Gender stereo typing is gradually fading away but a full integration of women in medical profession is yet to complete.

Traditionally, women play an important role in the family's health. Their involvement and performance level in this role is affected by their social status, education, employment and cultural practices that permit or inhibit them from family decision-making.

'Belief is everything in life' is more applicable in the medical field. It is a set of believes that the patient has mostly on the doctor. The society exists these days amidst of pluralism in the modern life characterized by commercialisms, market forces, egoism, dehumanization and deprofessionalization. Deprofessionalization can be defined as the decrease or loss of a special kind of commitment to competence, service, faith and selflessness that has often characterized physicians in the past. These factors are so powerful that they made their way to one of the noblest profession that is medicine to the extent of that many physicians these days are accused of being Materialistic, Heartless and Machiavellian.

Challenges faced by female doctors are in accord with the challenges faced by their counterparts in any other profession. They go through the

hardships of biasness, lack of support, glass ceiling, etc. One of the most prominent challenges which every woman doctor has to face in their life is work-family balance. It is very tough for the women doctors to synchronize a balance between family and rigid type of job like medical doctor (Nadeem and Abbas, 2009). Research has found that significant numbers of women doctors were dissatisfied with their work-family balance because of over burdened with night shift, limited time with the family (Kumari et al., 2015). As a result, such pressure affects their physical and mental health, thereby leading to absenteeism from professional field.

The timing for starting a family is a critical decision for women in medicine. The most opportune time biologically for a woman to have children coincides with the phase of life when career demands are most intense, making the balancing of career and family particularly difficult for women during their 20s and 30s.This period in a woman's life coincides with medical school, residency, and fellowship training, when work demands are high and finances are strained, with little money available to hire support personnel. Many important issues must be weighed in the balance when deciding to have a child and begin a family. If postponed until a woman's mid-30s or later, the risks of infertility and congenital anomalies increase. Infertility clinics are on increase in Kerala today due to the preference of women for employment in their good fertile period.

The impact of pregnancy and childbirth is somewhat lessened in large residency programs or physician practices, and can be minimized by notifying

colleagues well in advance of the impending birth and the mother's plans for maternity leave. The discrimination or negativity from colleagues had a negative impact on the satisfaction in balancing career and family life. The choice of specialization determined by care of children and possibility of combining work and responsibilities for children and family. The most prestigious specialties within hospital medicine, like surgery and internal medicine, are only opted by a few women.

The health and well-being of physicians is causing some concern. Important aspect of general well-being such as balancing work and home lives and reducing conflicting relationships between the home and work domains are crucially important not only to female and male physicians that strive to deliver their work with the highest possible quality, but also to the organizations and governments that employ them and are concerned with work performance so that patients expect high quality service from them.

The question is not about the devotion of woman's time to profession but for the cooperation and ego of husband who wants to have a working and earning wife who first cooks, cleans, manages children and his parents.

It is an added merit that educated women especially professionals are enabled to make use of modern social network systems. This again gives them opportunities of widening their knowledge, information and social support systems. Contemporary facilities like mobile banking and plastic money adaptable to women and it makes their life easier.

Medical field is so risky today than in the past. Patients now know even medical terms and many related things which earlier considered unknown for the public. A growing minority from the general public refer internet to know about the content of medicine prescribed for them by their doctor. The rights of patients have been increasingly accepted by the authorities. There is criminal liability for medical errors in our society. All in all, if physicians are punished for any medical mistake they make, as it was the case with the hammurabian society, it is possible that the modern society might find itself in a very critical situation without any dependable doctor. (Clarkson and Cunningham 2008). There are various ways through which the aggression of the public towards physicians and health establishments has portrayed itself. However it has resulted in an increase in legal action as well as violence against health professionals (Me Evoy2007).

Self Esteem

Self esteem is a feeling developed by an individual as a result of a number of conditions. It is a result of positive attitude and self worthy in a person. Education, employment, financial independence, attitude towards life etc are the motivating factors of self esteem. Perfection or completeness of a person is not the criteria for developing self esteem rather it is a mental condition of self acceptance with all positives and negatives. Self identificationof one's strengths and weaknesses help the person to perform well towards success by concentrating the enrichment of positives and dealing effectively with negatives. This self realization is very important in our life.

Self confidence is a mark of self esteem. It reflects in other important areas like decision making, critical thinking, emotional balance, time management, effective communication etc.

Males are perceived and accepted as the responsible and powerful persons in our society. Unemployed women's dependency on their husbands create a feeling of insecure and negligence. Usually in such situation women were used for fulfilling their urges. Depending on others expectations create negative thinking.

For working women professional role is a source of self fulfillment helps to score high level of satisfaction. Multiple role enhance the self esteem of a person through the feeling that 'I am something' through various tasks. It grows gradually with social net working and maintaining relations outside their kith and kin groups. This unconditional positive regards helps to maintain quality in their life.Self esteem marks successful relationships and leads the persons in to stabilize their mental health. Positive attitude towards working women helps to shelter them from feeling of rejection and being failure or mental illness. They feel confident and honorable in the societal responses.

High education, profession, salary, prestige and social acceptance facilitate women medical practitioners a high self esteem. Their positive attitude benefited for the poor patients and their relatives. Ability, will power, enthusiasm and moral responsibility to do something for the society are there among women medical practitioners but the work load in the professional field as well as in the household prevent them from engaging in social activities.

Employed women and marital satisfaction

Satisfaction as a person is very important for anyone. Then only they can have it in their relations too. Marriage is a bond between husband and wife in the ground of psychological and social coherence above a legal tie up. Two individuals from different social and familial background and personality traits unite together; starts interact and cohabit together for cause of establishing a family. There are chances of having conflict and adjustment problems since both enter marriage with higher expectations of interpersonal communication, intimacy and sexual satisfaction hence unmet needs results stress and dissatisfaction. Adjustment and understanding with each other is not an easy thing. Sometimes, it is not constrained among two, rather influence persons and things related to the couples directly and indirectly.

Marital satisfaction is an essential element for successful family life and personal growth. The fulfillment and positive development will be possible only when the relationship between couples turns coherent and satisfactory. Significant influence on the marital satisfaction made by different factors like personality of the partner, nature of job, child rearing responsibility, sexual satisfaction and communication patterns. The active engagement of women's in the employment sector and their dual role has significant correlation with the marital satisfaction, especially in a society like India. Professionals who are engaged in health care sector, especially private sector are having stresses in relation with shifts, long hours of duty etc. Apart from this they are playing

dual role as breadwinner and the care taker of family. These aspects are having significant correlation in the family life too.

Education and income have also been linked to marital satisfaction,normally greater levels of education and income predicting greater marital satisfaction and less conflict. Economic stress creates a negative effect on marital satisfaction and a positive influence on relationship dissolution (Johnson & Booth, 1990).

The presence of children has both negative and positive relation on marital satisfaction. In addition, studies have shown that there is a relationship between number of children, particularly preschool children, and marital satisfaction of couples (Stevens, Kiger & Riley, 2001).

The factors that influences marital satisfaction has a double effect in the case of employed women. They are often stressed by the dual role in the office and home. Although their role in house hold labor still performed without much marked changes from the traditional pattern. Research suggests that men report higher levels of marital satisfaction compare to women (Swensen, 2000), and women have more negative experiences than those of men (Heaton & Slake, 1999). Earlier studies found that marital satisfaction was related to a number of interrelated factors like higher occupational status, higher income, and higher educational level, similarities between spouses in age and religion, esteem for the spouse, sexual satisfaction and companionship (Steinmetz, Clavan&Stein, 1990). In the case of medical practitioners, nature of their

course and job equip them to create such an atmosphere in the family to bring out marital satisfaction.

As an individual, the most important one which determine the personal and professional responsibilities is pride and self respect. Qualification and employment alone cannot boost self-esteem. Our life is depends on our self-esteem. Medical practitioners with all their achievements in life are dealing with those who are struggling with life or with pain. The self confidence in what is doing is very significant. It will help to improve the professional quality. The reciprocity between these two helps the individuals in a great deal. Knowledge, skill and confidence powered with experience and shared views, assisted by technology. They should alert all time with a fear of handling with lives.

Dual role performance of women medical professionals is performance of two expressive roles. In both sides they have those who demand their presence and help. Mostly doctor can't wait for favorable conditions rather convert the conditions favorable. Dual role is like a bicycle ride. Others who see one with two bicycles may feel that it would be easy for the person to ride both at a time. One can ride only one bicycle at a time. The person can ride the second one only after the first one put in stand.

Decisions on important matters like education, career, marriage etc. would turn one's life. Right decision at right time is very essential. Some decisions can be changed or short term in nature rather some are not easy to change or long term or permanent in nature. Through decisions with effective

planning and knowledge one can improve or change the world around. Taking a decision may be easy but its impact on other persons or conditions should equally consider while forwarding.

Medical professional cannot work in accordance clock time like office work. Duty may exceed and may be late at home. Sometimes not only duty time but also time for travelling also make problem. A successful professional is one who pave due importance to his work and it will cause some shortage in family responsibilities. It can be making up by using all available support systems. So generally, it is the family which compromise or suffer due to women's dual role.

Islam as a holistic religion gives a complete package of one's life right from the very beginning. Relations especially personal ones are so special in it. For Muslim, marriage is a contract and motherhood is so important. According to Islam, the only one who deserves worship after Allah is mother. The heaven of siblings is mother's foot. Islam place so importance to personal relations. For a woman, somebody should be there to protect her throughout. With respect to education and employment, she is permitted with certain conditions. Medical profession needs more careful approach. Even a woman's aurath or private body parts should keep privacy from another woman too. So it is so sensitive issue to deal with woman patient. Above that many areas of medicine or treatment like cosmetic surgery, family planning, surrogacy, organ transplantation etc. comes clash with belief system.

It has been strictly practicing that male guardians such as fathers and husbands did not consent to their wives or daughters being examined by male practitioners unless absolutely necessary in life or death circumstances. The male guardians direct their women towards female practitioners for the sake of privacy. The women similarly felt the same way that the case with pregnancy and the accompanying processes such as child birth and breastfeeding, which were solely reliant upon advice given by other women than men.

Family is the fundamental institution of organization in society. It provide the atmosphere where individuals are born, nurtured, learn to socialize and where an individual's behaviour and views take shape. However, factors like globalization, economic boom, inequities, social determinants of health, urbanization, gender issues and so on are influencing the traditional joint family norm. Traditional roles ascribed to men, women and the aged are undergoing a wide transformation. The increasing participation of women in the workforce is challenging the stereotype patterns in the society that woman as a home-maker and man as the breadwinner. Whatever it is joint or nuclear, family will continue to play a pivotal role in nurturing and socializing children and influencing the development of adolescents, serving as a support structure for family members, influencing health impacting behaviors – both positive and negative and providing opportunities and role models for healthy living.

Network and Social Support

Close relationships with family, friends and neighbours make women a part of fairly large group of relationships and integrate into it. It gives them

greater feeling that they are a valuable person and have somebody to approach for help in times of need. This social linkages help women both in their career and familial life to coping with the changing circumstances in their life. Such interpersonal relationships function as a booster for their life. All sorts of personal relationships provide different kind of support. The relationship with family,neighbours and friends are very important in one's personal and employment life. For a medical professional the help extended by these sources are too important for the maintenance of work-family balance.

The nuclear family with face-to-face contact and emotional involvement with the members refers probably the most important source of support. It addresses the immediate needs of its members with its limited size and resources. In the modern period it is not sufficient to satisfy the wide variety of specialized support needed.After marriage the network members of the spouse added automatically hence an increase in their relations. Kin group as a permanent membership group makes family relations more suitable to provide support and care in a long term basis. With the features of geographical proximity and reachability, neighbourhood community beneficial to the individual in providing minor and short term helps in case of emergencies. Friends are another most important category of network which provides love and sharing. According to the nature of employment, the choice of their selection varies. The medical practitioners with more challenges of work and family maintain balance with the strong support and coordination of network relations. They provide major sources of emotional, financial, companionship,

instrumental and informational support. Larger networks tend to provide more support (Burt, 1987; Fischer et.al, 1987).

Conclusion

For a Muslim, there are many situations to go through as a medical professional which are subjects of hot discussion in the community. They sometimes due to busy work schedule can't be regular in their prayers, which is mandatory for a Muslim. There exist issues related to taking night duty for lady doctors. Then subjects like medical ethics includes examining a male patient by a female doctor and vice-versa, surrogacy, family planning, plastic surgery, cosmic surgery etc usually they have to go throughout their life as a part of their profession.

The art of healing, which is called the medical profession in modern language, has been highly respected all through the ages. For a long period in human history this art was closely correlated with religious leadership and quite often confluent with magic and miracles. Nevertheless, the medical doctor has persistently captured the appreciation and respect of his contemporaries, especially as medicine was usually associated with other philosophical and social knowledge. By accepting the fact that God is the healer - and that the doctor is only an agent, both patients - irrespective of their creeds - and their doctors, fight their battle of treatment with less agony and tension. It is an established fact that such spiritual conviction does improve the psychological state of the patient and boost his morale, and thus help him overcame his physical weakness and sickness.

To conclude the acceptance of women as human power to be utilized for the society yet to be happen. Inferior treatment of women just as a source of fulfilling selfish needs produce conflict not only among them but also in the system as a whole. This is essentially because of the misplaced patriarchal notion of the male as the primary bread winner and also the notion of females as the custodians of the honor of family. It is a conscious effort for restricting their spatial mobility as a way of controlling their sexuality outside the socially sanctioned bounds.Proper channelizing of the power of this half of the population would benefit the humanity. It is important to turn the conditions favourable rather waiting for evolving favourable conditions in favour of women in the society. It is very important to note that along with growing participation of women as medical practitioners there should facilitate conditions of work life balance. It would inversely affect their personal and professional well being.Health sector badly in need of a group of professionals to maintain its credibility and women are assets in this field with more humane approach and less bribe.

Chapter II

REVIEW OF LITERATURE

Family is the area in which the role of women is traditionally the most prominent. The participation of women in employment outside home has greatly changed their family lives. Economic independence attained by working women redefined her role and redistributed the work within the family. Employed women still participate in their work while continuing many of their traditional obligations. Professional field and family are the two different worlds of Muslim women medical practitioners which often conflict with each other. Two emotionally involved expressive roles balanced by them with the support of a number of factors. Participation in decision making, level of self-esteem and marital satisfaction, network and support system etc. help them to achieve empowerment through their education and employment.

WOMEN EMPOWERMENT

Woman is the heart of human existence on this planet and plays an important role in the society. But her importance and roles are underestimated all over the world. In the 21st century majority of poor women are home makers. The elementary reason for this suffering is illiteracy and social orthodoxy hence creates a hindrance for the women to earn their livelihood. Due to all these reasons women are supposed to remain at home, where they get very little exposure. Women were in abject conditions, but times are

changing fast and there is a ray of hope. It has been agreed that it is necessary to educate the women for empowering them. Many NGOs and the government agencies are working for bringing the women out of this condition. They are not only encouraging employment of women but also helping them to save and get financial support, a prerequisite for attaining equal status in the society.

Devi (1979) identifies four variables for assessing the changes in the status of employed women, such as the extent of power of decision-making in family, freedom in spending help received in household responsibilities and deviations from traditional customs. Employed women were found to have higher scores in all the 4 elements. Therefore it can be concluded that employment contributed significantly to the social status of women in the society.

Warren and Gielnik (1995) views at empowerment as a condition which lacking responsibility, achieving self confidence and exercising decision making power. By allowing other people to take decisions for us, we are giving them our power. Empowerment is not easy for women, since they are always encouraged not to take up responsibility. Empowerment underpins the quality of our work life by creating in us, greater confidence in our ideas, skills and judgment.

Smith (1996) explains the needs, benefits, barriers and source of empowerment. According to her, empowering people means, encouraging them to become more involved in the decisions and activities that affect their jobs.

Rosa (2010) observes, in her study on empowerment of women the impact of employment, that the remarkable presence of women in the service sector is a unique achievement of Kerala, among the Indian states. A good number of educated women are employed in education, banking, hospital, government offices and in IT sector.

WOMEN AND HOUSEHOLD DUTIES

Steidl and Bratton (1968) have defined household work as "tasks performed for subsistence and cultural development to maintain the family with food and clothing and to provide an atmosphere that helps each family member to achieve his/her goal". According to Hoeflin (1970) the housewives have become a discontented class with the rising standards of living. But psychologically the availability of labour saving gadgets on one hand and the alternative way of life as an independent wage earner on the other hand have made domestic routine more burdens to the housewife. Household work is invariably carried out by women, whose role is identified as homemaker. Other members of the family may help the wife or mother, but she continues to have the sole responsibility for the operation of the household.

Schalfly (1973) views that employed women in all types of work—clerical, semiskilled, professional or domestic—carry the dual responsibility of managing a house and a job. According to prevailing role norms in India, a housewife is expected to be expert in cooking, in looking after children, in keeping the house neat and clean and in entertaining guests and visitors. She has to bathe the children, keep them tidy and feed them. It includes food

preparation, dishwashing, house cleaning, maintenance of home, yard, car and pets, care and construction of clothing and household linens, shopping, physical and non-physical care of family members and management (Walker and Sanik, 1978). Thomas (1978) indicated the additional housekeeping tasks such as collection of firewood and fetching water.

Life certainly becomes easier once we acquire and use household gadgets (Riti et al, 1997). Traditionally the male heads in Indian families may lack domestic skills due to their conventional upbringing and may think that, as they are providing their wives with household devices, their participation is not required. Availability of household gadgets leads to reinforce stereotyped task assignment and reduce the amount of help from others. By having equipment, some individuals or families may undertake tasks and responsibilities that were not formerly a part of home (Decon and Firebough, 1981).

Swanson (1981) in his study on comparative analysis of women house hold duties shows that household operations by the homemaker who is not gainfully employed has not drastically changed since the 1920's. The amount of time spent by the employed homemaker is less than that spent by the full-time homemaker. An average of forty hours per week is engaged by all homemakers in household operational tasks. Work simplification is therefore important to both outside employee and full-time homemakers. The physical energy and time requirements for household activities today are rather limited in developed nations. Material household equipments make household activities easier, but do not necessarily reduce the time spent on the work.

Kamalamma (1981), in her study of household work of rural families has shortlisted the household tasks as food preparation, care of utensils, care of clothing, care of house, care of family members, fetching water, firewood collection and marketing. In the case of urban families fire wood collection does not form a separate task. Household work comprises heavy, moderate and light tasks. Kneeing, darning, sewing by hand or motor driven machine, ironing napkins, peeling potatoes etc., fall under light domestic work. Moderate work includes dressing infants, sewing with a foot driven machine, beating batter, rid kneading dough, heavy work comprises washing clothes by hand, cleaning dishes and kitchen, wiping and mopping the floor, which require more energy as more parts of the body and different postures are used (Bharathi and Jacrntlia, I991).

Shervani (1984) in her study on women and household duties states that married women find the dual responsibilities as source of great though. They are able to perform their routine act as homemakers with children of different age very difficult. An important transformation in the Indian family is the increasing number of nuclear family system (Jain, 1995). The elderly couple living alone found it difficult to manage the routine household work without any help.

Menon (1987) in his study about change in household duties maintains that by using labour saving devices the most disliked jobs can be made glamorous. Electronic devices like washing machine, iron, vacuum cleaner and toaster are necessary time and energy savers. The cost of equipment is

economical when compared to the time and energy saved by their use. The labour saving electrical devices are time and energy savers and make the homemakers happy by relieving their tension in performing day to day activities. Such devices may play a vital role in women's welfare and development, by removing the toughness experienced in performing household activities (Jeyagowri and Jagadeesan, 1993).

Jeyagowri (1993) in a study on smart domestic work views that by using various labour saving equipments one can conserve 40-65 percent of the time spent on household work. Equipment in the home is really a tool. The economical and useful equipments used should be labour saving, be efficient, do what one expects it to do, and be in a price range that one can afford (Sandhya, 2000). Brahmbhatf (1984) has found that management of time by most of the families extensively by employing labour minimizing gadgets, which not only lighten family's work and reduce time consumption, but also change its character. With efficient equipment at hand, household work becomes less strenuous and is more willingly performed by any members of the family. All women want to use their leisure time productively and so look for gadgets that can help them save their time. Rekha (1994) has stated the reasons for purchase of labour saving electrical gadgets as simplification of work, substitution of paid domestic help and desire for more leisure time.

Berardo et al. (1996) compared the amount of time dual-career husbands and wives spent in her study on housework of women in the modern society. Wives spent considerably more hours on housework than husbands and

performed about 79 percent of all the housework that was done in their homes. Husbands' actual share in housework ranged between four and six hours per week, which represented about 14 percent of the total amount of lime that was spent on housework. The changing role of women creates strain into the family structure and led to modify their family roles. This new role of women has forced husbands to participate in home making activities and has thus changed their traditional role as exclusive bread winner to that of partner sharing home making activities (Madhana, 2001).

Riti (1997) in his study on women and household duties reveals the view that women can no longer be divided into categories like housewives and working women, and targeted separately. Both men and women work and they have little time to spend for the home. In most of the middle class households for monetary benefit both the parents work (Kaur, 1988). The day for women starts in the early morning before sunrise and go last to retire to bed at night. With industrialisation and urbanisation, many changes have occurred on a global scale. Women have started taking up jobs or careers outside the home. As women engaged themselves in wage labour at increasing rates, the division of household labour became overburdened for women (Shah, 1995).

Most men still maintain full involvement in their outside employment because their spouse assumes the responsibility for caring their children. Thus, we can deduce that women will suffer more by the interference of the family at work, because their greater involvement in the family will subtract their time, strength and dedication to their work. In fact, a high implication in the family

sphere has been shown linked to a higher family-to-work interference only in women (Hammer et al., 1997). Moreover, men do not feel an obligation when they are involved at home they perceive it more as a hobby or a free choice. The traditional house chores that keep the women engaged daily for long time (shopping, cooking, washing dishes, washing clothes, and cleaning the house) are considered feminine, while those considered male or neutral tasks (paying bills, taking care of the car or home maintenance) not a daily routine affair. Some cultural interpretation argue that women are more involved in house chores and do not want to fully share because of the belief that this is central to their gender identity whereas for men whose gender identity has traditionally been marked by paid work, would not object to do less household chores than their wives (Martínez and Paterna, 2009).

Miglani (1993), from her study have concluded that compared to urban, rural homemakers spend more time on household activities. In both the areas food preparation activity accounted the greatest time and expenditure. Bincy's (1998) study reveals that 69 percent of the homemakers spend three to six hours on kitchen activities on working days. Others spend three to four hours per day for kitchen work.

Parakkath (2000) in his study reports that four hours of routine kitchen work for working women in a day. According to Bianchi et al. (2000), in 1965, women in America spent about 30 hours weekly i.e., 4.3 hours per day, doing unpaid household work. The activities included such core tasks as food preparation, meal clean-up, house cleaning, and laundry, as well as more

discretionary or less time consuming tasks such as outdoor chores and repairs, gardening, animal care and bill paying.

WORK-FAMILY BALANCE

Greenhaus and colleagues (2003) defined work-life balance as the "extent to which an individual is equally engaged in and equally satisfied with his or her work role and family role". Work-life balance consists of three components: time balance, psychological involvement balance, satisfaction balance. Time balance refers to equal time being given to both work and family roles; involvement balance refers to equal levels of psychological involvement in both work and family roles; and finally, satisfaction balance refers to equal levels of satisfaction in both work sphere and family sphere. All these components should be considered when studying work-life balance. Evidence from the case studies of Nigeria showed that the task of combining multiple roles was very difficult for Nigerian female doctors. It has been identified that, when women doctors found the occupational workload of the medical profession, they became fatigued and drained and were unable to perform their family responsibilities at the closing of their daily shifts (Adisa, Mordi, &Mordi, 2014).

Shukla and Saxena (1988) assessed satisfaction with house work, paid work and dual work roles among married, employed women. Aspects of job, family and self related to women's satisfaction with dual work roles were also examined. Data were gathered from 74 women working in clerical jobs and 45 women in professional jobs. Findings suggest that (1) professionals have

greater satisfaction with both house work and paid work and experience more job challenge; (2) both groups evaluate themselves negatively in comparison with men but positively in comparison with unemployed housewives and unmarried, employed women; (3) dual work role satisfaction among clerical Ss is positively related to job rewards and job comfort and negatively related to job challenge, and (4) among professionals, satisfaction is positively related to job challenge and a favorable self image.

Neena (1988) in her study on women position and power in dual career families finds that involvement in decision making as predominantly by husband and wife and by both in connection with household management, child care and financial management. When decisions are made almost independently by either of the partners, it is working wife who predominates. In the small households they have more say in financial management than those in the large household.

Bharat (1994) compared the responses of 100 Indian career women in professional and high-paying jobs with those of an equal number of Indian women who held low-level jobs and with the responses of their spouses concerning their perceptions of "Indian women." They were required to describe the element that they did not desire in Indian women. Compared to the nonprofessional women, the professional women and their spouses perceived Indian women in emphasizing their ability to strike a balance between their family and work spheres.

Chowadhary (1995) examined the features of the families with employed women and young children in India. The affect of working mothers on marital relations, child care and her own health were studied. It was found that a majority of mothers work outside due to economic necessity, although 50% of mothers were against it. As for husband's attitudes toward their wives' employment, it was revealed that more than half (55%) of the husbands approved their wives' working as a full time worker. However, nearly forty percent (38%) of selected employed mothers stated that they were not happy with their work outside the home, and felt guilty of neglecting their children and family. About three fourth (74%) of the mothers expressed should their dissatisfaction over lack of alternative child-care facilities available. It was concluded that it was necessary to re-examine the role which fathers take household and child care roles in order to fill in gap of the mother's employment.

Thakar and Misra (1995) examined the pattern of daily hassles experienced in relation to perceived control, social support, mental health and life satisfaction of 40 dual career women and house wives in India. Dual career women reported significantly greater incidence of daily hassles but displayed a greater degree of life satisfaction than did housewives. Older (aged 40+ yrs) dual career women from nuclear families perceived a greater degree of control than did Ss from joint families. Social support was shared similarly across from joint families. Social support was shared similarly across all groups.

Pillai and Sen (1998) investigated the life of working women with regard to their dual role, as professionals and family care-takers. 100 married women (aged 25-54 yrs), representing 4 professions (doctors, lawyers, media women and executives), were examined to see how many were successfully able to combine these 2 roles. Job involvement, family support and 6 life aspects, i.e., (a) personal time, (b) physical strains, (c) psychological conditions, (d) marital life, (e) physical life and (f) professional commitment were assessed. An attempt was also made to elicit the possible solutions to the problem faced by those women. Results indicated that only as low as 7% of working women were able to harmonize their dual roles. Most of the strategies suggested as solutions revolved around government initiatives, family-friendly organizational schemes, and a general societal reorientation

Akanji. (2012) contributed scholarly knowledge in areas of holistic factors that can be found to influence people's perception of work-life balance practices and various coping strategies which can serve to buffer imbalances encountered. Yan Ma (2008) made a research study on Chinese women employees in administrative roles at Auckland University of Technology, New Zealand explored the work-life balance experiences of Chinese women in administrative roles. Its aim was to contribute to the body of knowledge on work-life balance issues and to investigate Chinese women's coping strategies for integrating work and non-work lives. It was found that coping strategies helped women employees to manage the work and personal life (Yan Ma, 2008).

Laxshmi and Gopinath (2013) study on the effect of work-life balance on performance of women employees. They identified the variables that affect work-life balance. It was found that women who had low work and family-related issues were highly able to achieve work-life balance than those who had high rate of these issues. Akram&Hassaan (2013) examined the impact of work-life conflict on job satisfaction among doctors in the cultural context of Pakistan. The findings exposed that there is a significant negative relationship between both types of conflict (work to family interference and family to work interference) and job satisfaction.

According to Boles, Howard and Donofrio (2001), after an investigation into the inter-relationships of work-family conflict, family-work conflict and work satisfaction that when work-family conflict increases, the level of job satisfaction decreases. Conflict between work–family is more closely related to employee job satisfaction than conflict between family–work.

Kamran, Jafar& Ali (2012) discussed the nature of work and family policies in Pakistan's environment, particularly in Education Sector. There was found a positive moderate relationship between job satisfaction and work-life balance which suggested that universities should focus their efforts on formulating and implementing work-life balance policies. Aryasri and Babu (2004) analyzed the impact of flexi time on retention. There was found positive correlation and significant association between flexi time and employee retention. It was concluded that, when the average flexi time increases, the average employee retention scores also increases proportionately. Better work

arrangement helped the employees to obtain a better blend between work and non-work lives and helped organization by motivating, recruiting and retaining employees within the organization (Bachmann 2000). Impact of family-friendly policies on job satisfaction and alternative work schedule and compressed work-week are positively related to job satisfaction among bank employees (Muhammad, Muhammad, and Irfan 2010).

Rezene's (2015) study was aimed at exploring the impact of work-life conflict on job satisfaction in selected Banks in Addis Ababa. The finding of this study was that work-life conflict was negatively related to job satisfaction. Hashmi, Malik &Hussain (2016) studied on literature review to summarize the research findings among developed and developing countries, as well as Pakistan, related to different work-life balance factors and their impact on job satisfaction. The review concluded that there is a need for reinforcing the relevant human resources policies and improving working conditions of pharmacists in Pakistan. Marta Mas-Machuca, JasminaBerbegal-Mirabent and Ines Alegre (2016) also explored the relationship between work-life balance, organizational pride and job satisfaction. It was found that work-life balance is positively related with organizational pride and job satisfaction.

MUSLIM WOMEN AND EMPLOYMENT

Woman who is following religion of Islam is a Muslim woman. Females in Islam are regarded as individuals with the same needs as those of males. Women are at liberty to work or not to work outside. They are not

breadwinners so it gives them certain liberty to do any profession by choice and not by compulsion.

The wide and developing body of micro level studies on aspects of Muslim women's economic lives augments more research on women's paid work, formal and informal. The body of studies is particularly pertinent to debates about whether women's increased participation in paid work necessarily betokens enhancement in women's status and well-being. Women who perform substantial amounts of paid work arguably face only a "double burden" and not an automatic empowerment from their subordinate status. Insofar as the micro level studies on Muslim women's economic problems suggest that earnings, like other assets, improve women's bargaining power, the work suggests that they, like women longer in the workforce, have an improved capacity to renegotiate family roles, as well as to be more assertive in public dimensions of their lives, whether the economic or political.

Asghar (1996) in his study on Rights of women in Islam observes that patriarchal societies often harnessed even just and egalitarian norms laid down for women in divine scriptures to perpetuate their hold. The Quran, which is comparatively liberal in its treatment with respect to women, also suffered the same fate. Today many of the old social structures are crumbling fast and modern social orders, rational and liberal, are emerging in our society. In the changing social structures it is becoming increasingly difficult to maintain the old attitudes towards women. The scriptures are therefore being re-read and re-interpreted, at least among the progressive sections of these societies.

ArifZain (2000) in his study on Muslim women in hijab on the road to progress tried to get answer to the question, Is hijab, the Islamic dress code a hindrance in woman's progress? To find an answer to this frequently asked question come to Kerala where the number of Muslim women, who work in different capacities with hijab, is increasing with each passing day. These women stamp their true mettle in each and every field they are involved. The success of women with headscarf in their respective fields gained attraction of social scientists.

Terrie Reeves (2002) in his study on Muslim women's workplace experiences: implications for strategic diversity initiatives observes that Religion is one diverse category that can be invisible yet still has a significant impact on working population and their engagement in their respectiveworkplace.Organizations engaged in strategic diversity initiatives may require to better identify specific nuances of diversity concerning religious expression and the potential psychological toll hiding those expressions may have on workers.

Priscilla Offenhauer's (2003) study on Women in Islamic Societies reveals that only in the last two decades, the voluminous and fastly expanding social science scholarship on women in Muslims societies offers an impressive corrective for the monolithic stereotypes that have long existed about the world's half a billion Muslim women. The potential diversity of those lives belies the idea that the single factor of "Islam" could be a primary designer of Muslim women's status and well-being. Rather, Islam itself is caught up in,

and colored by, the specific histories and socioeconomic backgrounds that shape the lives of Muslim women.

The review done by OdehYosef (2008) on the healthcare beliefs of Arab Americans further expressed that some of the cultural barriers related to modesty, and gender preferences in seeking and receiving healthcare from male or female providers. Certain religious requirements may interfere with the more traditional approaches that health providers adapt to establish rapport with patients. For instance, some Muslims, probably those who observe the hijab, may not shake hands with someone of the opposite sex. Without realising of and respect for these cultural norms, people might unintentionally alienate Muslim women, despite intentions to create them feel part of the group. (Hammoud et al., 2005).

According to the study done by OdehYosef (2008), some health-related and social practices might create challenges to Muslim women as service providers in the Western world. Further, the studies revealed that prescribed religious practices of the Islam like fasting, taking time off for prayers throughout the day, or wearing hijab might create the image that this population could change public space (Kulwicki et al., 2008). It draws light on the impression that Muslim women can be at a substantial disadvantage due to negative attitudes that are being depicted through media, which may be seen as a cause for concern, because it could limit their liberty and independence in terms of practicing their faith, as well as hamper their work performance. Islam insists both sexes to dress modestly, to maintain a moral social order and to

save a person's honor – so the basic perquisite for Muslim women is that clothes are neither transparent nor shape-revealing and that arms, legs and hair are covered, especially in the presence of any adult male who is not in the woman's direct lineage.

Hammoud et al. (2005) suggested "although Westerners tend to view themselves as human beings searching for spiritual experiences, Muslims are more likely to view themselves as spiritual beings having a human experience. Further, according to OdehYosef (2008), "the notion of healthcare and health promotion practices is prevailed in the Islamic faith. The author also suggested that these findings explained due to the traditional Islamic belief system embedded in Quran which placed an emphasis on individual's health".

Annie Siddiqui (2012) in her study on Experiences of Muslim women as healthcare professionals in Canada observe that being professional was an important part of their religious duty for women in this study. Islamic belief system emphasise in the understanding that God's message to humans is based on the notion of justice (Jouili, 2011). "According to this belief, then, Islamic rights are not only cemented into a religious-moral framework of divine origin, but are also fundamentally linked to a certain ethical practice…reflecting in notions of obligation, responsibility and duty" (Jouili, 2011). Most current studies related to the topic of the Muslim women give much emphasis to spiritual factors which supposedly play a predominant role in shaping the experiences of the Muslim women. However from the findings of this study it could be stated that many more factors such as culture, class, social relations,

economic, and education also design and shape the experiences of the Muslim women in the Canadian social environment.

Jibin and Naseema (2017) in their study on "Muslim women in Malabar-transition in education" reveals that today Muslim women of Kerala are showing willingness to express their problems without any hesitation in public and analyze social problem in their own outlook. The status of Muslim women in Kerala is higher when compare with other states of India. Education is the primary factor that affects the life style, culture and status of Muslim women in Kerala.

MEDICAL PRACTITIONERS

Pandey and Geetha (1996) study on women in medicine shows that working hours are not fixed specially for those who are practicing in a big hospital with indoor duties. A call at odd hours is a routine for such doctors. In such a state of affairs domestic work is bound to be affected badly one way or the other. To avoid such situations, they compromise with career.

VinodVallikunnu, Ganesh Kumar, SonaliSarkar, Sitanshu and Harichandrakumar (2000) conducted a qualitative study on the professional experience of rural doctors in Malappuram highlighted that the medical officers are struggling in managing the work in stipulated time period. They were competent to manage the clinical workload, but due to time constraint, they cannot work satisfactorily. Majority of women doctors are face difficult to find sufficient time for properly examining, diagnosing, and providing treatment to the patients. Most of them reported that they have no sufficient

time for taking rest and have refreshments, even during the break time in the hospital, and 60% of them faced problems with patients. However, a majority (83.3%) of those who reportedly faced problems with patients revealed that these patient-doctor issues had never affected their management with OP duties in anyway.

Joyce Lebra, Joy Paulson and Jana Everett (2001) in their study on women and work in India observes that medicine is one of the oldest and the lucrative and most prestigious professions for women in India. Because of the cost of training the medical profession is restricted largely to the upper classes. The practice of women consulting women developed because of strong cultural preferences exists in our society.

Farr Curlin and associates (2005) in a study on religious characteristics of U S physicians state that compared with the general population, physicians are more likely to be affiliated with religions that are underrepresented in the United States, less likely to say they try to carry their religious beliefs over into all other dealings in life (58% vs 73%), twice as likely to consider themselves spiritual but not religious (20% vs 9%) and religious belief influence their practice of medicine.

RakeshChadda and MamtaSood (2010), in their study on women in medicine find that medicine has been a male dominated profession because it demands long working hours that are disadvantageous to women who, even in this modern period, struggle to balance career and family responsibilities.

Earlier women were largely restricted to fields like obstetrics, gynecology and pediatrics, this was changing.

Kapur and Bharti (2012), study on about health care sector in India, found that the public health care sector is no longer the dominant player in Kerala. Recently private health care sector has outgrown the public health care sector and private expenditure on health care has increased. The implications of the creation of a situation for disease control and betterment of the health status of the population are not yet clear.

Neena and Donna (2013) studied on technology and work-family equilibrium among medical practitioners found that modern technology revolutionized the life of married women doctors. It helped to minimize the time spent for various domestic activities. It makes life easier and less confusing. Professionally, modern technological devices make work easy.

RemaNagarajan (2016) in her study on Medical profession reveals that more women study medicine, but few practice' revealed that women were earlier largely restricted to fields like obstetrics, gynecology and pediatrics and this trend has been changing. 'There has always been a predominance of women in preclinical subjects like anatomy, physiology and bio-chemistry and paraclinical subjects like pharmacology, pathology and microbiology rights from the 1970's. Women comprised 50.6% of medical college admission in 2014-15. However this figure reduces to 1/3 at PG and doctoral level. Only 17% of all allopathic doctors in India are women. Experts say this could be because women even today have to struggle to balance work-family balance'.

Indian Medical Association (2017) reveals that doctors heal and help people live longer, but it seems many of them are dying younger when compared to the general public in Kerala. Doctors are generally working under a lot of stress irrespective of other government and private jobs. Increased working hours, the number of patients they attend to and high expectations from doctors by the patients and relatives contribute to this increased stress.

MARITAL SATISFACTION

Marriage is a bond, rather than a legal tie up between two individuals in the ground of psychological and social coherence. It is a union in which two individuals from different background and personality traits started to interact and cohabit together for cause of establishing a family. 'Both men and women enter marriage with higher expectations of interpersonal communication, intimacy and sexual satisfaction' (Furstenberg, 1996).

Aliya (2013) in her study on marital power and marital satisfaction among American Muslims reveals that a common Muslim saying attributed to the Prophet Muhammad states that marrying fulfills half of one's religious duties (Hogben, 1991), and divorce for Muslims is allowed but discouraged by God. Family constitutes the unit of society, and its health directly influences the health of the larger Muslim community because of the family's role of passing along social and spiritual values (Hodge, 2005). Marriage among Muslims is considered a social contract and union not only of two people but also of two families, who often facilitate heavily to mate selection (Haddad et al., 2006; Smith, 1999). As may be visualised from this emphasis on healthy

families, much effort goes into maintaining the Muslim couple's stability and healthy functioning (Alshugairi, 2010). Muslim couples are promoted to work hard to resolve marital conflicts. Yet, they may struggle to obtain the necessary support and seek mediation from family in times of marital disputes recommend and backed by religious teachings (Qur'an verse 4:35).

According to Fowers (1995), 'Love and marriage is the primary source of individual happiness and meaning in life. These fulfillment, happiness and positive development will be possible only when the relationship between couples is coherent and satisfactory'.

'Marital satisfaction refers to an individual's subjective evaluation of the marital relationship (Taylor, Peplau& Sears, 1997). It is the quality of relationship, in which both of the partners can enjoy life from the companionship characterized by lack of stress and unhappiness'. 'Marital satisfaction is a complex process that has over time been thought to be influenced by many factors, including education, socio-economic status, love, commitment, marital communication, conflict, gender, length of marriage, the presence of children, sexual relations and the division of labor' (Hendrick&Hendrick, 1992).

Couples are striving for fulfilling the needs and expectations. Unmet needs and expectations are resulted in stress and dissatisfaction. One's education and income have also been linked to his/her marital satisfaction and marital conflict, with greater levels of education and income predicting greater marital satisfaction and less conflict. Economic stress has result a negative

effect on marital satisfaction and a positive impact on relationship dissolution (Johnson & Booth, 1990). The presence of children in the family has both negative and positive relation on marital satisfaction. In addition, studies have reveals that there is a relationship between marital satisfaction and number of children, particularly preschool children (Stevens, Kiger & Riley, 2001). Being an important determinant of marital life, sexual relationship and satisfaction derived from it has significant relation to have a warm, close and sustaining relationship between spouses. 'Husbands' and wives' ratings of satisfaction with their sexual relationship were significantly related to the overall satisfaction with their marital relationship' (Young &luquis, 1998:116). The widening gap in communication between the couples results in failure to understand the aspirations and taste each other, furthermore consequence will be negative. Gottman's theory (1999) opines that positive interaction and friendship are the keys to marital satisfaction of couples and the prediction of marital stability over time. Learn the skill to manage conflict constructively, of course, is very important. But so is working on creating deeper friendship, intimacy and positive affect in the relationship underpinning both of these is a focus shared meaning that is couples exploring what hidden dreams and expectations constitute their conflicts and what visions they share for friendship and intimacy.

Mary Holland Benin and Barbara Cable Nienstedt (1985) investigate the conditions and reasons of happiness and unhappiness among housewives. It was states that the marital happiness and job satisfaction inter ply to produce

global happiness in dual-earner homes but not in single-earner. TamunoimamaJamabo and Sunday Ordu (2012) studied the marital adjustment of women in working class and non-working. Data was collected by using the Marital Adjustment Questionnaire. Results state that, women from both working class and non-working class exhibit no clear difference in their marital adjustment. Study by Hashmi, Khurshid and Hassan (2007) focused at exploring the relationship between stress, depression and marital adjustment. The study applied Urdu Translation of Dyadic Adjustment Scale (2000) for marital adjustment. The findings also show that working married women have to face more hardships in their married life as compared to non-working married women.

In a study by SheemaAleem and Lubna Danish (2008) 60 single and dual career women aged between 25 to 45 years were administered 30 items Marital Satisfaction Scale to measure the level of marital satisfaction among both the groups of women. It was found that pressure and hassles of jobs not only affect marital life but also their productivity. Askari, Marouzi, Shams and Tahmasbi conducted a comparative study on marriage satisfaction in housewives and employed women. There was a significant difference with respect to marriage satisfaction between employed women and housewives.

Nathawat and Mathur (1993) compared marital adjustment and subjective well-being of educated housewives and working women in India. Significantly better marital adjustment for the working women than for the

housewives indicates but the working women scores positive affect than the housewives.

Aminabhav and Kulkarni (2000) studied the significance of difference in marital adjustment between working women and housewives. The sample consists of 50 working women and 50 housewives (age ranges between 23-55). Results revealed that compared to the housewives, working women have significantly higher marital adjustment. In addition to this it is also observed women who came from nuclear families and comprised in the adult group have significantly higher marital adjustment than their counterparts.

Swensen, (2000) shows that the natures of employment the spouses are engaged also have significant influence on the marital conflict, schism and satisfaction. Females have high degree of marital dissatisfaction compared to males in this regard. Research on marital satisfaction suggests that men reflects higher levels of marital satisfaction than women and that women's' experiences of marriage are less positive than those of men (Heaton & Slake, 1999). This phenomenon of less satisfaction is much complex among employed women. Marital satisfaction were reflected to higher occupational status, higher income and educational level, similarities between couples in age and religion, esteem for the spouse, sexual satisfaction and companionship (Steinmetz, Clavan&Stein, 1990). Among these aspects occupational aspect has high relevance just as the result of modern scenario which provides extensive opportunity for women than early. Despite women's employment status, they

supposed to do a great majority of childcare responsibilities in families (Peterson &Gerson, 1992).

Stevens, Kiger and Riley (2001) reveal that marital satisfaction has a double effect if we take the case of employed women. Generally they are often stressed with the dual role in the office and home. Culturally and traditionally women are engaged in house hold labor and child rearing but the socio-economic changes empowered women to have outside employment in a number of diverse fields.

Agarwal and Dhawan (2005) conducted a study among 120 Married males belonging to Hindu middle class families about spouse role expectations. It was found that the spouse role expectations of Indian husbands are more traditional and found significant difference between spouse role expectation and spouse role performance.

Abdul Azeez(2013) in his study on Employed Women and Marital Satisfaction, throw light upon the different conditions that possibly influence the marital satisfaction of married working women with special attention on married female nurses. Maintenance of a coherent and harmonious marital relationship is resulted by many factors, including personal, relationship, psychological and social factors. Age and duration of marriage are found to be two influential matters in relation with the marital satisfaction of different sub categories. Women are more prone to problems of marital satisfaction that has correlation with the employment they engaged. Men are more likely to withdraw from negative marital interactions, while women are more likely to

pursue the conversation or conflict (Johnson, 1996). Women are more likely to show the emotional quality of marital functioning and more sensitive to events that occur in the relationship (Johnson, 1997).

DECISION MAKING

Decision making of working women with respect to household affairs is a significant area of study. Traditionally it is a masculine authority with very limited feminine participation. Since women started to earn themselves, their voice started to hear in the family decisions along with male counterparts in the society.

Blood and Wolfe (1960) first developed "theory of resources" which indicates that husband wife decision-making power depends upon the resources they own. Resources refer to income, education and occupation. This theory also indicates that women decision-making power may increase along with increase in her resources. Various theories supported this view that if a person has more resources in a family he/she will have more opportunities to express power in decision-making within the family (Saffilios-Rothschild, 1969; Lamouse, 1969; Lupri, 1969; Kandel and Lesser, 1972). Denise and Gerald (1972) further tested through survey research Blood and Wolf's theory of resources in family decision-making power Danish and American families shows that wife's employment if it is fulltime or part-time play an important role to increase her decision-making power in family.

In our modern society the variables like education, employment, income, and social participation are the important determinants of status of

women. These status variables empower women with authoritative positions of autonomy and decision making and these are considered as the development resources for women. Since education provides opportunities for awareness, personal advancement, social mobility, hence educated women have greater degree of decision making power (Dandekar: 1965). Puri (1971) in the study on the factors affecting participation of women in household decision making shows that an important role was played by women in decision making of domestic aspects while they were consulted by their counter parts in activities related to farm (Puri, 1971). During occasions like marriage, farm related tasks and expenditure pattern the main decision makers were the head of the family, whereas in cases such as higher education of children, selection of career of children the decisions made by the whole family.

Women's economic participation enhance their access to financial resources, control over income and their contributions to household expenditure. They are able to strengthen their position in family and fortify autonomy in family decisions because of their ability to share family budget (Krishnaraj and Chanana: 1989). According to Dube, (1989) although, it is agreed that women's education, income and occupational status are the significant resources which provide a power base so that they can acquire decision making power, but the same perspective doesn't practical in all Indian families where power is not defined strictly in terms of resources. However it is true that, education has a long lasting impact on women's values and attitudes and as a result growing number of urban women in particular, are entering the

workforce, seeking their identity as members of society equal to male members and also seeking power in different areas of decision making both in family and society (Blumberg: 1984).

Maitreye Dixit (1998) in her work 'Women and Achievement, Dynamics of Participation and Partnership' has observes about women's decision making power. He referred that in patriarchal system women are always considered as weak, fragile and needs protection of men at all stages of life and therefore, are not in a position to participate in decision-making process in the family. LeelaDube (1988) in her edited volume 'Visibility and Power Essays on Women in Society and Development' pointed out that, gender differences are embedded in our culture. The distinction between feminine and masculine work starts set in childhood and becomes sharper with child grows up. Therefore, it may take years for women to acquire any power of decision making or any autonomy within the family.

UshaTalwar (1984) in her work titled 'Social Profile of Working Women' has attempted to identify the facts of life of the working women. The book also presents a comparison between division of labour, decision making in the family and marital relations among working and nonworking women. Robert Blood and Donald Wolfe (1960) in their pioneering work 'Husband and Wife: The Dynamics of Married Life' have presented their resource theory of family power and argued that, power exercised by husband or wife depends much more on the relative resources that each of them contribute to the family. They focused their study on the resources of income, educational attainment

and occupational prestige and based on interviews with 100s of middle class women in Detroit, shows that, the greater the men's resources in those areas, greater the men's perceived power within the family. The resource theory of family power is applicable in the sense that, it suggested the idea that starting of women's access to resources outside the family could result in a more evenly balanced distribution of power within the family.

Safilios-Rothschild (1970) in their work 'The Study of Family Power Structure: A Review 1960-69' reveals that that, in every society it is perceived that, males have more power in families because of patriarchal beliefs about male authority, although male dominance in families might be diminished through women's entry into paid jobs.

Kapur (1972), one of the few notable social scientists in the country, has taken a keen interest in studying the course and pattern of changes in the life and attitude of educated married working women in India. In her pioneering work 'The Changing Status of Working Women in India' she mentioned that, after India got independence the altered socio-economic conditions have made it imperative for women particularly from the lower and middle class to take up gainful employment. She has revealed that this emancipation of women from their set tradition-bound ethos has mainly been instrumental in transforming their life. Her findings also points out that working women have come to realize that work gives them personal status and liberal social standing. Women should become intellectuals and should work towards social transformation.

Olson (1975) in the study titled 'The changing Positions of Women and Men in Comparative Perspective' have examined family decision making and reported that key resources such as education, job status and income have great influence on their family decision making processes. Disparity in income between the husband and wife also enables us to understand the impact of income on decision making.

Cromwell and Safilios (1979) in his work ' Sex-role Attitudes and the employment of Married Women' indicates that, decision making in the family is a critical element while assessing the status of family members since it involves the allocation of resources and the distribution of role among the family members in the process of decision-making. He also focuses on who makes important or unimportant decisions, which makes frequent or infrequent decisions and how these dimensions interact. He says that, there are some important decisions such as changing residence or buying a car, schooling of children and so on. The insignificant decisions include menu planning or deciding to visit parents or in-laws. He observes that employed women due to the contribution to the family's income now have equal share with their husband in most of the important areas of decision making and their implementation. Kliger (1954) in his work ' The effects of the Employment on the Married Women and Husband and Wife Role' argues that, than non-working wives, working wives influence family decisions on major purchases, loans, savings and investments to a greater extent. David M. Heer (1958) in edited volume ' Dominance and the Working Wife' from a sample containing

respondents from all social classes shows that, really important decisions such as, money centered and children centered decisions significantly made more by working wives. R. Sood (1991) in her study on 'Changing Status and Adjustment of women' presented that a deep understanding of the role played by education and employment in raising the status of women. The book says, education and employment have emancipated women to a considerable extent from traditional socio-cultural rigidities. Today, they are equipped with a certain degree of autonomy, identity and self esteem. A sense of equality among women has reduced the superiority of men over them. She also indicated that working women not only participate merely in decision making, but they stamp their presence almost in all spheres of family life.

John Scanzoni and Szinovacz (1980) in their work 'Family Decision Making: a developmental Sex Role Model' have tried to share the point that there is a close relation between gender roles and decision making power in the family. They argue that men become attached to position that exists in public sphere, women's positions are found in the private sphere, i.e., most significantly in family. Further, the role men perform consists of 'exchange value' .In contrast, the role that women perform generally consists of 'use value' and thus they have no power to change the existing gender stratification even if they wanted.

Bharati Debi (1988) in her study 'Middle Class Working women of Calcutta' has looked at women through the perspective of their work and according to the her, education as well as economic emancipation has positive

association with status of women, since the former has influence upon the nature of gainful employment of women outside home. To what extent such exposures and consequent attainment of status could free women from their responsibilities.

M.Dutta (2002) in an article titled "Women's power and authority within middle class households in Kolkata' focuses on gender equality within families of urban middle-class Bengali women in Kolkata. The study indicates that some equality and mutual discussion between wives and husband in the exercise of domestic authority has emerged in the families of middle class Bengali women as a consequence of the increasing participation of paid employment among educated women. Another contributing factor to the shift in the authority pattern has been a change in the domestic roles due to the participation by husbands in household roles. However, although paid employment appears to have slightly increased still husbands tend to retain the final say in major domestic decisions.

Women involve most actively in home management and men in money management (Sinha&Sinha, 2007). Women reported that they become more emotionally participated in decision making discussions than men (Caprino, 2016; Huston, 2016). The Qualitative Report 2017 women's participation was high in activities like utilization of milk, number of milk animals to rear, quantity of milk to be kept and sold, medium participation in activities like deciding the rate of milk, which animals to be sold, breed selection, treatment of animals and housing of animals (Dubey, Singh, &Khera, 1982). There have

low participation in decision-making in utilization of income, vaccination, grazing of animals and breeding practices in animals.

Susheela, Surendra, and Phadnis (1990) their study in decision making pattern in household aspects by rural families, expressed that the type of family was found to be the determining factor in decision making. As it was evident, in nuclear households' percentage of joint decision was found to be high in children's education, marriage and also in all other aspects when compared joint and extended households where head of the family alone making decision.

Bala, Moorti, and Sharma (1993) in their study on participation of rural women in decision making found that more than 90 per cent of the decisions, was only of supportive nature participated by women. Lower participation identified as a result of their Illiteracy, awareness and lack of knowledge. Munjal, Punia, and Sangwan (1985) in study on role of rural women in decision making for credit procurement shows that money related decisions are dominated by males and very low involvement of rural women in decision making regarding credit procurement (Sangwan, 1990).

Patki and Nikhade (1999) noticed in their study on participation of rural women in decision making that both husband and wife play important role in decision making. It reveals that in the areas which are risk involving practices and need skill, women decision making was less.

Minaxi and Lopamudra (2000) revealed that women are regarded neither knowledgeable nor competent enough to participate in the process of decision making. Major decisions were taken by the male head of the family

like farming. Only a supportive influence in decision making has been taken by women.

Jan and Akhtar (2008) study on decision making power among married and unmarried women reveals that there is no significant differences between these two categories of women regarding their decision making power. Women generally hold low power in decision making and are mainly approach masculine and/or familial decision making. Kavita (2014) observed that women's decisions were found prominent in petty household issues only. Women, in most of the cases act in the initial stage of deciding about some major household affairs but final decisions were being taken by men. In the case of rural India, even though women participate in economic activities they have little part in decision making especially in matters related to agriculture and finance.

Sabina Bano (2014) in the study women and decision making in urban India stated that socio-economic status of women decides the participation of women in decision making and is likely to be affected by Gender differences in the decision making on various issues occurring in their daily activities. Likewise roles and responsibilities of women and their choices are restricted to specific sphere.

Giriappa (1986) considered that the role and status of women has been undergoing a continuous shift in recently in both female and male headed households. The participation level of women in decision making was found to be increased (Giriappa, 1986).

Mona Mehta and ShilpiSaraswat (2014) in a study titled "Decision Making Pattern of Working and Nonworking Women in Family Affairs" revealed that the patterns of decision-making were collective with regards to specific areas of family affairs. The study also found that even if most of the women were educated the role is lesser in decision making (O'Neil & Domingo, 2015). Empowerment to participate in decision making is hardly found among women even though contribute more than half of the duties and responsibilities of the family (Mehta &Saraswat, 2014).

DUAL –ROLE

Dual –role of women as house wife and outside employee is an emerging area of research. Traditionally women in general and married women in particular regarded for domestic duties. Husband and children is her world. But numerous factors pulled her to the world of outside employment as an earning member. It results a number of positive and negative impacts on women, family and society.

According to Bagilhole (1994) there are structural and cultural barriers both outside and within the work environment constantly threaten women, which compel to keep most women at a disadvantage in the world of work and stand against their advancement.

Blood (1963), study on husband-wife relationship in dual career families. According to him couples with dual income expect more interaction and joint activity during their leisure time. The reduction in the leisure time

they got, when housework must confine to off work hours, interferes with the more time consuming of leisure.

Powell (1963), has stated in the study on students of the family have assumed that adding the role of an employee to the women's role of wife and mother often necessitates a redefinition of the role of family members in terms of duties and responsibilities. A working wife may not deal effectively the household job and employment if she is supported by her husband in the household work.

Hate (1969), found that the balancing of outside job and home found difficult for the married working women. Though they might consider it to be possible to combine marriage with work, they come forth difficulties and increasingly they are looking for a satisfactory combination of motherhood and paid work. The newly enjoyed liberty to have education and economic independence has brought a woman of urban India new avenues for self expression and personal satisfaction. But with new responsibilities and obligations they carry out successfully with their newly gained privileges and freedom.

Kapur (1970) revealed that even if many of the working wives accepted their dual roles, they normally received little help from husband in carrying out their dual responsibilities and thus experiencing role conflict.

Singh (1972), working on data from Punjab says that only 25 percent of the working women are fully satisfied with the time they were spending to their

children, 75 percent replied that they really not able to devote properly to attent their children and consider home as the major part.

Kala Rani (1976) revealed that among those working women who required and expected help from their husband, there was role conflict if husband did not give them support in fulfilling out these responsibilities. She further observed that, "the husbands refusal to help his employed wife in household jobs was also the outcome of this vigorous resistance against change in his traditional attitude towards wife's duties in the house because acceptance of the changed pattern of husband-wife role in the house threatened his self esteem as a patriarch and prevented him from enjoying the patriarch privileges".

Ramanamma (1979) conducted a study of graduate employed women in an urban setting. The study sought to examine the alterations happening in the marriage patterns due to education and employment in urban women (Poona city). A sample of educated women from six varied occupations was selected for the study. The study pointed out that changes were happening among the educated and employed women and life and marriage appeared difficult to handle with dual career women.

Gupta and Ganguli (1982) developed a marriage-work information schedule and administered to 80 married women doing their clerical job in financial organizations in Delhi, India. Result shows the both positive and negative effects of the marriage-work relationship. The negative effects of work on marriage were comparatively shows greater significance than those of

marriage on work. It experienced the greatest conflict over the "mother" role. Situational variables that were significantly related to the level of adjustment achieved between marriage and employment were type of family, the degree of husband's approval of wife's employment, the presence of children, and the age of the youngest child.

Hemalatha and Suryanarayana. (1983) sought to examine the role interactions of 150 married working mothers in Tirupati, India, in the fields of teaching, clerical work, and various employments in hospital. The reasons motivated them to take up employment, their role interactions and communications with husband and other family members, care of children, household duties, relationship with colleagues and boss, and official responsibilities were examined. It was concluded that wives had made to more adjustments in family maintenance than did husbands and 85% complained of problems in the area of child care. However, most of them were struggling yet somewhat successful in combine their role as workers and housewives successfully.

Baud (1992) study on forms of production and womenslabour reveals that, women's responsibilities within the household constraint the types of employment that she is engaged and the kinds of household activities with which she can combine them. Her employment and income can lead to changes in her bargaining capacity within the household, as reflected in the division of domestic labour distribution of resources and decision making pattern. FlippoOsella and Caroline Osella shares that professional employment is not

gender based, allowing women to participate without necessarily losing status: low-status work is highly gender based and is thought to say something about both type of women who does it and the type of family she comes from. Making of female lawyers, doctors, lecturers and school teachers have their own name and status augmented by gender-neutral titles (Adv, Dr, Saar). The social prestige of professional occupations is so high-as is the existing social status of the women involved- that negative effects are limited: significant monitory benefits render professional women largely indifferent to criticism.

Chowadhary (1995) examined the significant features of the families of employed women and young children in India. The major areas of study were influence of working mothers on marital relations, child care and own health. It was revealed that a majority of mothers held outside work due to economic pressures, rather 50% of mothers not have the same opinion. To assess husband's willingness toward their wives' employment, it was observed that 55% of the wives are working as a full time worker with the consent of husband. However, 38% of selected employed mothers stated that they were unhappy with their outside employment, and felt sorry of neglecting their children and family. 74% of the mothers expressed their dissatisfaction on alternative child-care facilities existed in the society. It was concluded by emphasizing the necessity to re-examine the restructured role of father inside home in order to manage the gap of the mother's employment.

Saxena and Rani (1996) examined family and employment of women as factors reflecting life satisfaction and happiness in India. In the study sample

equally consisted of 40 employed and 40 unemployed middle class women. Self-made tools test life satisfaction, perceived happiness, attribution, anxiety and family structure by work roles compatibility were measured life satisfaction and happiness. Results showed that working women experienced lower life satisfaction and happiness than non-working women.

Pillai and Sen (1998) enquired the life of working women with respect to their dual role, as professionals and family care-takers. 100 married women (aged 25-54 yrs), engaged in 4 variuos professions (doctors, lawyers, media women and executives), were examined to identify how they were successfully able to combine these 2 roles. The items assessed were their Job involvement, support from the family and 6 other life aspects, like (a) personal time, (b) physical strains, (c) marital life, (d) psychological conditions, (e) physical life and (f) professional commitment. Suggestions for possible solutions to the problem faced by those women also asked. Results indicated that only a few of working women were able to maintain balance their dual roles. Most of them recommended certain ways like government initiatives, family-friendly organizational schemes, and a general societal reorientation.

Vats and Mugal (1999) in their enquiry on women in various professions draw a different picture. They support that women should get close access to the nontraditional female areas like market place, work place and modern technology and they should be able to organize commercial and entrepreneurial ventures in order to remold and balance the social structure.

Aminabhav and Kulkarni (2000) assessed the significance of difference between working women and housewives in their marital adjustment. The sample consists of 100 samples equally from both 50 working women and 50 housewives (23-55yrs of age). The marital adjustment inventory developed by C.G. Deshpande (1988) was applied to measure the marital adjustment of both the groups. Results shows that the housewives have significantly lower marital adjustment than that of the working women. In addition, it is also observed that women of the adult group and women with nuclear family background have significantly high marital adjustment than their counterparts.

Dutta (2000) examined the impact of the employment of women on the structure and functions within the households among the Bengal community in a part of northeastern India. This demographic grouping remains largely unstudied despite its greater cultural significance. Questionnaire distributed among 65 married and 40 unmarried women (aged 20-60 yrs) to enquire about social background, household decision making, division of housework, and attitudes toward social issues. The results show that the entry of women into the paid work force has had a partial transformative effect on the household duties and decision-making. In addition women remain unmarried are started to view marriage in distinctly non-traditional terms. The author suggests that salaried jobs have the potentiality to alter deeply-rooted and well-established cultural norms.

Nassbaum (2000) envisions family as a basic social institution in which the state should actively intervene to safeguard the interest of women and

children. According to her, new trends of relationships in various organizations make positive changes in the family relationship by giving women new strength to defend against domestic violence, winning them new respect from husband and sons. There is often a valuable synergy between reciprocity of care outside the family and a positive restructuring of that institution.

According to Verma and Larson (2001) employed women have to deal with six preoccupied commitments namely marriage, children, career, house, friends and community involvement. The four strategies to be adopted to tackle this problem and experience life satisfaction are Role sharing, Role substitution, Role cycling and Role disengagement.

Jenitta, Chidambaranathan and Allen (2001) argued that through increase of women in taking up work, yet they have also come forth a lot of role conflict. Earlier they were supposed to belong exclusively to their home and its responsibility. Today the working women while go for work are conditioned to conflict and feel guilty of neglecting her home and children. She feels, it is her moral responsibility to fulfill both the jobs efficiently. In this process she develops feeling of guilt for not devoting full time to her children and home envisioned by our social system.

Bhatnagar and Rajadhyaksha (2001) analysed attitudes towards employment and family roles of dual career men and women in India. 92 husband-wife pairs from salaried, upper middle class, dual-career Indian families participated in the study. They were tested propositions based on adult development theories of men and women, regarding reward value derived from

and commitment made to occupational, parental, marital, and homemaker roles over the life cycle. Results points out that there were no difference with age, in their attitudes towards occupational and homemaker roles. Instead, differences in attitudes based on gender towards these roles were observed. Attitudes towards the marital and parental role shows variance across the life cycle, although not keeping with propositions based on the adult development theories of both men and women. There was no reversal in attitudes towards work and family roles of men and women in the second half of their life. Rather, some transition from traditional attitudes appeared to happen between the marital and parental role, over the life span of both men and women. Their implications for the career development of women were discussed on the basis of the results reviewed within the Indian cultural context.

Murthy (2002) study focused on women, work and empowerment, list the problems experienced by employed women as limited attention paid to family, double burden, reduced amount of entertainment and social activities, inconvenient working hours and lack of cooperation of male colleagues. Most of the employed women are able to provide better standard of living, better facilities and better atmosphere to the members of their family because of better economic status through their employment. They were receiving more respect both at home and society due of their job.

TalalAlGhamdi (2002) in his study on balance between career and family life among female doctors in Saudi Arabia find out that only 19.5% were satisfied in balancing career and family life among Saudi female

physicians working in National Guard, Riyadh. Saudi female physicians have poor satisfaction in balancing between career and family life because it is significantly associated with discrimination or negativity from colleagues because of their family status, negative impact of career obligations on the relationship with spouse or child, negative impact of career obligations on performance of children at schools, difficulty in transportation to the hospital and hours of work.

Mishra (2005) enquired whether today's women are competent enough to successfully discriminate between work and family roles/identities and could present her as a model before others or fails to climb the ladder made her unsuccessful. This study based on the data from a large sample of career women highlighted the prime issues that place obstacles in their way to success and it is also supported by some ways and means to overcome the irrelevant stresses and strains of life positively and gracefully.

Carmel Foley (2005) in her study about women's leisure states that the quality and time of leisure time activities of women are different with their economic and social position. Leisure activities limited among women with smaller children and have outside employment. The availability of leisure time and its activities related with their role. Lack of leisure opportunities in the lives of women burdened with domestic responsibilities.

SzilviaÁdám (2008) study on Work-Family Conflict among Female and Male Physicians in Hungary demonstrate that spousal support with household work (instrumental support) is rare among female physicians. She is also of the

view that the division of domestic roles and duties in majority of such families still reflects traditional sex-role stereotyping. Lack of emotional support from the spouse has also been reported by most of the female physicians. This finding merits further investigation as emerging evidence suggests that in predicting work-family conflict lack of emotional support may be more important than instrumental support (Kaufmann &Beehr, 1989), which may explain the lack of associations between lack of spousal support with household duties and work-family conflict in the present research.

KogiNaidoo and Fay Patel (2009) based on their study on working women observe that women experience pressures in a number of contexts: cultural, domestic, work and profession. Despite women professionals hold all the requisite qualifications and experience; they are constantly undermined, unsupported, undervalued and marginalized. The age old stories reflect their personal struggle in the work place since its beginning. Women find themselves in situations which they recognize very late as unfair and unjust and many could not save and remain trapped and finally succumb.

SELF-ESTEEM

"Self-Esteem", the term was first coined by William James in 1890 to express about a person's overall sense of self-worth or personal value. In other words, means how much a person appreciate and like his self. It is often seen as a personality trait, which means that it tends to be stable and enduring. Self-esteem is the term that can involve a variety of thinking about oneself, such as the evaluation of own appearance, beliefs, emotions, and behaviors.

In psychology, self-esteem reflects a person's overall subjective emotional evaluation of his or her own worth. It is a judgment of oneself as well as an attitude toward the self. Self esteem envisage beliefs about oneself, (for example, "I am competent", "I am worthy"), as well as emotional states, such as triumph, despair, pride, and shame (Hewitt, 2009).

Self-esteem of a woman defined as “a realistic respect for or favorable impression of oneself,” and it can have a continuous impact on her overall life choices and outlook.

Coleman and Antonucci (1983) reported that higher self-esteem reported among women employed outside the home than those who are not employed. The self-esteem of earning wives was significantly high than housewives. The women who occupied many roles and positions in their life have higher self-esteem compared to those who occupied fewer roles. The more roles women occupied, they utilise more source of pleasure they reported in their life (Pictromonenco&Manis 1987).

Hemlata and Suryanaraynam (1983) in their study about working and nonworking women analysed that 89.3% women thought that employment and education enhance their status and so they liked their jobs. Because of this positive attitude they were able to combine the role as an earning member with that of a housewife successfully. University graduates who are not employed reported more depressive symptoms than employed sample. The presence of lower self-esteem and limited scope of organization and had no life aspirations with them. (Feather and Bond, 1983). Employment enhance the emotional

maturity' of the working women and it also indicated that working women have shown higher emotional maturity' than non-working women (Vaghela, 2014).

Gove and Zeiss (1987) observed that paid employment increased the self-esteem, efficacy, perception and status among working mother. The work place expected to offer benefits such as challenge, control, structure, support, positive feedback and self-esteem to provide a valued set of social ties. Some studies reported that family and occupation are fundamental components of women's image and they stopped thinking about family as an obstacle in their occupational activity in their better self-esteem (Strykowska, 1991; Nathawat&Mathur, 1993).

Azar (2006) identified the association among quality of life, hardiness, self efficacy and self-esteem among both working and non-working married women. 500 women were taken as a sample. Among them 250 were taken from employed and 250 from unemployed. Results highlight a positive relation among quality of life, hardiness, self efficacy and self-esteem on working and non-working married women.

Gunthey (2001) examined work status and dual role of working women and the way it influences their mental health. This study also examined the adjustment problems of working women and tests the hypothesis and the result that adjustment problems would be higher among working women. Among working and non-working women, questionnaire was to measure marital adjustment and other adjustment problems. Results indicate that working women had low understanding, less marital satisfaction and low fulfillment of

expectations; whereas the non-working women perceive more personal responsibilities for marital outcomes. Working women also reported more hassles, less support, more psychological adjustment problems and higher level of mental health hazards

Mohan, Sehgal, and Tripathi (2005) express that before the advent of positive psychology movement, professionals in psychology were mainly interested in exploring what's wrong with people and their emotions and the way therapy could be provided these mentally ill people than appeared the movement of positive psychology, spearheaded by people like Martin Seligman, who supported the study of positive emotions like happiness, joy hope, optimism and life satisfaction with health, well-being and stress. With this purpose, a sample of 50 male college students in the 18-20 age group was chosen and administered a battery of tests and results were discussed with respect to highlighting how positive emotions have the unique ability to increase health and well-being

Bhushan and Karpe (1996) observed how the psychological and cultural factors contributing to familial role stress in an exploratory study of working women in Mumbai, India. The target group consisted of 45 married women, aged between 25-40, who worked full time or were self-employed. They examined stress experienced both at the work place and in the home, and its impact on the relationship with spouse and with children and other family member (identified) causes familial role stress, its direct and indirect

consequences, and the various strategies that working women use to cope with stress (offered) recommendations for reducing familial role stress.

Elloy and Smith (2003) found that Dual career couples experiences increased stress, work-family conflict, life ambiguity, role conflict and overload than single career couples. Sherson and Dill (1983) in their study on men's work satisfaction in dual career families identified that since family lives are bound two jobs rather than one, these marriages necessarily less in different quality to marital negotiations.

Fathima (2007) in a study on Social Status of Rural and Urban Working Women in Pakistan found that working women, generally, has a higher level of formal education, a higher level of income, and more social relations than the counterpart. A working woman also typically lives in a resource rich environment and has greater access to prenatal care and public transportation. Less social isolation for working women as compared to the non working women through reduced geographical distance between family and friends.

According to Kitchener and Jorm (2002) observes that psychological wellbeing can be described as a state of mind which absent a mental disorder, from the perspective of positive psychology, it may include an individual's capacity to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience. Ryff and Singer, (2008); Ryan and Deci, (2001); Waterman (1993) described positive well-being as subjective (hedonic) wellbeing, which emphasizes happiness and pleasure; and psychological (eudaimonic) wellbeing, which focuses on the accomplishment of human

potential. Snyder and Lopez (2007) correctly proposed the formula: Happiness + Meaning = Well-being. In words of Ryan and Deci (2001), "it refers to subjective well-being by which an individual subjectively assess one's life. Psychological well-being (PWB) is about lives going well. It is the combination of feeling good and functioning effectively".

Support System

The term "support" used widely to refer to the mechanisms by which interpersonal relationships presumably buffer one against a stressful environment. Cobb (1976) defined support as, "information that prompts the individual to believe that he or she is cared for and loved, esteemed and valued and belongs to a network of communication and mutual obligation".

For a wife, husband is a confident person with whom she shares about things that trouble her and expects high level of support. Social support received from various sourses serves as a buffer against stress by helping people reassess a situation as less threatening (Cohen and Mckay 1984). Children, friends, relatives and spouses are the main sources of high level emotional support (GurungTylor, and Seeman 2003).

The members of the personal network extend support in terms of crisis or in everyday situations. The personal networks of women do not contain a larger proportion of kin than the networks of men. Women seem more oriented towards their own kin than men, since they include more siblings in their networks (Van der Poel, 1993). Siblings share emotional feelings, confide personal matters gift, pay causal visit, provide emotional warmth to children

and play guardianship roles and form a major proportion of kin ties (Arunima 1993, SivagnanaSelvi 1993).

Thakar and Mishra (1999) analysed the role of social support received in daily hassles and well being experiences of women. 196 employed and 54 unemployed married women included as sample. 3 measures of social support were used by considering the complexity of social support. It was found that the employed women experienced more hazards and enjoyed less support than their unemployed counterparts, they received better well being. Employed women's higher well-being shows the relative deprivation in the role of housewives and desire for avenues to use their potentials for self-actualization and self-gratification. Income and status, the basic resourses of empowerment generated through employment appear adequate not only to cope with stresses emanating from multiple roles, but to enhance well-being.

In Ginac's (2002) research seemed a common attitude of mutual encouragement and support. Many of the happiest and most fulfilled couples, both professionally and personally, seemed to live for the "family first". Beverly Baskin in his study argue that the hallmarks of a successful dual-career marriage appear to be flexible nature and a mix of liberty and in a study by Haddock and colleagues (2001, as cited in Haddock &Rattenborg, 2003), "virtually all of the couples indicated that marital equality or partnership was one of the strategies they believed was central to their successful balance of family and work". Counsellors extent help in assisting couples who need to negotiate an equitable division of labour (Haddock, 2002) and to address the

challenges of mutually conflicting multiple roles. Parker and Arthur's (2004) study produced similar results.

Social Network

Mitchell (1969) defines a social network as "a specific set of linkages among a defined set of persons, with the additional property that the characteristics of these linkages as a whole may be used to interpret the social behavior of the persons involved".

Close relationships maintained with family, neighbors and friends make women feel a part of and integrate into a fairly large group of network relationships. It gives them a confident feeling that they have someone to rely upon and approach for helps in times of need a need arise. These social linkages itself gradually help the women in coping with the changing life situations. The individuals in any society are surrounded by a variety of network members since childhood. As the individuals grow and nurture their relationship with network members also found change (Kahn, 1979; Antonucci 1981).

Active ties are usually dispersed ties and kinship ties are especially able to endure over long distances because of their densely-knit structure and normative obligations encourage mutual contact (Litwak and Szelenyi 1969). It is notable that immediate kin diminishes less with greater distances than does contact with extended kin (Adams, 1990, Klatzky 1971, Leigh 1982, Gaint 1988).

Women participate more than men in ties with kin and friends. If one has a partner siblings-in-law are also more likely to enter into network (Broere Van Groenou and Van Tilburg 1996).

THEORETICAL BACKGROUND

Spillover Theory of Work-Family Balance

Edwards &Rothbard, (2000) stated that Spillover refers to "the effects of work and family on each other, and is described in terms of affect (mood and satisfaction), values (importance of work and family), and skills. Spillover has also been termed generalization, isomorphism, continuation, extension, familiarity, and similarity". There are two major interpretations of spillover, firstly the positive association between work satisfaction and family and work values and family and secondly the transference in entirety of skills and behaviors between various domains such as when fatigue from work is expressed at home or when family demands disturbthe work schedule.

The spillover theory proposes the most popular view of interaction between work and family. It is suggested that, "workers carry the feelings, emotions, attitudes; skills and behaviours that they establish at work into their family life and vice versa" (Belsky et al., 1985). Positive or negative notions of spillover can be perceived theoretically and can be diagnosed using multidimensional aspects of work and family relationship. Positive spillover refers to the fact that satisfaction and achievements in one domain creates or produce satisfaction and achievement in another domain. Negative spillover on the other hand refers to the fact that problems and despair in one domain may bring an equally negative emotion into another domain (Xu, 2009).

Application of Spillover Theory in the study of Work-Family Balance among Muslim Women Medical Practitioners

Work and family are two determinants in the socio-cultural life of individuals in our society. Muslim women are entitled to work and earn equally with their male counterparts. Women in general, have to juggle these two equally demanding roles. Over concentration or avoidance of any sphere results in imbalance and problems. Monetary benefits are not the only reasons that spur women to maintain balance in both lives. The smart work overthe hard work helps the professionals to develop balance between these two spheres. There are many contributing factors for the maintenance of work-family balance. But these conditions are not always positive for all. In this study of work-family balance of women medical practitioners, the positive association between work satisfaction and family is produced as a result of correlation. The negative correlation results by fatigue from professional field of the doctors and is expressed at home or when family demands disturb their professional schedule. As it is a combination of two different but coordinated aspects of life, the clarity about the influence made by one domain over other and vice versa should be examined. In this study two different scales of work hindrance on family and family hindrance on work were applied to collect the data.

Economic Modernity: The Classical Development Perspective.

Focusing on economic development, the classical modernization perspective considers progress in democracy and human choice as a direct

outcome of economic development (Lipset 1959; Rostow 1960; Deutsch 1964; Bell 1999 Inkeles& Smith 1974). In relation to gender equality, this approach places the economic development as central to increase the pool of women eligible for positions of social power. The scholars associate the increased economic development with a more broad based distribution of educational and occupational resources. Greater access to educational and occupational resources opens women's chances of professional development, creating a larger pool of women eligible for power positions such as political office. The gradual realization that women need not confine themselves to plain jobs like nursing or just being a secretary to important men encouraged them to be doctors, scientist and engineers. Others note that higher levels of economic development create a situation which brings more social services to societies. Through their alleviation of the costs in labor and time of everyday responsibilities in association with care giving (e.g., child-rearing, domestic work), increases in these services free up time for social pursuits in women's lives.

Application of the Theory of Modernization in the study of Work-Family Balance among Muslim Women Medical Practitioners

Women empowerment is a relevant topic of discussion since many years. The creation and utilization of a woman friendly environment is the responsibility of those who achieve success in life, irrespective of their sex, which in a way is their payback to the society. Backwardness of women not only creates problems for their individual life but also for the wider society.

Education and employment are the two parameters of empowerment. Women medical practitioners represent the empowered women with high level of education and profession. Higher levels of education and profession provide them with opportunities of social interaction. The society is badly in need of dedicated and selfless persons who can be catalysts in introducing women-friendly measures for its reformation. In such a condition, they can function as a boost for social rejuvenation. It is very heartening that medical professionals with awareness about the social cost of their education can render more social services and become more social.Empowerment is serendipitous experience. It can be individually attained. It is the responsibility of the society to create an atmosphere that provides opportunity so that the women can empower herself, womanhood and by extension, total humanity.

The Status-Signaling model of Self-esteem

The status-signaling model of self-esteem (Zeigler-Hill, Besser, Myers, Southard, and Malkin, 2011) was developed as a complement to status-tracking models such as the Sociometer model (Mark Leary). The status-signaling model refers to the possibility that level of self-esteem of an individual may influence how he or she presents oneself to others and, as a consequence, how that individual is perceived by those who constitute his or her social environment. This model presents a view that, an individual's level of self-esteem may influence how one is perceived on different dimensions relevant to evolutionary outcomes (e.g., romantic desirability). A basic prediction of the status-signaling model is that individuals who developed high levels of self-

esteem should be viewed more positively than those with low self-esteem on a wide-array of dimensions. As initial support for the status-signaling model, Zeigler-Hill (2011) found that "the perceived self-esteem levels of targets fully mediated the association between their self-reported levels of self-esteem and perceiver ratings of their interpersonal behavior (e.g., social dominance)". This also presents the view that the ability of individuals to convey certain levels of self-esteem may play an important role in how individuals are viewed by their social environments.

Application of the Status Signaling model of Self-esteem in the study of Work-Family Balance among Muslim Women Medical Practitioners

Self-esteem is one of the most important aspects of success in one's life. The individual develops the idea of self through contact with their family as well as with society after a long period. People develop self and evaluate themselves from point of view of others. Self-esteem of an individual is influenced by a lot of factors. The people who are socially privileged maintain high self-esteem, which in turn helps such persons to be successful in life. Self-esteem as a creative and constructive aspect of personality provides positive life situations such that he/she can turn things positive. Critical thinking, positive thinking, decision making, time management, emotional balance, communication etc are the skills related to self-esteem. Social position, education, economic status etc are connected with it. Women medical practitioners with all the positive aspects of life are addressed as the high self-esteem group. The society view women medical practitioners with high

appreciation and positive regard. They are models for society by acquiring education and acceptability. They are seen with great respect by patients who repose their trust in them to save their life. Confidence and a feeling of worthiness are very much needed for this profession. Once they lose the morale then the society panics. Network and support system help them to develop self esteem. Marital satisfaction, support to profession, network and so on maintain work-family balance through self-esteemamong Muslim women medical practitioners. A self developed scale of 15items by using five point Likert scale was applied in the study for self-esteem.

Maslow's Hierarchy of Needs Theory

Maslow's Hierarchy needs theory divides human motivation into five levels such as physiological needs, safety and security needs, social needs, ego/esteem needs and self actualization needs. Fulfillment of one need leads to the desire to get the next levels of needs fulfilled. Maslow suggests that higher needs like ego/esteem needs and self actualization needs arise only after when once the lower order needs are fulfilled.

Physiological needs

Physiological needs are the needs that are registered for human survival. If this requirement is not met, then the human body cannot work properly. We can say that physiological needs are those that are necessary for sustaining life. Examples for such items are air, water, nourishment and sleep. Job is the only source to overcome poverty, if anyone loses it, their family may starve.

Safety and security needs

At this second level in the hierarchy of needs, people seek security and safety. It can be job security, life security and financial security. Employees may continue to work hard to maintain job security. If an employee is sure that his job is secure, that thought itselfgives him/her job satisfaction.

Social needs

Social or belongingness need seeks to fulfill the next level of need after once the first two needs of a person are fulfilled. People need to have healthy social relationships for which they make friends and have familiar attachment, religious contracts and so on.

Ego/esteem needs

The next level of need arises when people need to achieve; issues related to self esteem, self confidence, respect and status. People who achieve this level of need are often motivated. The superiors should give a chance to persons to share his idea in a particular task to create happy and motivated workers; they should be appreciated and rewarded often, when the persons do any innovations or become first in finishing of any project. At any stage no one is eager or accepting ofpunishment from superiors, which when happens their ego will be affected. Such situations will lead to dissatisfaction of an employee in his work.

Self actualization needs

This is the highest level of hierarchy of needs. Self-actualizing people have self- awareness and are only concerned with their own personal growth.

They are less concerned with the opinions or thoughts of others and are more interested in fulfilling their potential and are inclined to have needs such as truth, justice, meaning, wisdom.

These four items have been distributed in this type of need and it reveals that the person was highly satisfied.

Application of Maslow's theory of Hierarchy of needs in the study of Work-Family Balance among Muslim Women Medical Practitioners

As an employed woman, medical practitioners expect satisfaction of various levels of needs to attain different goals of life. Their position as a doctor is the result of continuous and tireless efforts made in their life. Working women face various conditions so as to achieve success in their life. For this they also go through various stages of satisfaction as stated by Maslow'sphysiological needs, namely safety and security needs, social needs, ego/esteem needs and self actualization needs. As the basic condition for the very existence of life, the women medical practitioners need the basic requirements of life like air, water, food etc. The security and safety in life and employment are also aspiredto by these women. As a woman they need to be accepted by the family, society, groups etc. and the recognition as a respectful person is their social need.The social acceptance as a dignified individual helps them to create an inner self which place oneself as a self esteemed person. The education, employment and social position help them for achieving positive rewards from the society. Rejection or punishment is not accepted by them at this stage. They always look towards positive experiences. The last stage of self

actualization helps them to be selfless and truthful professionals in the service of humanity. This theory helped to formulate questions on perception and attitude of women medical practitioners.

The Dynamic Goal Theory of Marital Satisfaction

Among the modern theories on marital satisfaction, dynamic role theory is gaining increasing concern. According to this theory, people in any society get married to satisfy multiple goals like personal growth goals, companionship goals and instrumental goals. The priority of the three types of marital goals is categorized under dynamic changes across adulthood. Young people give importance to personal growth goals, middle aged people on instrumental goals whereas old people emphasise on companionship goals. Marital satisfaction determined on the basis of whether the prioritized marital goals are achieved by the individuals.

Application of Dynamic Goal theory in the study of Work-Family Balance among Muslim Women Medical Practitioners

Marriage is a contract for Muslims. It is a not just relationship between two individuals, rather two families. The most important goal of marriage is companionship between couples and replenishing of individual needs. As individuals both husband and wife need to satisfy their own goals through the companionship. Education and employment develops high marital expectations among women medical practitioners. As the dynamic theory presupposes, marriage helps them for their personal growth. When the marriage does not provide the desired result, it may break or dysfunction, hence these goals will

not be fulfilled. As professionals with high social responsibility, they expect more cooperation and concern from their partner. They are somewhat free and safe from conflicts during the early stage of marital life. With passage of time, the tendencies to accommodate each other's demands reduce. Adjustment instead of understanding creates problems later. Children may or may not be the reason for such conflict. Satisfaction and peaceful life are the basic determinants of an individual's performance. A person with low marital satisfaction suffers in his/her career. Professions such as a medical practitioner's in general and women in particular involve too much of emotions. A person with problems in marital relations and familial instability develops stress and loneliness. It directly influences the work-family balance of the medical practitioners. While studying work-family balance the level of marital satisfaction needs to be considered. In this study, level of marital satisfaction was measured with 15 parameters, by using five point Likert scale.

Chapter-III

METHODOLOGY

Medical doctor is a well paid profession as well as a prestigious and status oriented position in any society. It is fulfillment of long cherished dreams and result of extreme hard work. Academic qualifications along with a number of related and supporting factors help one person to be competent in this field. A popular doctor is one who has the skill, practice and acceptance among his patients. It further enhances his/her responsibility and challenges the ability to maintain quality in such a competitive field.

All these conditions added with religious and cultural ingredients lock the individual within a circle which sometimes burn or blast the system. Imbalance in the work and family domains turns the conditions negative for the individual. For any woman dual role performance becomes convenient and she develops self-esteem if supported by men and materials. Presence of a network of all the supporting factors equates her efforts with success. The family, especially husband is probably her greatest strength and support by sharing worries and chores. Such a situation though ideal is not very common because male dominant pockets still exist in all sectors in our society.

Statement of the Problem

In fact, education and employment are two major indicators of empowerment. When we talk about women empowerment these two conditions

alone do not help them to uplift their position. Even the highly educated and paid women require more conditions to support them for better life. A woman can claim satisfaction and a sense of achievement only when she is able to manage both her professional and domestic sphere with dexterity. Increased prioritisation or avoidance of one or other part directly affect the individuals and their productivity. Usually, they are compelled to compromise or alternate the domestic duties for the cause of career. But in effect, it may break the relations or productivity in work due to stress and strain. To be perfect as a professional may require compromising with domestic duties and in turn to be acceptable in the traditional role of housewife demands less career orientation. But in this competitive professional sphere qualification along with skill, quality, competency and hard work equate success.

Women Medical Practitioners are celebrated as empowered category of women with high educational qualification, negotiable salary, social prestige, power in decision making in professional field, freedom of movement, sociability and so on. Education and employment are the two parameters of women empowerment. Today women display their intellectual power both at home and in the society. The emerging significance of women's economic participation is by breaking the shackle of traditionalism. However, the independent earning is a boost that provides her power and self reliance, especially in family decision making process as wife, mother and housewife.

Medical field, as a continuously growing field of knowledge and technology, demands high level of performance from health professionals especially medical practitioners. Many women medical practitioners end up leaving the field as a result of this dilemma. Those who remain in the scene adapt greatly to manage both in equity and struggle to maintain the same despite religious and cultural stigmas. Here rise some questions like: Does any conflict emerge while balancing work and family? Whether these women enjoy real decision making power? If they have a self-esteem in their complex life situations? Whether they can enjoy the positive aspects of a support system or a network in their life? There are several questions to be considered and answered when deciding a composite picture. But for the time being this research intends to focus on Muslim women medical practitioners in Kerala. The research will primarily be about work family balance in the lives of these Muslim women doctors.

Following are the major objectives set-forth for the present study.

Major Objective

To understand the work-life balance among Muslim Women Medical Practitioners

Specific Objectives

1. To find out the socio-economic status of the Muslim Women Medical Practitioners.

2. To know the level of belief and religious participation of these women.
3. To identify the role structure of the respondents within the household and to also identify the utilization of leisure time.
4. To identify the marital satisfaction level of these women.
5. To find out the level of participation in decision making in both personal and professional affairs.
6. To know the nature of social network, sources and kinds of social support received by these women.
7. To identify the level of self-esteem among Muslim Women Medical Practitioners.
8. To understand the dual role performance among these women and the favorable aspects to support them.
9. To know the perception and attitude of these women towards social issues regarding women

Hypothesis

H1. Women medical practitioners enjoy decision making power.

H2. The level of self-esteem will be high among women medical practitioners.

H3. High self-esteem and support received in the professional career are significantly related.

H4. Women medical practitioners get support from their male counterparts to fulfill their household role and mothering role.

H5. Increased specialization demands more from the professional which creates lag in the domestic role performance.

H6. Doctor couples have more marital satisfaction than doctors with husbands having other professions.

H7. Uneven prioritization of any one sphere causes role conflict in other.

H8. Women with husbands in same profession receive more support in their career.

Variables

As stated earlier the study is concerned with work family balance among Muslim Medical Practitioners in Kerala. Their dual role and role in decision making have been set up as dependent variable, hence these are influenced variables considered as independent. Age and age at marriage are independent variables coming under "personal zone". Income later excluded from this because somebody skipped this question and others who replied stands unreliable as they have other sources such as private practice which would not revealed by them.

Husband from same field, pattern of family, medical background of the family and number of children are included in "familial zone". These variables have very important role in determining work-life balance. Specialization,

occupational designation and years of experience are in "professional zone". Other variables like marital satisfaction, self-esteem, support to professional career, awareness, social network and support were taken for analysis.

Clarification of concepts

Marital Satisfaction:

It is often viewed as an individual's interpretation of the overall quality of the marriage and is the degree, to which an individual's needs, expectations and desires are being satisfied in their marriage (Roach, Frazier, & Bowden 134). Marital satisfaction is often considered as a subjective condition 'which can only be described by the individual spouse after an evaluation of their marriage. It refers to a global level of favorability that individual spouses report with their marital relationship. Marital Satisfaction is generally viewed as an individual's interpretation of the person's happiness and overall quality with the marriage (134).

Work:

Work is any activity involving mental or physical effort done in order to achieve a purpose or result. It involves mental or physical activity as a means of earning income.

Family:

In the context of human society, a famil**y** is a group of peoplerelated either by consanguinity (by recognized birth), affinity (by marriage or other

relationship), or co-residence. It is a union of father, mother and their children with informal and close relationships.

Work –family balance:

It is defined as, "The extent to which individuals are equally involved in-and equally satisfied with their work role and their family role." (Greenhaus& Singh, Collins & Shaw). Dual responsibility is when effort goes in for maintaining the home and family and carrying out paid work

Muslim:

A Muslim is an adherent of Islam, a monotheistic Abrahamic religion guided by the Qur'an which is considered as the verbatim word of God as revealed to Prophet Muhammad. "Muslim" is an Arabic word meaning "one who submits to God".

Muslim Women:

Muslim women are women who follow or practices Islam, a monotheistic Abrahamic religion, who are part of a Muslim Family and a part of its belief and practice by birth or by conversion.

Medical Practitioner:

Medical practitioner is a person holding medical qualification and who practice as a doctor in a hospital or doing private practice.

Empowerment:

It implies a process through which women would be able to develop self-esteem, confidence, realize self potential and enhance collective bargaining power.

Self-esteem:

The term used in Psychology to reflect a self judgment or person's overall emotional evaluation of his or her worth. Nathaniel Brandes in 1969 defined self-esteem as "the experience of being competent to cope with the basic challenges of life and being worthy of happiness".

Women medical practitioners:

Women medical practitioners are those women who are practicing as a medical doctor or have profession or career as a doctor after completion of their medical qualification.

Professional career:

Persons with productive skill performance and receives benefits of some kind.

Dual-role:

The role as a housewife and as an earning member by doing productive paid work inside or outside the house.

Operational definition of concepts

Marital Satisfaction:

It is a condition that the individual couple enjoys happiness through fulfilling their expectations of marriage among medical practitioners for their overall wellbeing and productivity.

Work:

The entire group of activity which is related to the practice as a medical doctor is referred as work in this study irrespective of whether practice is in a hospital or in any other place and if it is remunerative.

Family:

Family as the most basic and influential institution in our individual and social life, in this study, definitely includes husband and their children. Other members like parents, siblings and in-laws if are living with them are also included. It does not matter whether or not they are living with family of orientation or family of procreation.

Work –family balance:

The extent to which the medical practitioners are equally involved in / and equally satisfied with their medical professional role and their household and mothering role.

Muslim women:

Those women who follow the religion of Islam are referred to as Muslim women. Born in to a Muslim family or converted thereafter to Islam is included in this category.

Medical Practitioner:

Allopathic doctors with minimum MBBS qualification come as medical professional in this study. Those having minimum 3 years experience after completion of the course were selected for the study.

Empowerment:

Not only through high educational qualification and employment but also through the highly respected and status oriented position women medical practitioners are satisfying the basic requirements of definition of empowerment. All these conditions help them to easily attain other parameters like decision making power, financial independence, freedom of movement, liberty etc.

Self-esteem:

Education and employment provides chance of self-esteem through confidence, problem solving skill, time management, decision making and so on. Muslim women medical practitioners with high status and position in society can develop the above said attributes. The qualities of self correction, problem solving, positive thinking etc. can be possible for them.

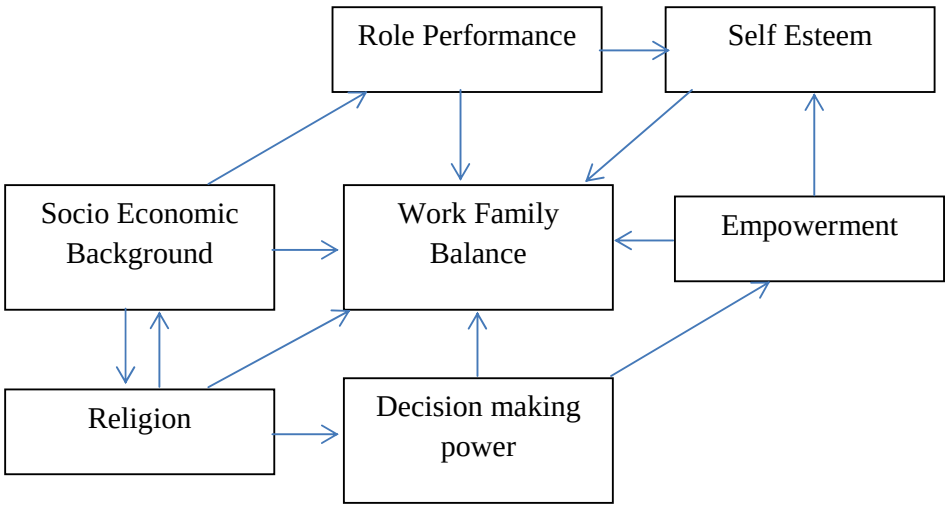
Dual-role:

Role of women as a housewife /mother and medical practitioner is taken as dual role in the present study. The profession as a medical doctor and role as a housewife are two parallel and fulltime engagements. It is a challenge to those women who expect maximum output from both sides and need to struggle to maintain this dual status.

Conceptual frame work

A conceptual frame work is formulated for the study according to the general assumptions and studies conducted about Muslim women medical practitioners. Empowerment is placed as the basic condition which provides the opportunity to reach the work-family balance. Firstly the socio-economic profiles of the respondents were analysed. Religious belief and participation is the basic concern. The pattern of dual role performance, network and support to professional career and decision making in various levels were analysed. These background factors directly or indirectly affects marital satisfaction, social perception, attitude and self-esteem. These factors are mutually connected. Finally, the work-family balance was analysed. This concept is interrelated to all other concepts in this study. All concepts are mutually contributing with each other.

Fig 4:1 Conceptual Frame Work of the study.



Research Design

The present study about the women medical practitioners is both descriptive and explanatory in its nature. It helps to describe the data and characteristics of population to be studied. Description can be used for frequencies, averages and other statistical calculations. It helps in prediction and its explanations. This study attempts to examine the work-family balance among Muslim women medical practitioners. The study explains various factors influencing dual role performance and its effective coordination and support for the work-family balance.

Pilot study

A pilot study was conducted in 25 samples to test the feasibility of conducting the study. It helped the researcher to identify the research design and decide the tool of the study and sample.

Tool for data collection

A structured questionnaire based on objectives was constructed and used as research tool. The introductory part contains the personal profile of the respondents including socio-economic status of the respondents. Open ended questions and closed ended questions with and without options are also included.

Total nine scales included both adopted and self developed scales in the questionnaire. Self developed scales are developed to assess management of household activities, decision making, self-esteem and support to professional career. Marital satisfaction, work hindrance on family and family hindrance on work are the three scales adopted in the study.

Three point scales were used to assess the management of household activities, participation in household activities, participation in child care activities and role in decision making in five different areas like household management, financial management, and child care, professional and personal matters.

Intensity of support to professional career, marital satisfaction, role conflict and self-esteem were analysed by five items remarked from strongly agree to strongly disagree.

The role conflict of Muslim women medical practitioners measured with seventeen questions from two sections like work hindrance on family and

family hindrance on work with questions related to their physical and mental stress, feeling and attitude towards family and work.

Table 3:1 Details of scales applied.

Sl. No	Scale Applied	No of items	No of points
1.	Management of household activities	7	3
2.	Support to professional career	15	5
3.	Participation in household activities	10	3
4.	Participation in child care activities	7	3
5.	Decision making 1. Household management 2. Health and reproductive right 3. Financial management 4. Professional career 5. Regarding children	 12 4 10 5 10	 3 3 3 3 3
6.	Marital satisfaction.	14	5
7.	Self esteem	15	5
8.	Dual role performance 1. Work hindrance on family 2. Family hindrance on work	 7 10	 5 5

Pre-test

Before finalizing the tool, a pre-test was conducted among 25 samples to test the validity and reliability of the scales applied in the study. Test re-test method was adopted for it. New questionnaires with same questions redistributed to the same respondents with one month interval between two sessions.

Reliability of the tool

Internal consistency reliability test was applied in the study to test the reliability and validity of the scales used. We get out of a reliability analysis a coefficient called Cronbach's alpha. It ranges between 0 and 1. However, there is actually no lower limit to the coefficient. We expect from this coefficient, it should be closer to one. It is never more than one. Generally the coefficient is more than or equal to 0.8 is quite acceptable and it is considered to be a very good Cronbach's alpha and if a scale of that coefficient means the scale is reliable enough. That is the closer Cronbach's alpha coefficient is to 1 the greater the internal consistency of the items in the scale. Based upon the formula =rk/[1+(k-1)r] where k is the number of items considered and r is the mean of the inter-item correlations. The size of alpha is determined by both the number of items in the scale and the mean inter-item correlations.

Table 3:2 Reliability Analysis of Scales used.

Sl.No	Variable	Cronbach's alpha
1.	Management of household activities	.803
	Support to professional career.	.890
	Participation in household activities	.892
	Participation in child care activities.	.892
	Decision making	
	1. Household management	.890
	2. Private matters	.980
	3. Financial management	.930
	4. Professional career	.952
	5. Regarding children	.965
	Marital satisfaction.	.968
	Self esteem	.868
	Dual role performance	
	1. Work hindrance on family	.942
	2. Family hindrance on work	.932

Sampling procedure

Universe- All the married Muslim women allopathic medical practitioners with minimum MBBS degree in Kerala who is a parent with minimum three years of professional experience formed the original sample frame or universe of this study.

Sampling- The quantitative information was gathered through questionnaire from 250 samples. Social survey method mainly multistage sampling procedure followed for the data collection. By using snow ball

sampling method sample collected from almost all districts of Kerala. Special attention given to Kozhikode and Malappuram districts based on higher concentration of Muslim population in these districts.

Sampling Unit- A married Muslim woman allopathic medical practitioner with minimum MBBS degree in Keralal state who is a parent with minimum three years of professional experience formed the sampling unit of the study.

Inclusive criteria

Since exact statistics is not available the selection of sampling size not able to make by following proportionate sampling procedure so followed a way to get an approximate number. Religious and gender wise data is not available and those who are completed the course may temporarily not practicing for personal reasons like child caring, preparation for higher studies, doing higher studies and so on.

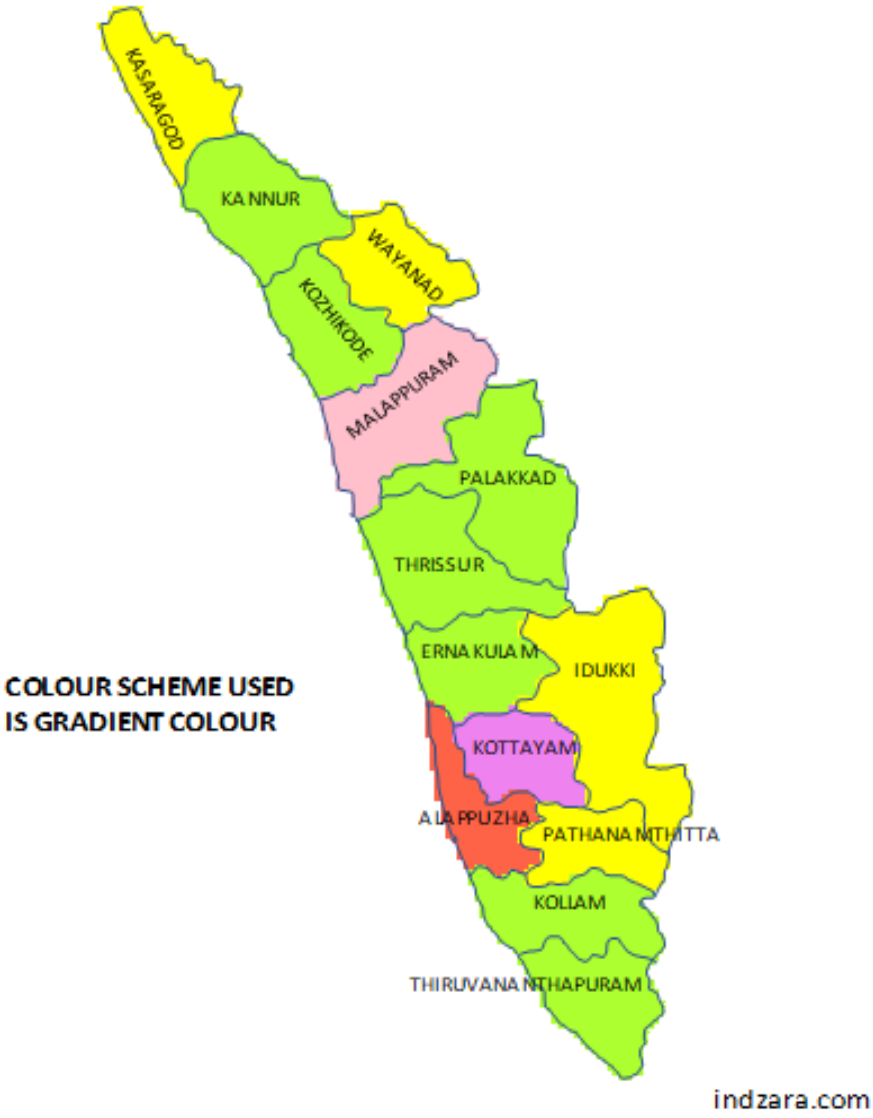
The source which mainly helped to draw sample is list of pass out students from various medical colleges after convincing them the purpose of the study.Among 278 responses a round figure 250 selected after scrutiny hence some of them are incomplete mainly due to lack of time for the respondents to reply due to their busy schedule. Even though sample is not taken proportionately from the districts, the available sample frame of the study is as below.

Table 3:3 Sample frame of the study

Sl.No	District	Frequency of Sample	Percentage
1.	Alappuzha	3	1.2
2.	Ernakulam	36	14.4
3.	Idukki	4	1.6
4.	Kannur	1	0.4
5.	Kasaragod	7	2.8
6.	Kollam	9	3.6
7.	Kottayam	11	4.4
8.	Kozhikode	38	15.2
9.	Malappuram	68	27.2
10.	Palakkad	19	7.6
11.	Pathanamthitta	1	0.4
12.	Thrissur	38	15.2
13.	Thiruvananthapuram	10	4.0
14.	Wayanadu	5	2.0
Total	14	250	100

Fig 4.2

Kerala - District Wise



Area description

Kerala is the Southwestern state of India, Spread over 38,863 km^2 (15,005 sq mi), Kerala is the twenty second largest Indian state by

area. Kerala has population of 3.34 Crores. It is one of the notable states among the states of India with respect to education and employment in general and women in particular. 94per cent of its population are literate and female literacy is 92.07 %. Kerala holds the first rank among the Indian state with regard to HDI, Gender related development index and Gender Empowerment Measures. According to 2011 Census of India figures, Muslims are the largest religious minority in Kerala (26.56%). Malapuram and Kozhikode are the largest Muslim concentrated districts in Kerala respectively.

Data collection and Field Work

After preparation of the tool, data collection started. Both field survey and online survey were followed for it. Data collection took about one year from June 2017 to April 2018. The questionnaire was distributed among the respondents in the first stage of data collection. About 115 hard copies were distributed directly. Then questionnaire prepared in the software and shared through Whatsapp and mail. Both hard copy and soft copy of the questionnaire were distributed to nearly 293 respondents. Due to unreliability of data of few of them a sample group of 250 was fixed after discarding the unreliable ones.

Field diary is also maintained to record the focused group interaction and case studies. Centre for Information and Guidance India (CIGI) one of the most important and popular Muslim cultural organization formed with the objective of sharing educational and career information and for guidance for the community and Friday Club, a cultural organization for the collective social

activities, functioning in Mala, Thrissur, arranged two focus group discussions. It included both men and women members of the organizations. Focused groups discussions were carefully transcript and translated into English.

Five cases of unique features are selected from different districts in Kerala to know the experiences gained by them, both positive and negative, success and failure, gains and losses, exposure, empowerment, support, threats and obstacles related to personal and professional life.

Analysis and interpretation

A qualitative cum quantitative method has been used for data analysis. The collected data scrutinized, edited, classified and coded. Master chart was prepared and then entered in Microsoft excel. Data analysis was done by applying Statistical Package for Social Sciences (SPSS). Descriptive statistics, percentage, range and average, multivariate techniques such as correlation-Spearman's rank correlation, Karl Pearson's correlation and chi-square were adopted in the study.

Scales used for Measurement

Seven scales were used in the present study. Support to professional career, management of household duties, self-esteem, marital satisfaction, decision making, work hindrance on family and family hindrance on work are the scales. Among them the scales to measure marital satisfaction, work hindrance on family and family hindrance on work are adopted scales.

Scales used for Measurement.

Marital satisfaction

Women medical practitioners are the cream of the women community in any society and have to perform multiple roles inside and outside of the family. As a life savior they are qualitatively and quantitatively engaged in the pulses of the society. As the well educated and high paid category, they are privileged to be the models for all women not only in the professional sphere but also any other arenas they came into contact especially marriage and family. Along with strenuous task of medical practitioner they have to fulfill several types of responsibilities within role of a home maker like wife, mother, daughter, sister, daughter-in-law, sister-in-law, mother-in-law, grandmother etc. in this context strong support and understanding of the spouses are very important. Several factors directly and indirectly contribute for the smooth running of marital life. Marital satisfaction is a mental state that reflects the perceived benefits and costs of marriage to a particular person. The more costs a marriage partner inflicts on a person, the less satisfied one generally is with the marriage and with the marriage partner. So marital satisfaction analysed by using a scale.

In marital satisfaction 5 point scale was used and the scale consists of fourteen items which is adopted from ENRICH marital satisfaction (EMS) scale (1993) with slight modification. Scores five was given to strongly agree and one strongly disagree. The total score in between 56-69 belongs to extremely happy in their married life. 42-55 is in very happy category, 28-41 is

in a little happy and 14-27nscored persons are a little unhappy in their marital life. Those taken scores 1-13 are extremely unhappy with their partners. The reliability of the tool is .968.

Role conflict

Women all over the world are pondering on their equality with men, especially in the occupational sector. Industrialization has brought a continuing shift from family centered to factory centered production, resulting in more women coming out to work. Greater opportunities opened for her and women have occupied almost every field of work. But financial independence not saved her from age old socio-economic backwardness. The family and work lives of individuals which are clubbed with each other cannot be studied in isolation. The challenges faced by married working women are multidimensional.

Every individual plays different roles at different stages of life. According to Merton's 'Role Set Theory', social status involves not just a single associated role, but an array of roles (Merton 1957). These roles are not static. 'Role set' indicates the various roles associated with a status. When the status of an employed woman is considered, the job and related roles form one 'role set'. Similarly, the conjugal, maternal and domestic roles become another 'role set'. According to the changes in the individual and social values new roles and re-defined old roles comes into play. Each individual is differently balancing these demands in the society. Married and employed women due to

their simultaneous involvement in various roles struggling to adjust the multiple roles.

In Indian society, two different roles of married women i.e, domestic and occupational are full time engagements. In the dynamic society, women are likely to suffer, owing to their extended commitments. The extend of problems faced by employed women in fulfilling the expectations of any role along with the other role. The theory relied upon is the 'work-family balance' theory of Arlie Russell Hochschild, which focuses on two aspects of conflicts-work to family conflict and family to work conflict. Work to family conflict occurs when experience at workplace affects the family life and family to work conflict occurs when experience in the family affects the work life.

Two different scales on work hindrance on family (7 Items) and family hindrance on work (10 Items) were applied in the study to explore about the dual role of Muslim women medical practitioners. Both are developed by DivnaHaslam, AniaFilus, AlinaMorawska, Matthew R Sanders and Rence Fletcher (2014) adopted in this study with slight modification requires for the study. Scores five was given to strongly disagree and one strongly agree. For the work hindrance on family the total score in between 29-35 belongs to very high problem category. 22-28 is in high category, 15-21 medium level and 8-14 scored persons are in low category. Those taken scores 0-7 are in very low category. The reliability of the tool is .942. For the family hindrance on work the total score in between 41-50 belongs to very high problem category. 31-40

is in high category, 21-30 medium level and 11-20 scored persons are in low category. Those taken scores 0-10 are in very low category. The reliability of the tool is .932.

Self-esteem

It is like a knife which shapes the individual according to the sharpness it has and in turn is conditioned to be sharper with the process of making individual perfect. The self-esteem of a person is constructed according to the socio-economic condition, education, socialization and so on. Self-esteem helps to enrich the capacity to frame the future. Highly educated and paid professionals like medical practitioners may have better opportunities to develop better levels of self-esteem. But some of the life conditions may have a negative impact on them. In this context their self perception and attitude towards others especially those who approach her for saving their life is significant. Help the poor and needy, give them confidence and courage, problem solving skill, time management, critical thinking, tolerance, decision making etc. enabled by their level of self –esteem.

A self developed scale was used to measure the self-esteem of the women medical practitioners. It is a 15 item scale and 5 score was given to strongly agree and 1score for strongly disagree. The total score reached in the inclusive interval 61-75 considered as very high esteem women and those who scored 46-60 are with high self-esteem. 31-45 scorers have medium level, 16-

30 have lower level and 1-15 occupies very low self-esteem. The calculated reliability for this tool is .868.

Decision making

It is one of the parameters of empowerment. Traditionally decision making is an unshared authority of men especially in a patriarchal society. The role in decisions regarding most personal affairs constrained for women. Women medical practitioners are the most privileged category of women who are with respectable position enjoy higher position in the society. It is necessary to analyse their role in decisions related to personal to professional life. Acceptance and individual space in decisions framing their life is the primary step towards the empowerment.

Measurement of decision making was done by classifying it into five sections like household management, decisions in health and reproductive right, financial management, decisions on professional career and decisions regarding children. Household management scale includes 12 items regarding choices and freedom related to personal tastes and preferences like purchase, menu, employing servants, inviting friends etc. .890 is the reliability of this tool. In all the decision making scales options given as decisions mostly by the respondent, by the husband and by both. As a three point scale and 25-36 is regarded as high level, 13-24 is medium level and 1-12 as low level.

Education enables women to achieve equality in various fields which regarded as masculine dominated areas. Women were seldom enjoyed to

express their views even in matters related to their body or sexuality. It is the right and property of the husband to do whatever and whenever with her body without her permission. Empowerment likely to change this situation from domination to shared one. So decisions on health and reproductive right a 4 item scale includes questions like family planning, reproductive health etc. in this study. The total score reached in the 9-12 is high participation in decision making, 5-8 is medium and 1-4 is low. The reliability of the tool is .980.

One of the most important areas of decision making is financial decision. High earnings alone could not save women to break shackle of traditionalism. The right to spend or deal the money matters steadily and slowly helps her to achieve those deprived conditions which dominated her for ages. It is one of the most important icons for women empowerment if she can break the chains which purposefully locked her. The scale used to explore the financial decision making power is a 10 point scale includes questions on savings, payment of bills, shopping etc. The score for the financial decision making are the following- high score with 21-30, medium with 11-20 and lower with 1-10. .930 is the reliability of this tool.

Employed women in general depend on husband, father or any other male members of the family for directions, advice or decision making related to their job. Outside employment opened a number of opportunities for women including financial independence. The courage to take up the role and related decisions enable her to be acceptable. 6 items included in this scale like

attending meetings, academic activities, official trips etc. The total score in between 9-12 is high participation in decision making, 5-8 is medium and 1-4 is low. The reliability of the tool is .952.

Rearing and caring of children are the major expressive roles assigned to women in our society. Women with any achievement cannot dissolve this responsibility. The role of care taker is safe in the hands of women with all its demanding features. But the decisions regarding this traditionally vested with male authorities so it is relevant to check the decision on child care in this study. A tem item scale used by including information on admission, higher studies, punishment etc. Those scored 21-30 has high level decision making on children, 11-20 has medium and 1-10 includes in the lower category. The reliability of the tool is .892.

Support to professional career

Opportunities of education and employment enabled women to take up challenges which pull her back to the cage of traditionalism. It is important to get strong support from various sources. The women who come with fly in colors backed by both men and material. Unfortunately the prime period to set career is considered in our society as best time for marriage and settle down for girls. Boys start marital life only after well settled in the real sense of the term.

The women, who are in the work field is facing a number of challenges in life related to work and family. The dual role performance of women is the output of a number of supporting elements. This support enjoyed by Muslim

women medical practitioners is analysed by using a 15 items in five points scale ranging from professional to familial aspects. Support from husband, in-laws, parents, colleagues, working atmosphere etc. Scores five was given to strongly agree and one given to strongly disagree. The total score reached in the inclusive interval 61-75 considered as strongly agree that they are supported and those who scored 46-60 agree it. 31-45 scorers are neutral, 16-30 have disagreement and 1-15 strongly disagree with the support they received. The reliability of the tool is .846.

Management of household activities

Working women are facing the challenge of management of household activities. Productivity of a person is influenced by the peaceful coordination of various spheres of life. Women are disturbed with the issues of dual role. Time management, help from servants, cooperation of family members etc. helps earning mothers to maintain equilibrium. Management is a skill which helps to develop self-esteem by many ways. Tension free life is possible through all these aspects. A seven item scale with three points of great extent, some extend and not at all used with the purpose to assess it. Those who score highest score 15-21 have high level management of household activities, the scorers between 8 and 14 have medium level and 1-7 the lowest scorers have low level management of household activities. .803 is the reliability of this tool.

Participation in household activities

Traditionally women are vested with household activities with strong cultural background. Modification of housewife role with that of bread winner not added much flavor to her life. She is trusted with the responsibilities of a house too. The same household with similar needs is awaiting her after her profession or job. Shuttle from one to other is the reality for her. The scale used to analyse participation in household activities includes ten items like food preparation, cleaning etc. and it is a 3 point scale. Participation by the respondent is provide value 3, jointly with husband provide 2 and by husband score 1. According to the values scored, the women medical practitioners according to their participation in household activities are classified into higher level (21-30), medium level (11-20) and lower level (1-10).

Participation in childcare activities

Child care is a cultural role close to biological role of motherhood. It is unconditional and nature assigned women for this role. Mother and child are too close. A child is a child for his/her mother even they grow. Child care can be performed by any person but the completion of that feeling possible only for mother. In the fast and busy world, numerous arrangements can be made for it. But still rather than other options, the mother figure glitters because it is not only a biological bond but mixed with emotions and sentiments. The scale used to analyse participation in child activities includes seven items like bathing, feeding, schooling etc. and it is a 3 point scale. Participation by the respondent

is provide value 3, jointly with husband provide 2 and by husband score 1. According to the values scored, the women medical practitioners according to their participation in child care activities are classified into higher level (21-30), medium level (11-20) and lower level (1-10).

Organisation of Thesis

The thesis includes 13 chapters as follows

Chapter I.	Introduction
Chapter II.	Review of literature and theoretical framework
Chapter III.	Methodology
Chapter IV.	Socio-economic profile
Chapter V.	Religious beliefs and religious participation
Chapter VI.	Role structure within the household
Chapter VII.	Marital satisfaction
Chapter VIII.	Participation in decision making
Chapter IX.	Social network and support system
Chapter X.	Level of Self-esteem
Chapter XI.	Dual-role performance
Chapter XII.	Perception and attitude towards social issues
Chapter XIII	Case studies and Focus group discussions
Chapter XIV.	Findings, conclusion and suggestions

Field encounters

Most of the respondents welcomed the study and as the field demands some of them apologized for noncooperation due to shortage of time. The researcher has collected the data from all districts of Kerala which was time consuming and economically challenging. Some are of the view that tool is so lengthy and some of them had inhibitions in answering some questions. Direct encounters required long waiting in the clinics and houses along with patients. Some regret to cooperate because of the fear to disclose financial matters. Some cooperated only after convincing the intention of the study after strenuous task. Many were convinced after a detailed discussion and were ready to cooperate.

Chapter - IV

SOCIO-ECONOMIC PROFILE

As mentioned in Chapter III this research intends to focus on Muslim women medical practitioners in Kerala. For this purpose a sample group of 250 medical practitioners who are married with spouses from both medical and nonmedical fields were selected. Some of these doctors were general practitioners while the rest were specialists. All of them responded via questionnaire about the various aspects of this study.

Socio-Economic profile of Muslim women medical practitioners reveals that about one third (33%) of the respondents are included in the younger age group of up to 30 and a little less than one half (44%) included in the middle age group of 30-40. Nearly one quarter (23%) falls in the elder age group that is 40 and above. The mean age of the respondents in the present study is 35.6. Contrast to student of other professional training and educational branches, a medical student takes longer period for finishing education and settling down. This finding is consistent with *The Study Among Women in Medicine* conducted by Pandey and Geetha Chaturvedi which indicated that the respondents included in their study were also above 30 years of age.

Nearly half of the respondents (48%) are first born child in their family. Being the first born is an added merit for them to receive support and concern from the parents and their family members.

The category of birth place (urban or rural area) has a vital role in boosting one's career opportunities. There is a belief that urban upbringing provides more opportunities and avenues for medical career as compared to rural areas. About sixty percent (62%) respondents were born in urban area, while others (38%) are from rural area. It shows a positive sign that educational opportunities opened for all irrespective of urban- rural disparities in our society.

The institution of joint family has deep roots in Indian tradition and culture. But now there is a growing tendency of individualistic way of life and increase of nuclear family system due to industrialization, urbanization and westernization. This has been emphasized by eminent Sociologists like Goode (1963) and Parsons (1961). Studies also indicate that working women prefer to live in nuclear family. Some women doctors in India enjoy the privileges of an extended family system and are able to pursue their busy profession. The present study shows that a little more than two thirds (68%) are following nuclear family norm and rest of them are from extended family.

Distance to work place is an aspect worth mentioning in a working woman's life. It has an impact on the quality of life and work. Usually peak time is used by the working population for daily travelling. Time used for travel can be turned productive by utilizing it to maintain contacts, reading and other official responses. But for women professionals it would be a hardship over their dual role performance. Medical professionals prefer to reside near their workplace. Three out of ten work within one kilometer distance from their

present residence. Only a little less than one fourth (23%) need to travel more than ten kilometers daily to reach their work place.

According to the nature of work, the type of residence may change. It can be elicited that practicing women doctors and those who are in medical colleges are not willing to go to various places of posting as they are a little hesitant to break the existing residence. Out of the total respondents seven among ten (71%) are living in their own residence, while a few (6%) reside in quarters offered by the organisation they work for. It also reveals that a good majority are able to own a house at a younger age.

With regard to the occupational designation, a little more than one fourth (27%) of them are senior consultants and they have more than 15 years of experience. Nearly one fourth (24%) have 8 to 15 years of experience and about half (49%) of the respondents are juniors with less than eight years of medical practice.

In India male members of the society have better social status. It is obvious that husbands are treated as superior to their wives. They are supposed to be more qualified to maintain their superiority in the house. Most of their partners (92%) have equal or higher qualification in the present study. Husbands of the respondents must be helping and motivating their wives in enhancing and keeping up their career. An equally qualified spouse is more prone to support his wife in uplifting her career and letting her avail opportunities.

Another point worth mentioning here is that nearly six out of ten (58.8%) spouses are in the same profession. Various studies (Tanika 2016 and American Medical Association 2019) also indicate that a woman doctor generally prefers to marry a doctor. This is necessary because she feels that a non-medical husband may not be able to understand her problems and difficulties.

Government service offers a fixed salary whereas private practice provides opportunities for enormous monetary benefits. Hence there are all the chances of wide discrepancies existing between financial aspects of government service and private practices. It is, to some extent, not reliable information in this study that respondents belonging to government service explicitly mention their monthly income except earnings from their private practice; whereas respondents have only private practice may not reveal the real condition. About sixty (61%) get up to Rs.50000 as salary and a small proportion (8%) earn above one lakh and rest of them belong to the income category between Rs. 50000 and One lakh.

Transport is inevitable for a working person to commute between residence and office. At the same time owning a vehicle has become a status symbol as well. Mode of conveyance and reaching on time play a vital role in one's performance and punctuality at work. Except a small proportion (10%) all others use vehicle for travelling. Among those who use conveyance, two out of every five (40%) use their own car and only one fifth (20%) depend on public transport system.

In medical profession working hours are not fixed in general. Hours of work are a significant one among young women professionals. Each role consist different activities and it requires definite amount of time in a day. In the present study about five out of ten (44.8) have a working time of maximum 8-10 hours per day and 3 out of ten (31.2) spending 10 to 12 hours in the hospital.

Nearly sixty percent (57.6%) hold post graduation degree with specialization and rest (42.4%) hold only MBBS degree. Those respondents who have minimum qualification are trying to specialise and are preparing for entrance examination. Post graduation qualification is somewhat mandatory in this era of specialization. Even though they get opportunities, cultural bonds and other family responsibilities provide limited space to avail this option.

As the qualification and specialization increase the person become more competent in his respective field. It in turn makes the professional more busy and in demand. It inversely affects the time that individual has in his personal life and family responsibilities and causes profound influence on his career. With regard to the specialization, more than one fourth (28%) are gynecologists.

In the present fast growing world, knowledge and technology make medical field more progressive and innovative. As a major branch of medicine, gynecology attained rapid progress hence its scope and avenues are on increase. Due to these advancements there is an increase in cost of high-tech care, changing patterns of child birth, family centered care, rising caesarian

births, early discharge, social role of fathers in child birth and decrease in prenatal risk factors. As one of the most suitable and highly challenging fields of medicine, Gynecology demands more female participation. So it remains an important specialization for women even today. As a science of women there is much advancement in obstetrical nursing.

The other most challenging areas of specialization preferred by women are anesthesia, surgery, cardiology etc. As the specialization varies the conditions of responsibility, acceptability and service may change. A number of studies have proved that working mothers experience role conflict. This study also reveals that women face or experience role conflict due to professional specialization. Even though working women keep a distance from more challenging fields for the well being of their family, many are still there as a part of fulfillment of their long cherished goals.

Family life in general and children in particular are highly salient factors in producing role conflict. A little more than two thirds (57.2%) have 2 and more children. The number and age of children are directly related to role conflict in working women (Bhatty and Bhatty 1971, Sachdev 1974, Singh 1972). The number of children is obviously relevant because fewer children mean less work (Hoffman 1963).

There is a common notion in our society that children of doctors become doctors and children of engineers become engineers. Studies reveal that even though the medical field is full of tensions and stress, doctor parents guide their children towards this glamorous and noble profession. The new middle class

developing in Kerala society also shows appreciation towards this profession. A little more than one third (36%) of the respondents are from families with medical background. Rest of them proudly becomes the pioneers in their family in this juncture.

Age at marriage indicates position of women in a society. Early marriages both for men and women are the norm for the Muslim community all over the world. Kerala is not an exception from this. But the present study shows a very positive indication that the mean age at marriage is 25.2 years and almost all of the respondents got married at 24 or above the age of 24. Unlike other professional courses MBBS demands more serious approach by the students. Almost all the respondents married after the completion of their course. Otherwise they won't be a part of this study because in such cases most of them couldn't complete their studies. It proves that, they showed very much concern in completing their studies with their parental support.

With regard to the age at marriage of their spouse it shows that as wives are married at a mature age no chance for early marriage of husbands since our society is patriarchal in nature and choose wives younger to their age. Mean age at marriage of husbands is 28.4

Education and employment have profound influence on marriage and being a parent. The mean age at first delivery in this study is 26.1. Both age at marriage and age at first delivery reflect the same result as studies conducted in advanced societies of the world.

The present study reveals the fact that nearly sixty percent (58%) of the respondents completed their post graduation and specialization only after marriage.

A little less than half of the respondents have 5 years of practice and more than one fourth (27%) completed 15 and above years of experience. Nine out of 10 have a break in service. It is mainly due to delivery and maternal care. A little more than one fourth took leave for completing their studies. Between productive and reproductive roles of pregnancy, lactation and bringing up infants adversely affect the years of service and efficiency in work

Chapter - V

RELIGIOUS BELIEFS AND PARTICIPATION

Since this research is about balance in work and domestic sphere among Muslim women medical practitioners a short description of the tenets of Islam is relevant. The followers believe that Islam is a religion with complete and universal version of a primordial faith that was revealed through a series of Prophets. 'The Pillars of Islam' comprised of five basic religious acts which are considered obligatory for all believers (Hasanuddin 112). The Quran presents them before the followers as a framework for worship and as a sign of commitment to the faith. They are (1) the creed (Shahada), (2) daily prayers (Salah), (3) almsgiving (Zakat), (4) fasting during Ramadan (Sawm) and (5) the pilgrimage to Mecca (Hajj) at least once in a lifetime for those who can. Notable religious acts apart from these for a Muslim are charity (Sadaqah) and recitation of the Quran (117).

The most basic in one's belief -Shahada, is a declaration of faith and trust that professes that there is only one God (Allah) and that Muhammad is God's messenger. The second is Salah (ṣalāh) consists of five daily Islamic prayers. All of these prayers, a mandatory aspect for Muslims, are recited while facing in the direction of the Kaaba in Mecca. A Muslim may perform their prayer at regular times, such as in offices, institutions, and fields and even during journeys however; the mosque is the more preferable place for prayers. Based on one's accumulated wealth one should give Zakāt or alms the giving

of which is a charitable act (119). It can be defined as purification and growth because it allows an individual to achieve balance and encourages new growth. It is the personal responsibility of each Muslim to help to ease the economic hardship of others and to strive towards eliminating inequality**.** It is notable that one is not deemed a believer who filled his stomach while the neighbor to his side goes hungry. Fasting (Siyam) is obligatory during the month of Ramadan, and every Muslim must abstain from food and drink from dawn to dusk during this month, and are to be especially mindful of other sins. Fasting is obligatory for every Muslim that has reached puberty (exceptions to patients, children, aged ones, pregnant and lactating mothers). The Hajj is a pilgrimage that is made during the Islamic month of Dhul Hijjah to the holy city of Mecca (121). Every able-bodied Muslim is obliged to make the pilgrimage to Mecca at least once in their life. Muslims recite and memorize the whole or part of the Quran as acts of virtue and it described as an excellent act of worship.

Religious concepts and practices which include the Five Pillars of Islam touches on virtually every aspect of life and society, from banking and welfare to women and the environment. As a voluntary submission to God, Islam provides complete and comprehensive guidelines of life. Like in all other Abrahamic faiths such as Christianity and Judaism, a believer must not think he is totally free and have permanent abode here and must strive to attain the higher reward of paradise as a measure of one's virtue. Muslims are encouraged to emulate Prophet Muhammad's actions in their daily lives (122). Islam as a way of life directs all in their every action right from the beginning

of the day. Even the most private routines like entering the toilet, eating etc are governed by Islamic rules.

Surely whoever believes in Allah fears Him, and whoever fears Allah guards himself against the evils of this world. Islam integrates all domains of human life, just like the different systems in the human body integrate to provide a complete human being (123). If one system does not work properly, it has got to affect the whole body. Likewise, Islam proposes systems of laws that integrate all parts of human society to bring happiness and peace to all its members.

Islamic principles and teachings can provide realistic, fair and objective solutions to prevent individual, family, social and international problems. It does not confine itself merely in purifying the spiritual and the moral life of man in the limited sense of the word. Its domain extends to the entire gamut of life. It seeks to mould individual life as well as the social order in healthy patterns (123). Man must live this life with the realization that he is to be judged and his sole objective should be to merit the pleasure of Allah so as to emerge successful in the hereafter. Conduct which is contrary to this would lead man astray. Faith in Allah is not a mere metaphysical concept; it is in the nature of a contract by which man barters his life and his belongings with Allah. His entire life is one of obedience and surrender and he never behaves in an arrogant or an autonomous way, except in a moment of forgetfulness (123).

Islam is the complete code of life and it gives details and mentions about each and every aspect of life. Therefore, by following the instructions of Islam one can live the worldly life in the best manner. Islam provides specific guidelines for all people to follow in their daily lives. Its guidance is comprehensive and includes the social, economic, political, moral, and spiritual aspects of life. By saying that it is a complete way of life, we mean that it caters for all the fields of human existence. Though Islamic tenets lay down certain boundaries, only a strict conservative interpretation and adherence to such rules cause obstacles to a professionally inclined woman. Social and familial pressures, citing religious sanctions may sometimes cause a woman to curb her desire to grow professionally

Islam provides prime importance to knowledge. The holy Quran was introduced primarily with the word 'Iqra' which means 'to read'. Knowledge accumulation is obligatory for every Muslim male and female. Islam encouraged religious education of Muslim women. According to a Hadith attributed to Prophet Muhammed, he praised the women of Medina because of their desire for religious knowledge (124). The question is not whether women should be educated, but what kind of education they should have and how much. In order to be aware of her moral rights and duties in Islam, a woman needs to know more of her religion than just her prayers, as an inadequately educated woman cannot raise her children properly, whereby society suffers.

Prophet Muhammad describes the believer in his sermon: "Blessed is he who earns his living through lawful ways and he whose inward status is good,

outward is decent; spends his surplus wealth in charity; abstains from excessive talking; people remain safe of (any) evil from him; he treats others with justice"(Abdel kader Deina,2003).

Islam does not mandate women to be housewives, but gives supreme consideration to harmonious management of a household which by itself is slightly obstructive to a career. They are not bread winners so it gives them certain liberty to adopt any profession by choice and not by compulsion. Women are at liberty to work or not work outside, subject to certain conditions, such as if a woman is in financial need and her employment does not cause her to neglect her important role as a mother and wife. It has been claimed that it is preferable for a Muslim woman to select work environments conducive to the practice of religion without obstruction. Islamic law therefore clearly permits women to work in Islamic conditions, such as the work not requiring the women to violate Islamic law, and that she maintain her modesty while she performs any work outside her home. "Islam works within a holistic framework for health care in which physical, social, spiritual, and environmental needs of the patient are taken into consideration. Muslims are required to live a healthy and balanced life incorporating God, family, and community" (Fonte & Horton-Deutsch, 2005).

Patterns of women's employment vary throughout the Muslim world in modern era. According to a 2012 World Economic Forum Report and other recent reports, Islamic nations in the Middle East and North Africa regions are increasing their creation of economic and employment opportunities for

women (Abdel Kader Deina, 2003). In some cases, when women have the right to work and are educated, job opportunities may be less available to women as compared to men.

Medical profession was open to women but with lot of restrictions in the form of directions. Medieval *bimarestan* or hospitals included female staff as nurses. Muslim hospitals were also the first to employ female physicians, such as Banu Zuhr from the family who served the Al Mohad Caliph ruler Abu Yusuf Yaqub al Mansur in the twelfth century and 1ater in the fifteenth century female surgeons were employed at Serafeddin Sabuncuoylu's.

More than any other professional, the Muslim medical doctor is confronted frequently with questions concerning the Islamic legitimacy of his activities. A Muslim, who has real faith in God, makes every aspect of his subservience including profession to the will of God. There are a daily basis, diverse controversial problematic issues on which a medical doctor is supposed to take a stand: e.g., birth control, abortions, opposite sex hormonal injections, transsexual operations, brain operations affecting human personality, plastic surgery changing physiognomy, extra-uterine conception, etc. which needs to be done only if there is no total violation of Islamic moral limits.

By accepting the fact that God is the healer - and that the doctor is only an agent, both patients and their doctors, fight their battle of treatment with less agony and tension. Women patients prefer women doctors over male doctors as a part of being habituated to conservative thinking. This conservative thinking in men too make families specifically turn to women doctors for the female

members. Moreover the unavoidably awkward situations like delivery definitely demand a female doctor. The role of Muslim women doctor in the community is essential and commendable.

Table 5.1 Participation in Religious activities

Sl. No	Items	Always	Sometimes	Never
	Are you religious	230 (92)	19 (7.6)	1 (0.4)
1	Regular in prayers	192 (76.8)	46 (18.4)	12 (4.8)
2	Visit religious places	100 (40)	82 (32.8)	68 (27.2)
3	Following religious dress code	184 (73.6)	34 (13.6)	32 (12.8)
4	Following religious food code	221 (88.4)	20 (8)	9 (3.6)
5	Attend religious functions	119 (47.6)	82 (32.8)	49 (19.6)
6	Take fasting during Ramsan	228 (91.2)	19 (7.6)	3 (1.2)
7	Reciting Quran	169 (67.6)	77 (30.8)	3 (1.2)
8	Inculcating religious values to the children	208 (83.2)	37 (14.8)	5 (2)
9	Following religious customs and practices	201 (80.4)	42 (16.8)	7 (2.8)
10	Went to Hajj or Umrah	104 (41.6)	3 (1.2)	143 (57.2)
11	As a Muslim women face problem in attending some cases	36 (14.4)	47 (18.8)	167 (66.8)
12	Feel difficulty to follow some religious believes during duty	70 (28)	72 (28.8)	108 (43.2)

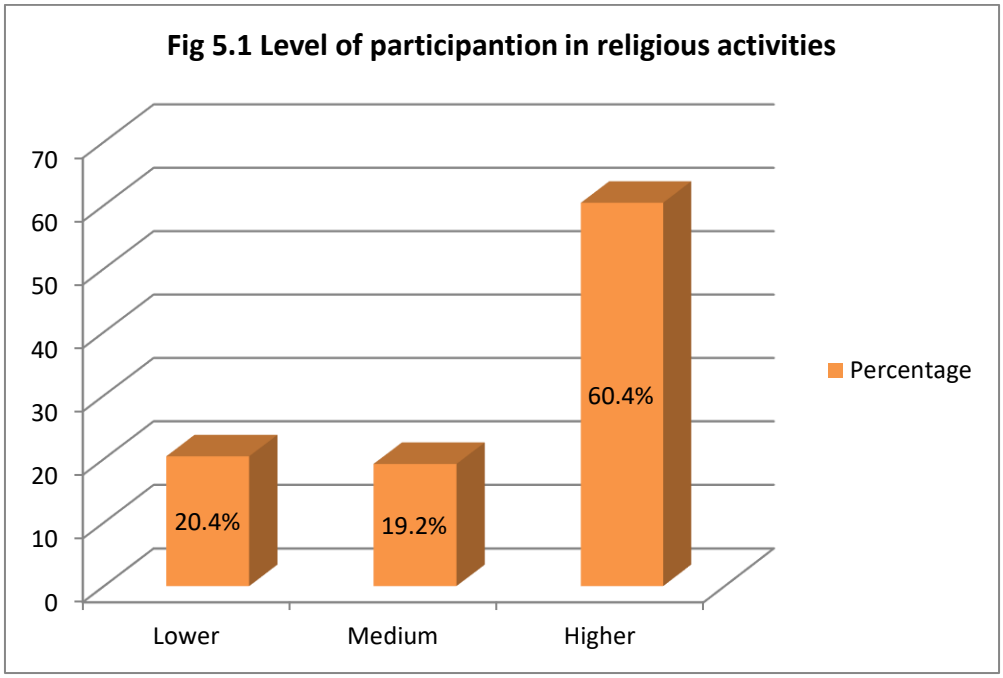
The table 5.1on participation in religious activities of respondents reveals that a great majority (92%) maintains their religious belief and follows religious obligations even in a busy professional schedule. More than three fourths (76.8%) are regular in their prayers. Four out of ten (40%) visit religious centers. A little less than three fourths (73.6%) follows religious dress code and about eight out of ten follow religious food code. A little less than

half (47.6%) attend religious functions and nine out of ten (91.2%) fast during Ramadan. More than two thirds (67.6%) are regular in reciting Quran and little more than eight out of ten (83.2%) inculcate religious values among their children. Again eight out of ten (80.4%) follow other customs and practices of Islam. A little more than four out of ten (41.6%) completed her Hajj or Umrah. The result of last two statements regarding hesitation in attending some medical cases as a Muslim and difficulty to follow religious believes in such situations shows that there is no remarkable or significant relation between religious belief and profession for the respondents.

The role of religion, as a central aspect of many Muslim's women experiences, was reflected by several authors as indicative of an integral part in their professional lives. This is to say that religious practice and tenets may have influenced the work culture of these women doctors to a certain extant but not to the degree that they completely modified their work to accommodate in the rules of religion. Being health care professional was an important part of their religious duty (Annie Siddiqui 2012).

Table 5.2 Level of participation in Religious activities

SL.No	Level of participation	Frequency	Percentage
1	Higher Level	151	60.4
2	Medium Level	48	19.2
3	Lower Level	51	20.4
	Total	250	100



The table 5.2 on level of participation in religious activities shows that 6 out of ten (60.4%) have higher level of religious activities. Nearly 2 out of ten (19.2%) have medium level of religious activities, whereas 2 out of ten (20.4%) have lower level of participation in religious activities.

Table 5.3. Age and believes and participation in religious activities

Age	Believes and religious activities			Total
	Higher level	Mediu m level	Lower level	
up to 30	47	17	18	82
30-40	68	19	23	110
Above 40	36	12	10	58
Total	151	48	51	250

P-value of Chi-square= 0.943 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.943) is greater than 0.05. Hence, there is no significant relationship between the age of the respondents and their religious belief and participation in religious activities. We can observe here that as age increases participation also increases.

Table 5.4 Profession of husband and respondents participation in religious activities

Profession of husband	Believes and religious activities			Total
	Yes	Sometimes	No	
Same profession	86	30	31	147
Different profession	65	18	20	103
Total	151	48	51	250

P-value of Chi-square= 0.862 of 2 d.f at 0.05% level.

The P-value of Chi-square (0.862) is greater than 0.05. Hence, there is no significant relationship between religious beliefs and religious activities of the respondents and husband who is from same profession.

Charity is a part of our personal life and value. Not only religion but also the very human nature demands to be part of it. In the present study a great proportion of respondents (92%) take part in charity activities which can be attributed to the fact that the religion demands it. Among them, almost all are financially supporting the poor and needy. Nearly half (48%) take part in provision of free medical service and visit bed ridden patients personally as part of voluntary organizations. Usually it is observed that religious beliefs are inversely proportional to the level of education, social position and employment of an individual.

Table 5.5 Believes and religious activities and various independent variables

Variables	Chi-square value	d.f	P value
Occupational designation	1.292	4	0.863
Medical background	6.111	4	0.191
Years of service	4.952	4	0.292
Educational specialization	0.192	2	0.908
Age at marriage	0.542	2	0.763

Table 5.5 on believes and religious activities of the respondents and various independent variables shows that there is no significant relation between these variables since the chi square values are greater than the table value 0.05.

Chapter - VI

ROLE STRUCTURE WITHIN THE HOUSEHOLD

Women of all ages still tend to do more home chores than their male partners, no matter how much they work or earn in a job outside the home. Historically, house regarded as the world of women. Day starts first for her and ends last. Varied responsibilities make her totally engaged throughout. In this changing scenario of work and empowerment of women, the household duties are still her responsibility (Martinez and Palerna 2009 and Fernandez and Angeles Quroga 2016).

In this chapter, an attempt is made to analyse the participation in household activities of working house wives and examine whether there is any alteration in role performance as result of education and more particularly due to the employment of wives.

Professional women can manage effectively both career and family roles with the support she gets from the members of the family. The husbands of working wives should share the responsibilities to enable them to cope with the new demands. But many of them are not willing to take up responsibilities even when they are free because of certain traditional patriarchal values and convictions.

Table 6.1 Performance in household activities by the respondents

Family as the primary institution of society exists as a result of its mutuality. It performs as a source of my services needed for its members for

their very existence. For the satisfaction of basic needs, members depend primarily on this system. Wife or mother is the most important service provider in the family (Steidl and Bratton, 1968 and Schalfly 1973). She has to offer or arrange the family as a centre of various services. Preparations of food, cleaning, treating guests, take care of children and adults, nurse the ill members of the family etc are major household duties assigned for women. Most of these duties are still performed by women along with their role as an economic participant.

Sl.No	Activities	Primarily by Self	Primarily by Husband	Jointly with Husband
1	Preparing food	141 (56.4)	3 (1.2)	106 (42.4)
2	Cutting Vegetables	151 (60.4)	1 (0.4)	98 (39.2)
3	Cleaning	148 (59.2)	3 (1.2)	99(39.6)
4	Putting Clothes in Washing Machine	123 (49.2)	15 (6)	112 (44.8)
5	Putting Washed dress for drying	120 (48)	17 (6.8)	113 (45.2)
6	Ironing	88 (35.2)	37 (14.8)	125 (50.2)
7	Dish washing	159 (63.6)	2 (0.8)	89 (35.6)
8	Arranging and Decorating the House	120 (48)	7 (2.8)	123 (49.2)
9	Treating Guests	41 (16.4)	2 (0.8)	207 (82.8)
10	Buying Household provisions	21(8.4)	44 (17.6)	185 (74)

Table 6.1 on household task participation shows that participation by husband is negligible, ranging between 0.4 per cent and 2.8 per cent for activities like cutting vegetables, dish washing, treating guests, cleaning, preparing food and dishwashing. Less than one fourth (6%) husbands are

involved in activities like putting clothes in washing machine and putting washed dresses for drying. Ironing and an outside activity of buying household provisions have a little higher male participation-14.8 per cent and 17.6 per cent respectively.

As far as joint participation is concerned a better proportion of them are sharing dish washing (35.6%), cleaning (39.6%) and cutting vegetables (39.6%). Joint participation also shows nearly half in preparation of food, washing clothes, ironing, arranging and decorating the house. Shopping, as an outdoor activity was jointly performed by 3 out of 4 and 4 out of 5 were involved in treating guests.

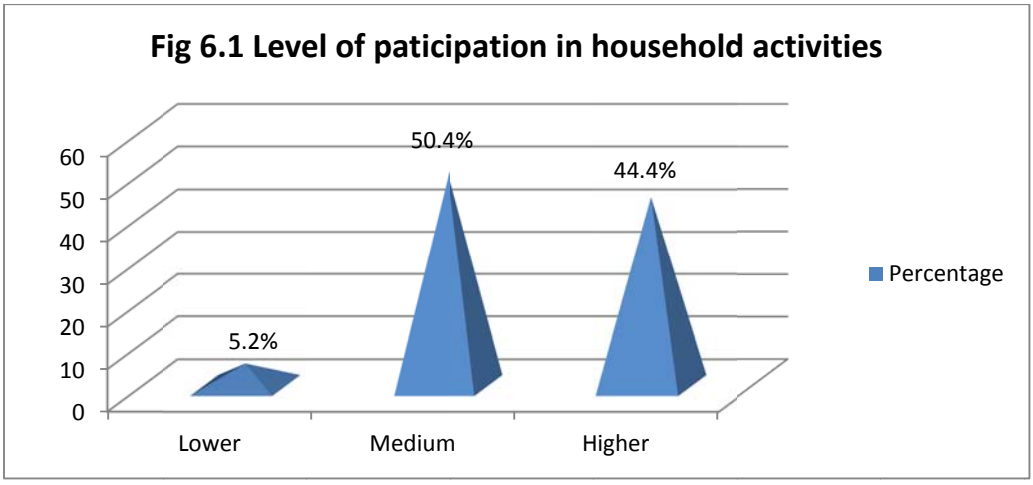
As to the mode of participation, it is better when shared. Wives would attend to some medical emergencies even at their home at odd times. The husbands inclined to participate in household duties do so mostly in the physical absence of the wife or when she cannot attend the task. It means they have accepted a new normative system governing the role situation. Indian culture ascribes the domestic duties to be unshared for women. Usually the mother never expects the son to help her in the kitchen. In some cases when a boy marries a working girl, he is well aware of the fact that the wife will work outside the home and that she will not be able to perform her traditional role due to added obligations and responsibilities. As he is aware, he extends his helping hand in domestic responsibilities.

It is noticed that there is a trend of change in the traditional division of labour in house work. The activities, which men share at large, like ironing,

provide better relaxation to women. Since the men take this responsibility women get time to relax. Most of the employed men spend time with friends in the club or other organizations, and many come home very late. But in the case of women, they have to rush to their houses, directly from the work place, to assume all the duties of a house wife. This drains out all their energy but if husbands are ready to share the household responsibilities along with their wives it will ease their burdens more. This result is consistent with the study conducted by Dutta (2000) that the entry of women into the paid work force has a partial transformative effect on the household duties and decision making.

Table 6. 2 Level of performance in household activities of Respondents

SL.No	Level of management of household activities	Frequency	Percentage
1	Higher Level	111	44.4
2	Medium Level	126	50.4
3	Lower Level	13	5.2
	Total	250	100



The table 6.2 on level of participation of household activities by respondents shows that 4 out of ten (44.4%) have higher level. Five out of ten (50.4%) have medium level of participation in household activities. One out of ten (5.2%) have lower level of participation in household activities. Women in this study not think of their professional enrichment by sacrificing their family system. They were ready to find time to do the basic things in the family. She feels, it is her moral responsibility to fulfill both the jobs efficiently. In this process she develops feeling of guilt for not devoting full time to her children and home envisioned by our social system (Jenitta, Chidambaranathan and Allen, 2001).

Table 6.3 Profession of the husband and respondents participation in household activities

Profession of the husband	Participation in household activities			Total
	Higher level	Medium level	Lower level	
Same profession	69	71	7	147
Different profession	42	55	6	103
Total	111	126	13	250

P-value of Chi-square= 0.535 of 3 d.f at 0.05% level.

The P-value of Chi-square (0.535) is greater than 0.05. Hence, there is no significant relationship between husbands' participation in household activities and type of profession of the husband.

Participation in child care activities

The socialization process is still the responsibility of the family even in the urban setting. Though nurseries and educational institutions have relieved the family from some of its functions related to children, the basic function of early socialization still rests with the parents. Bearing and rearing of children is both biological and social obligation for women. Their growth and development demands a lot of the mother's energy, time and strength.

Feeding, sending children to school, helping in their studies, and disciplining are important areas for role preference by the family members. At the school going age they require constant care and guidance. It involves tasks like dressing them up, arranging books, helping them to do their home work, taking them to the school as well as ensuring that they leave the house in time for school. Feeding children is by and large exclusively female's task in the Indian context (Ross 1961). However, the employed wives in urban areas find it difficult to perform these tasks. While some, particularly those in higher income brackets may transfer this task totally to domestic help; those who cannot delegate share it with the elders in the family. In such situations, the husbands have to perform or share these female-centered tasks.

This part of the study focused on child care aspect especially to find out whether the husband has started sharing the childcare responsibilities. This section deals with this aspect.

Table 6.4 Respondents participation in child care activities

Sl.No	Duties	Primarily by the respondent	Jointly with husband	Others
1	Giving bath and dressing	92 (36.8)	136 (54.4)	22 (8.8)
2	Feeding or packing food	110 (44)	93 (37.2)	47 (18.8)
3	Arranging Books and Uniforms	124 (49.6)	39 (35.6)	37 (14.8)
4	Assisting in doing Homework	128 (51.2)	85 (34)	37 (14.8)
5	Attending during illness	66 (26.4)	166 (66.4)	18 (7.2)
6	Taking them to School	31 (12.4)	94 (37.6)	125 (50)
7	Telling stories and entertaining them	53 (21.2)	162 (64.8)	35 (14)

Table 6.4 on respondents' participation in child care reveals certain dimensions and it clearly shows collective child rearing. Feeding or packing food mostly rests with women in comparison to other two categories. The women predominant in areas like assisting in doing home work (51.2%) and arranging books and uniforms (49.6%) is about half of the families. Taking them to school has the least female participation (12.4%) but maximum cooperation from husbands amounting to half (50%) with external help for the same being the rest. Only a little more than one third (36.8 %) were singularly involved in task of bathing and dressing. This finding is contrast with the findings of Szilvia Adam (2008) that spousal support with household work (instrumental support) is rare among female physicians.

In the group where child care was shared majority of the traditional tasks had equal participation. Two thirds of them jointly perform the task of attending during illness and telling stories and entertaining them. The least shared task is assisting in doing homework. A notable aspect is that 54.4 per cent share the activities of bathing and dressing up of children.

Table 6.5 Level of participation in child care activities of Respondents

SL.No	Level of management of household activities	Frequency	Percentage
1	Higher Level	93	37.2
2	Medium Level	111	44.4
3	Lower Level	46	18.4
	Total	250	100

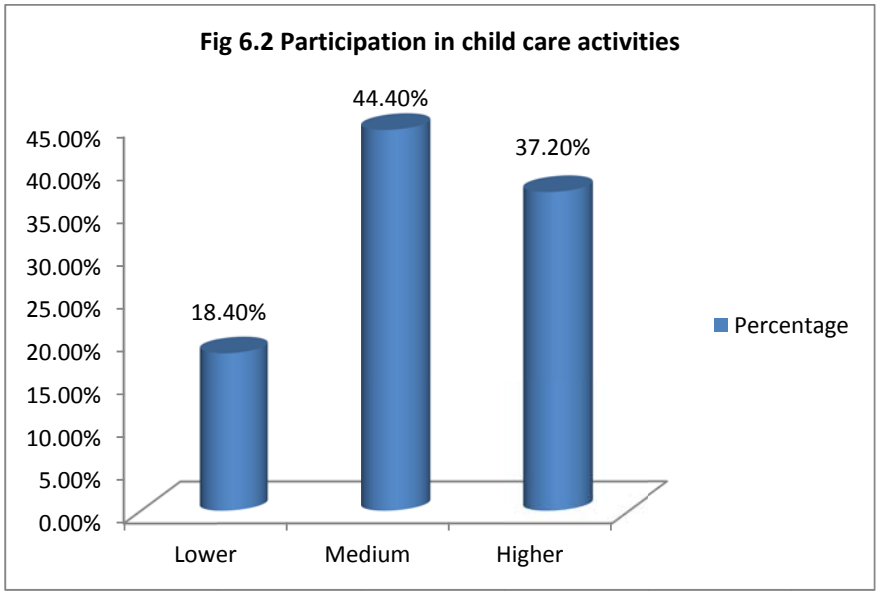


Table 6.5 on level of participation in child care activities shows that nearly 4 out of ten (37.2%) have higher level of participation in child care activities. Four out of ten (44.4%) have medium level of participation in child care activities. Nearly 2 out of ten (18.4%) have lower level of participation in child care activities.

Management of household activities

A large number of dual role women are confronting issues regarding management of household activities. As an employee they have assigned duties and timing in the work area. To a certain extant dual role women successfully manage to balance both duties. But household duties are unlimited and continuous hence efficient management is tiresome. Management is a skill and those with a strong support system can carry on efficiently. Husband, family, domestic help, technology etc. are the factors which help them to manage their work and family (Swanson 1981, Baud 1992 and Riti 1997).

Table 6.6 Respondents management of household activities

Sl.no	Household activities	Great extent	To some extent	Not at all
1	I can manage it with my own skill	52 (20.8)	182 (72.8)	16 (6.4)
2	I have servant to help me	93 (37.2)	103 (41.2)	54 (21.6)
3	I have pre-planned menu system	63 (25.2)	128 (51.2)	59 (23.6)
4	I am depending more on modern kitchen devices	106 (42.4)	115 (46)	29 (11.6)
5	I prepare food more easy type food	80 (32)	139(55.6)	31 (12.4)
6	I purchase more instant food making items	43 (17.2)	104 (41.6)	103 (41.2)
7	I have a good time management skill and apply in day today activities.	67(26.8)	143 (57.2)	40 (16)

The table 6.6 on respondents participation in household activities reveals that a great majority have the confidence that they can manage the household duties to some extent (72.8%) and (20.8%) to great extent. More than two out of ten (21.6%) manage their household even without domestic help. Half of them (51.2%) follow preplanned menu and more than one among every ten (11.6%) manage without modern kitchen devices. Except twelve percent (12%), 32 percent of the respondents resort majorly to more easy or simple or time saving type food while more than half (55.6%) resort to it only to an extent. Four out of ten (41.2%) do not depend at all on any instant food, a great

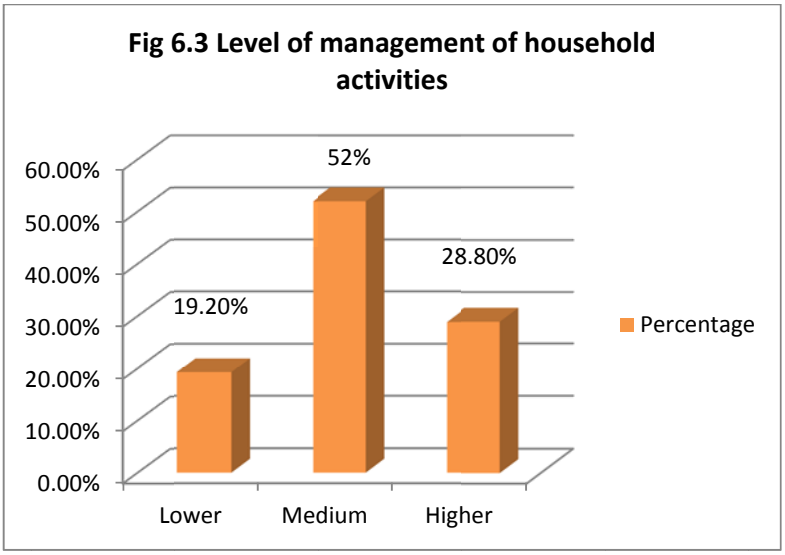
majority (84%) follow effective time management, a little more than one fourth (26.8%) follow time schedule. Nearly sixty percent (57.2%) follow time schedule to some extent while others (16%) do not have any time plan.

Hypothesis 4. Women medical practitioners get support from their male counterparts to fulfill their household role and mother role.

From the above Tables 1, 4 and 6 clearly shows that the women medical practitioners get support from their spouses to fulfill their household role and mother's role.

Table 6.7 Respondents level of management of household activities

SL.No	Level of management of household activities	Frequency	Percentage
1	Higher Level	72	28.8
2	Medium Level	130	52
3	Lower Level	48	19.2
	Total	250	100



The Table 6.7 on level of participation in management of household activities of the respondents shows that nearly 3 out of ten (28.8) have higher level of management of household activities. Five out of ten (52) have medium level of management of household activities, whereas nearly 2 out of ten (19.2) have lower level of participation in household activities.

Table 6.8 Age and management of household activities

Age	Participation in household activities			Total
	Higher level	Medium level	Lower level	
Up to 30	15	46	21	82
30-40	30	60	20	110
Above 40	27	24	7	58
Total	72	130	48	250

P-value of Chi-square= 0.005 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.005) is less than 0.05. Hence, there is significant relationship between the age of the respondents and their management in household activities. As age increases the participation in household activities also increases.

Table 6.9 participation level of Husbands from similar and different profession in management of household activities

Profession of the Husband	Management of household activities			Total
	Great extent	Some extent	Not at all	
Same profession	47	74	26	147
Different profession	25	56	22	103
Total	72	130	48	250

P-value of Chi-square= 0.370 of 2 d.f at 0.05% level.

The P-value of Chi-square (0.370) is greater than 0.05. Hence, there is no significant relationship between the management of household activities of the respondents and husbands from same profession.

Table 6.10 Respondents qualification and management of household activities

Qualification	Management of household activities			Total
	Higher level	Medium level	Lower level	
MBBS only	47	73	24	144
Above MBBS	25	57	24	106
Total	72	130	48	250

P-value of Chi-square= 0.903 of 2 d.f at 0.05% level.

The P-value of Chi-square (0.903) is greater than 0.05. Hence, there is no significant relationship between the specialized qualification of the respondents and management of household activities.

Hypothesis 5. Increased specialization demands more from the professional which the household role performance.

The null hypothesis for testing the above research hypothesis is that there is no significant correlation between specialized qualification and management of household activities.

Table 6.11 Number of children and Management of household activities

No. of children	Management of household activities			Total
	Higher level	Medium level	Lower level	
1	26	62	19	107
2	25	67	17	109
3	21	1	12	34
Total	72	130	48	250

P-value of Chi-square= 0.000 of 6 d.f at 0.05% level.

The P-value of Chi-square (0.000) is less than 0.05. Hence, there is significant relationship between number of children and household management of the respondents. Women who have more number of children are not participating in household activities than women who have one or two children. Women who have more number of children are prone to face more role conflicts and problems of adjustment in the family due to work. Study of Kala Rani (1976) and Chowadhary (1995) also support this finding.

From this analysis, it clearly reveals the fact that even though women do the household activities, the participation of their husbands are significant. A remarkable change is observed in the joint participation of husband and wife in

many activities as well as in the independent participation of husbands in some activities.

Table 6.12 Management of household activities and various independent variables

Variables	Chi-square value	d.f	P value
Occupational designation	0.712	4	0.950
Medical background	3.407	4	0.492
Years of service	2.755	4	0.600

Table 6.12 shows the relation of management of household activities with various independent variables. There are no significant relationship between there variables since all values are greater than the table value 0.05.

Leisure time activities

Leisure generally means free time and its effective utilization helps to energize the individuals and thereby reflect in productivity. There are many types of leisure time activities but women do not have completely free choice and are constrained by social pressures. Some others link it with their hobbies and attitudes and later turn this passion in to profession. Many employers provide compulsory leisure so that the increased quality and productivity of the workers benefit the company. The quality of a professional should be maintained and reinforced through refreshing activities. Economic and social

factors as well as roles, especially which of a wife and mother have profound influence on leisure.

Women's perception and attitude to leisure and inability to have leisure are products of socialization in the society and it stems from patriarchy system. Women have no much time for leisure as their children, husband and family chores mainly take their time (Okumdi and Asiazobor 2011) and mostly women spend leisure time inside their house (Gilligan 1982). Working women, in general, while struggling to balance both work and family divert their leisure time into some of the related ones which would ease their professional and familial burden. Medical practitioners who juggles their busy professional lives may not get enough time and space to ease their stress through leisure activities without adequate help from their support system. There is a marked difference between the quality and quantity of leisure among different categories. Generally women spend their leisure time watching cinema, serial, gossiping etc. But when we take the case of educated women all these shows a different pattern. They select their leisure activity according to the nature of education they obtain. If she is a career woman, again visible changes reflect in the leisure activity. They purposefully or not are influenced by the field of her work and infuse leisure with their profession (Henderson 1990). Women in the medical profession sometimes tend to favour activities that are connected to the medical field such as tending herbal gardens, chatting with like-minded friends about latest trends in medicine or even listening to music that benefits medically.

Table 6.13 Utilization of leisure time activities of the respondents

SL. No	Spending of leisure time	Yes	Sometimes	No
1	Reading books	86(34.4)	101(40.4)	63(25.2)
2	Watching movie	129(51.6)	77(30.8)	44(17.6)
3	Engaging in social media	178(71.2)	57(22.8)	15(6)
4	Chatting with my friends	167(66.8)	69(27.6)	14(5.6)
5	With my husband	184(73.6)	52(20.8)	14(5.6)
6	With my children	210(84)	18(7.2)	22(6.8)
7	With my husband and children	200(80)	32(12.8)	18(7.2)
8	Going for shopping	177(70.8)	64(25.6)	9(3.6)
9	Going for parlor	58(23.2)	67(26.8)	125(50)
10	Going for health club	11(4.4)	18(7.2)	221(88.4)
11	Gardening	52(20.8)	50(20)	148(59.2)
12	Updating Knowledge	152(60.8)	74(29.6)	24(9.6)
13	Social welfare Activities	61(24.4)	119(47.6)	70(28)

The table 6.13 shows reading as one of the popular leisure time activity followed by one among every three (34.4%). Nearly half (51.6%) watch movies, and seven out of ten (71.2%) engage in social media. Two thirds (66.8%) spend time chatting with friends. Eight among ten likes to spend their leisure with husband and family. Seven out of ten (70.8%) usually go shopping. Half of them (50%) preferred to go to beauty parlors and about nine out of ten (88.4%) disliked health clubs. Only two out of ten (20.8) spend time for gardening and six out of ten (60.8%) use time to update knowledge and one quarter (24.4%) engage themselves in social welfare activities. Many researchers (Allison and Duncan 1987; Chambers 1986; and Shank 1986) have

found that the leisure time activities of the dual career women are largely associated with family environments, particularly children.

Table 6. 14 Respondents level of ways of utilization of leisure time activities

SL.No	Level of leisure time activities	Frequency	Percentage
1	Higher Level	128	51.2
2	Medium Level	61	24.4
3	Lower Level	61	24.4
Total	250	100	

Table 6.14 on level of ways of utilization of leisure time shows that 5 out of ten (51.2) have higher level of leisure time activities. Two out of ten (24.4) have medium level of leisure time activities. Again two out of ten (24.4) have lower level of leisure time activities.

Table 6.15 Leisure time activities and various independent variables

Variables	Chi-square value	d.f	P value
Age	0.340	4	0.987
Educational specialization	0.087	2	0.957
Age at marriage	0.246	2	0.884
Husband from same profession	0.076	2	0.963
Occupational designation	0.499	4	0.974
Medical background	2.767	4	0.598
Years of service	2.157	4	0.707

Table 6.15 on the relation of leisure time activities with various independent variables shows that there is no significant correlation between them since its values are greater than table value 0.05.

Chapter - VII

LEVEL OF MARITAL SATISFACTION

One of the most important relationships between a man and a woman is marriage. Marriage is a lifelong bond which aims at the individuals' biological, emotional, social and spiritual fulfillment and development and which cannot be achieved in isolation (). It involves long-time emotional and legal commitment that is quite important in any adult life. Moreover, selecting a partner and entering into a marital contract is considered both a maturational milestone and personal achievement. There is no doubt that the choice of marital partner is one of the most important decisions one makes in a life time. Marriage is a commitment bound by love and responsibility for peace, happiness and development of strong family relationships.

For a long number of years men were not accustomed to a concept called working women as women were not required to directly supplement family income. Women who were by birth were so by devolved inheritance of land or jewelry. Changing circumstances like industrial revolution brought about new requirements where women had to participate in bringing home the bread. Slowly but surely women joined the workforce first as teachers and in other minor professions like domestic servants and seamstresses. Growth in population and orphaning of families due to wars caused more and more women to enter work force to support their families.

Though men has begun to accept the concept of a working women very few actually participate in managing a household to aid the women as many still subscribe to the traditional role of a patriarch who only oversaw a household but never worked in it. Woman who goes out to work faces stressful situations in marital and family setup as well as interpersonal relationships at work sphere. In the marital relationship, the woman's status, outlook and changed social role certainly affect the husband also. An important feature of the dual-earner family is the segregation of work and family life. The skill of doing a tightrope walk by a working woman between her career and her home is phenomenal.

Marital satisfaction is an essential element for successful family life and personal growth. The fulfillment and positive development will be possible only when the relationship between couples is coherent and satisfactory. Personality of the partner, nature of job, child rearing responsibilities, sexual satisfaction and communication patterns are the factors that influence marital satisfaction.

Women burdened by the expectations of a demanding household are less productive in their respective employment sectors. Professionals who are engaged in health care sector, especially medical practitioners in the private sector are over burdened with excessive responsibilities like night duty, responsibility of admitted patients etc. These aspects have significant correlation in their family life too. Both men and women enter marriage with high expectations of interpersonal communication, intimacy and sexual

satisfaction (Furslenberg 1996). Couples strive towards fulfilling such needs and unmet needs results in stress and dissatisfaction. Education and income predicting greater marital satisfaction and less conflict (Johnson and Booth 1990).

Table 7.1 Respondents marital satisfaction

Sl. No		Strongly disagree	Moderately disagree	Neutral	.Moderately agree	Strongly agree
1	My partner and I understand each other perfectly	1(0.4)	7(2.8)	38(15.2)	101(40.4)	103(41.2)
2	I am pleased with the personality characteristics and personal habits of my partner	1(0.4)	8(3.2)	30(12)	126(50.4)	85(34)
3	I am very happy with how we handle role responsibilities in our marriage	1(0.4)	9(3.6)	53(21.2)	94(37.6)	93(37.2)
4	My partner completely understands and sympathizes with my every mood	4(1.6)	10(4)	80(32)	70(28)	86(34.4)
5	Our relationship is a perfect success	2(0.8)	5(2)	58(23.2)	92(36.8)	92(36.8)
6	I am very happy about how we make decisions and resolve conflicts.	1(0.4)	10(4)	49(19.6)	108(43.2)	82(32.8)
7	I am happy about our financial position and the way we make financial decisions	2(0.8)	17(6.8)	55(22)	110(44)	66(26.4)
8	I have satisfy my needs by our relationship	2(0.8)	2(0.8)	42(16.8)	124(49.6)	80(32)

9	I am very happy with how we manage our leisure activities and the time we spend together	3(1.2)	14(5.6)	51(20.4)	101(40.4)	81(32.4)
10	I am very pleased about how we express affection and relate sexually.	2(0.8)	9(3.6)	45(18)	92(36.8)	102(40.8)
11	I am satisfied with the way we each handle our responsibilities as parents	2(0.8)	11(4.4)	34(13.6)	119(47.6)	84(33.6)
12	I have never regretted my relationship and with my partner, not even for a moment.	3(1.2)	26(10.4)	51(20.4)	92(36.8)	78(31.2)
13	I am satisfied about our relationship with my parents, in-laws, and friends	0(0)	11(4.4)	49(19.6)	119(47.6)	71(28.4)
14	I feel very good about how we each practice our religious beliefs and values	1(0.4)	15(6)	77(30.8)	101(40.4)	56(22.4)

The table 7.1 reveals that four out of ten strongly agree and moderately agree (41% and 40%) respectively that they perfectly understand each other. Around half (50.4%) were pleased with personality characteristics and habits of their husband. Four out of ten strongly express their affection for each other. Half (49.6%) satisfy their general needs with their marital relationships. Four among ten (40.4%) feel good about the way they practice religious beliefs and values. About half (48%) are satisfied with the way they handle responsibilities as parents. Less than half (47.6%) of them agree that they are satisfied about

their relationship with parents, in-laws, and friends. About forty percent (40.8) strongly agree that they are pleased about the way they express affection and relate sexually to each other. About forty to sixty percent respondents said that their partner also have religious beliefs and adopt religious value. 62.8% agree that they feel good in both husband and wife practicing their religious beliefs and values.

Table 7.2 Level of Marital Satisfaction of Respondents

SL.No	Level of Marital Satisfaction	Frequency	Percentage
1	Higher Level	185	74
2	Medium Level	53	21.2
3	Lower Level	12	5.2
	Total	250	100

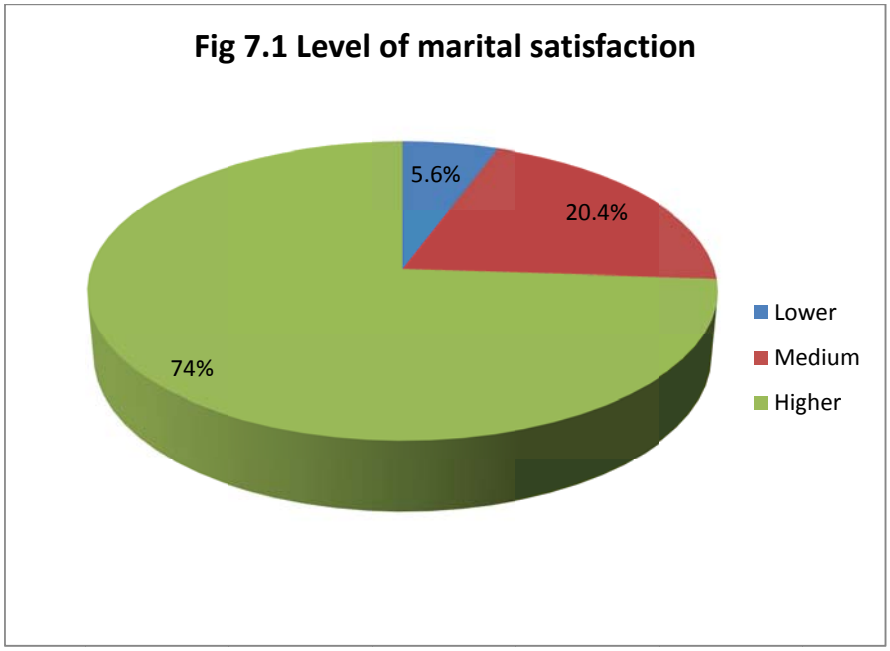


Table 7.2 shows that with regard to level of marital satisfaction seven out of ten (74%) have higher level of marital satisfaction. Two out of ten (21.2%) have medium level of marital satisfaction, whereas a few of them (5.2%) have lower level of marital satisfaction.

Table 7.3 Age of the respondents and their marital satisfaction

Age	Marital satisfaction			Total
	Higher level	Medium level	Lower level	
Up to 30	67	12	3	82
30-40	76	27	7	110
Above 40	42	14	2	58
Total	185	53	12	250

P-value of Chi-square= 0.201 of 8 d.f at 0.05% level.

The P-value of Chi-square (0.201) is greater than 0.05. Hence, there is no significant relationship between the age of the respondents and their marital satisfaction.

Table 7.4 Marital satisfaction and self-esteem of the respondents

Marital satisfaction	Self esteem			Total
	Higher	Medium	Lower	
Higher	146	28	11	185
Medium	27	17	9	53
Lower	7	4	1	12
Total	180	49	21	250

P-value of Chi-square= 0.000 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.000) is less than 0.05. Hence, there is significant relationship between self esteem of the respondents and their marital satisfaction.

Table 7.5 Respondents marital satisfaction and profession of the husband

Profession of husband	Marital satisfaction			Total
	Agree	Disagree	Neutral	
Same profession	94	6	3	103
Different	91	47	9	147
Total	185	53	12	250

P-value of Chi-square= 0.001 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.001) is less than 0.05. Hence, there is significant relationship between the marital satisfaction of the respondents where husband and wife are from same profession.

Hypothesis 7: Doctor Couples have more marital satisfaction than doctors with husbands in other professions.

Table 7.6 Marital satisfaction and various independent variables

Variables	Chi-square value	d.f	P value
Educational specialization	0.427	2	0.808
Occupational designation	3.402	4	0.493

Significant at 0.05 level

There is no significant relationship between educational specialization and occupational designation with marital satisfaction.

Chapter - VIII

PARTICIPATION IN DECISION MAKING

In patriarchal joint families, decision making is largely considered an unshared male prerogative. Decisions are primarily influenced by customs and practices. Family members are obliged to follow these decisions. Important events like marriage is an absolute family affair and the decisions on it are made by a first circle ring containing eldest male members of the family. The role of women in family decisions is strictly limited. Mother or the eldest female member of the family may get an opportunity to share some views.

Along with the trends of modernisation, our society too is influenced by placing nuclear families as its norm. A nuclear family is where every single individual even the children considered as a person with own decision. The role and status of women has been undergoing a continuous change in recent years. The type of family was found to be the influencing factor in decision making as it was evident that in nuclear household's per cent of joint decision was found to be high in children's education, marriage and also in all other aspects when compared with that of head of the family alone making decision in joint and extended household.

A woman is generally consulted only for household matters. Financial decisions are dominated by males. The term women empowerment presupposes a condition of achieving decision making power among women. Decision

making power is one of the indicators of self-esteem. Decisions based on knowledge and planning are more successful and result oriented. Such decisions should be possible for those who are cognitively modified and trained. The right decisions at right time are more fruitful. Radical decisions taken in our life may oppose or re-define the established customs and traditions. It is rather tough task to stick on to the decisions till success or cognitive alteration or modification is visible in the feedback.

The factors that influence decision making of women are type of family, education, employment, economic independence, motherhood, law of the land, pro-women policies of the governments and confidence in self-power and quest for change and energy and aspiration for better life. Above all, it should be understood that delegating decision making power to others empowers them and also lessen our burden. Women empowerment is a direct indication of the fact that more and more women are taking decisions as their own.

With education and employment of women, patterns of interaction of family with the outside world and the constant familial adjustment on all fronts result in the emergence of new roles. The present study focuses on five major areas of decision making in family like household management, decisions on personal matters, financial matters, decisions on professional aspects and decisions regarding children. Since education provides opportunities for awareness, personal advancement, social mobility, educated women today have greater role in decision making power (Dandekar: 1965) The woman who is

respected by her own family members have more confidence to seek better position in her work sphere. This confidence extracted by women through her participation in decisions regarding her home chore equips her to take up challenging positions filled with more power outside it.

Table 8.1 Respondents participation in decision making in Household Management

Sl.No	Statement	Primarily by respondent	Primarily by Husband	Both
1	Purchasing provisions required for the kitchen	41(16.4)	36(14.4)	171(68.4)
2	Deciding about the menu	81(32.4)	7(2.8)	162(64.8)
3	Employing servants	62(24.8)	15(6)	173(69.2)
4	Assistance from outside agencies	37(14.8)	66(26.4)	147(58.8)
5	Arranging and decorating house	96(38.4)	12(4.8)	142(56.8)
6	Repairing and painting	49(19.6)	84(33.6)	117(46.8)
7	Inviting friends	20(8)	24(9.6)	206(82.4)
8	Inviting relatives	19(7.6)	16(6.4)	215(86)
9	Visiting friends	15(6)	14(5.6)	221(88.4)
10	Visiting relatives	16(6.4)	10(4)	224(89.6)
11	Taking the sick family members to the hospital	17(6.8)	52(20.8)	181(72.4)
12	Decisions regarding family health	8(3.2)	23(9.2)	219(87.6)

The Table 8.1 on respondents participation in decision making in household management reveals that many of the traditional concepts of authority regarding household management shows a transformation. Most of the decisions are taken by husband and wife jointly and it ranges from 46.8% to

89.6%. Men slightly predominate in areas such as repairing and painting of house (33.6%), arrange assistance from outside agencies like help from plumber or electrician etc. (26.4%) and taking sick family members to the hospital (20.8%) whereas women predominate in areas like arranging and decorating house (38.4%), decision on family menu (32.4%) and employing servants (24.8%). Purchasing provisions required for the kitchen is mostly a joint activity with only 14.4 percent showing husband as dominant and about seven out of ten (68.4%) purchase household things jointly. Husband enjoys very limited power to decide about the daily menu of the families. In traditional Indian families usually the menu will be decided by men only. The women cook food as per the likes and dislikes of their husbands or other elder male members of the family. A very a few (2.8%) husbands only enjoy this power. About one third (32.4%) of women independently decide their family menu and a majority decide it by husband and wife jointly. Respondents' knowledge and their awareness on health and diseases make them to involve in family food habits and become promoters of family health. Arranging and decorating house is regarded as a sole female responsibility dominated by women. About four out of ten (38.4%) dominate in this field. Another traditional role of women is deciding about the care of sick people. For more than seventy percent (72.4%) of families it is a joint responsibility. Independent decisions of husband predominate in some fields not because women are unable to do those activities, but because they are professionally preoccupied. Though one of the major responsibility of the medical practitioners is caring sick people, the

independent role of women medical practitioners are very much limited in this decision. At the same time a great majority (72.4%) predominate in joint participation

Along with decision making power, she charged herself with the power to implement or to make it into effect. This self discovered empowerment of women through utilizing or channelizing her available resources helps to be powerful and maintain work-family balance. When analyse the empowerment of these women with respect to their participation in household decisions reveals the facts that they are in a moderate level in their achievement. This is a much commendable position that she get into this from a low level participation in decision making. If she can improve it with bettering her position can reach at its zenith so that they can maintain a balance between work and family without losing or compromising any of them. No one can break the family system because it is the basic of human life, by referring it as an obstacle for the development of women hence can bring ahead by moving smoothly both.

Table 8.2. Respondents level of participation in decision making in household management

SL.No	Level of decision making in household management	Frequency	Percentage
1	Higher Level	38	15.2
2	Medium Level	182	72.8
3	Lower Level	30	12
	Total	250	100

The Table 8.2 on level of participation in decision making in household management reveals that nearly 2 out of ten (15.2%) have higher level of participation. Seven out of ten (72.8%) have medium level of participation while one out of ten (12%) have lower level of participation in decision making related to household management. Women are not involving themselves much in household decisions due to the responsibility and commitment related to their profession.

Women and decisions in health and reproductive right

Reproductive health is defined as "a state of complete physical, mental and social wellbeing and not merely absence of reproductive diseases or infirmity. It deals with reproductive process, functions and system at all stages of life" (ICPD 1994). The ability to decide freely the number, spacing and timing of one's children is a basic human right. But gender differences influence decision making about reproductive health. Education and awareness

make women more talented to make strategic life choices, they might want to plan for the future and widen their life roles above being a wife and a mother since using family planning would allow them to delay, space or limit their pregnancies, freeing their time for other pursuits. In our society women do not have the sufficient power to make decisions freely about sex issues and contraception. Because various socio-cultural barriers influence women's contraceptive choices and decisions about childbearing. Women should be empowered to make their own decisions concerning their body and have children. It is their right, and they should be able to exercise this right by having access to education on family planning and contraception. Only women who plan about her children can plan and control the rest of her life in future, improving her life options and so on. This would in turn positively affect others around her. This capacity to make choices and plan her pregnancies also helps to increases the likely hood that she and her children will be healthy. Women having the ultimate decision on pregnancy will benefit themselves, their children, their family and finally wider society.

Participating women in reproductive health decisions is the key factor for Personal empowerment. This personal empowerment involves developing the confidence and strength to set realistic goals and fulfill their potential. This section deals on the role of women medical practitioners in their reproductive health decisions.

Table 8.3 Respondents participation in decision making in health and reproductive right

Sl. No	Statement	Primarily by the respondent	Primarily by Husband	Both
1	Spacing of children	0(0)	8(3.2)	242(96.8)
2	Family planning	2(.8)	8(3.2)	240(96)
3	Timing and numbering of children	5(2)	5(2)	240(96)
4	Parity of children	0(0)	5(2)	245(98)

The table no 8.3 on respondents role in decision making in personal matters shows that almost all items on decisions in private matters taken jointly by the couples. Most of the respondents discuss matters related to reproductive health and take decisions jointly by husband and wife regarding reproductive health. Except a few, all others (96.8%) have common decision on spacing of children. Family planning decisions are mostly (96%) taken by the couples together. About the parity of children husband and wife take joint decision in most of the cases (98%). Major reasons for this change may be their knowledge in the subject and the very nature of the profession. Women who enjoy this power are very confident in sharing and advising about reproductive health with their patients.

Table 8.4 Respondents level of participation in decision making in health and reproductive right

SL.No	Level of decision making in health and reproductive right	Frequency	Percentage
1	Higher Level	2	.8
2	Medium Level	241	96.4
3	Lower Level	7	2.8
	Total	250	100

The Table 8.4 on level of participation in decision making in health and reproductive right reveals that only two of the respondents (.8%) have higher level of participation. A great majority (96.4%) have medium level of participation, while only seven of them (2.8%) have lower level of participation in decision making related to health and reproductive health. The analysis clearly reveals the fact that neither men nor women dominating in these decisions. All decisions related to reproductive health are taken husband and wife jointly. Therefore, high rate of medium level of participation of the respondents in decisions in this area.

The reproductive role of women is highly appreciable and unquestionable. But their role in deciding about that reproductive role is not much discussed in our society. Marriage regarded as an event thereafter the husband is the sole authority of a women, not only the property which brought by her but her body also treated as an object under the authority of husband without considering 'she' as a person with her own likes and dislikes. She is

depicted as a thing which can be used for the pleasure of her husband at any time he likes without her consent. She has no voice or decision with regard to it. But the present study shows the fact that as joint participation; women medical practitioners were asked their consent or decision by their spouse for the utilization of their body to fulfill the functions of the marriage. This is a milestone with respect to their empowerment or considers women as an equally important person in the marital relations so that they can keep their dignity as a person than a thing or source of husbands' pleasure and be proud to be a woman and have peaceful coordination of their family and profession.

Table 8.5 Respondents participation in decisions making in financial matters

Sl. No.	Statement	Primarily by the respondent	Primarily by Husband	Both
1	Payment of bills (electric, phone, NET, water, rent)	18(7.2)	142(56.8)	90(36)
2	Savings	18(7.2)	57(22.8)	175(70)
3	Bank transactions	12(4.8)	75(30)	163(65.2)
4	Wages to servant	66(26.4)	80(32)	104(41.6)
5	Paying school fees	19(7.6)	109(43.6)	122(48.8)
6	Purchasing of clothes	26(10.4)	52(20.8)	172(68.8)
7	Buying household appliances	25(10)	59(23.6)	166(66.4)
8	Money spent for gifts	31(12.4)	41(16.4)	178(71.2)
9	Money spent for luxury items	21(8.4)	80(32)	149(59.6)
10	Money spend for family trips	8(3.2)	111(44.4)	131(52.4)

Table 8.5 on respondents decision regarding financial matters shows women's better participation in financial decisions. Decision making is

regarded as one of the most important part of empowerment of women. Payment of bills to the services received like electricity, phone, internet connection, water supply etc are largely duty of husband (56.8%). This study shows a decrease from male domination in this area and joint participation is on increase. Recently e-payment facilities of bills in an easy way through phones and other gadgets opened a revolution in this world. Now women can do it easily without spatial disparities. Wage to servant is the one area which women dominate with one fourth (26.4%). Four out of ten (43.6%) husbands are still dominating in paying school fees of children. In the areas of savings (70%), bank transactions (65.2%), purchasing of clothes (68.8%) and household appliances (66.4%) and money spend for gifts (71.2%), luxury items (59.6%) and family trips (52.4%) are made after joint decision by husband and wife.

Table 8.6 Level of participation in decision making in financial matters of respondents

SL.No	Level of decision making in financial management	Frequency	Percentage
1	Higher Level	25	10
2	Medium Level	147	58.8
3	Lower Level	78	31.2
	Total	250	100

The Table 8.6 on level of decision making in financial management shows one out of ten (10%) have higher level of decision making in financial

management. Nearly 6 out of ten (58.8%) have medium level of decision making in financial management. Three out of ten (31.2%) have lower level of decision making in financial management.

Financial empowerment regarded as the most significant area of women's' development. Women enjoy the right to participate in the financial activity outside the home, still lag with respect to their involvement in decision making and appropriation of that money for her will or benefit. The participation of women in low paid works contributes not much for improving her position. But the professionals like medical practitioners with their high economic achievement can change her conditions favourable to her. This study shows that, with medium power in the decision making regarding financial management, she can betterise her bargaining power in the family and turn the situation more supportive for her profession, hence enrich the conditions of her work-family balance.

Table 8.7 Respondents age and participation in decision making in financial matters

Age	Decision making			Total
	Higher level	Medium level	Lower level	
Up to 30	8	46	28	82
30-40	10	67	33	110
Above 40	7	34	17	58
Total	25	147	78	250

P-value of Chi-square= 0.928of 4 d.f at 0.05% level.

The P-value of Chi-square (0.928) is greater than 0.05. Hence, there is no significant relationship between the age of the respondents and their decision making in household management.

Table 8.8 Profession of husband and respondents participation in decision making in financial matter

Profession of the husband	**Decision making in financial matter**			**Total**
	Higher level	Medium level	Lower level	
Same	20	79	48	148
Different	5	68	30	103
Total	25	147	78	250

P-value of Chi-square= 0.044 of 2 d.f at 0.05% level.

The P-value of Chi-square (0.044) is less than 0.05. Hence, there is significant relationship between the decision making in financial management of the respondents and husband from same profession. When the husband is in similar profession, wife is freer to spend and have a good say in financial management.

Table 8.9 Respondents participation in decision making regarding children

Most important decisions regarding children are related with their education. The areas of decisions of childcare cover areas of decisions other than educational activities such as giving pocket money, visiting friends, participation in sports, games and arts, discipline and giving punishment or reward etc.

Sl.No	Statement	Primarily by the respondent	Primarily by the husband	Both
1	Admission to school	12(4.8)	31(12.4)	207(82.8)
2	Higher studies	15(6)	26(10.4)	209(83.6)
3	Arranging tuitions	22(8.8)	10(4)	218(87.2)
4	Permitting them to go for movie/picnic and other entertainment	8(3.2)	31(12.4)	211(84.4)
5	Inviting their friends	14(5.6)	4(1.6)	232(92.8)
6	Allow them to stay in relatives house	10(4)	3(1.2)	237(94.8)
7	Punishment	35(14)	14(5.6)	201(80.4)
8	Amount of pocket money	3(1.2)	37(14.8)	210(84)
9	Allow them to visit friends	19(7.6)	15(6)	216(86.4)
10	Participation in sports, games and arts	12(4.8)	6(2.4)	232(92.8)

The table 8.9 on respondents' decision regarding child care shows her role in one of the most important roles of women as mothers. But the decisions related to it are not at all feminine in character. The stereotype role of a mother is demanding too many responsibilities attached with child care. More than eight out of ten (82.8%) were jointly involved with the husband in deciding the correct age at which schooling has to be started for the child, the type of school, the medium of instruction, higher studies etc. More than eighty percent

(83.6%) jointly take decision about their children's higher studies. Nine out of ten (92.8%) permit jointly the child to invite their friends to the house. More than nine out of ten (94.8%) take joint decision to allow the children to stay in relatives house. A little more than nine out of ten (92.8%) jointly decide about children's participation in sports, games and arts.

The table highlights the role of women in decisions along with their husbands. It positively indicates that their role as joint decision maker with husband is on increase. A notable increase in the role of a punishment giver is a step in to the male dominated area. The permission to visit friends' houses is rather another new area showing steady increase. Joint participation is high in areas like giving punishment (80.4%) and giving permission to visit friends' house (86.4%). Traditionally, these two spheres were dominated by men.

Table 8.10 Level of respondents participation in decision making regarding children

SL.No	Level of decision regarding children	Frequency	Percentage
1	Higher Level	15	6
2	Medium Level	217	86.8
3	Lower Level	18	7.2
	Total	250	100

The Table 8.10 on the level of participation in decision regarding children reveals that one out of ten (6%) have higher level of participation in decision regarding children. Eight out of ten (86.8%) have medium level of

decision regarding children. One out of ten (7.2%) have lower level of decision regarding children.

Women are more emotionally participate in decision making discussions than men (Caprino; Huston:2016) One of the most important emotional area of decision making in the family sphere is on child care. As decision regarding molding the future citizens, the participation of women practitioners in decisions in child care is significant. In our society father is the authority to take decisions on children even if they are not directly participating in child care activities. The present study is significant not only with respect to the womens participation in decisions on child care activities but also the message that passed to the future society that the role of women as mothers in the growth of children she gave birth to along with her husband. The realization of this big acceptance itself helps her to be inspired to achieve more in future endeavors and maintain a balanced state of work-family equilibrium.

Table 8.11 Respondents age and participation in Decision making regarding children

Age	**Decision making regarding children**			**Total**
	Higher level	**Medium level**	**Lower level**	
Up to 30	5	73	4	82
30-40	7	98	5	110
Above 40	3	46	9	58
Total	15	217	18	250

P-value of Chi-square= 0.04 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.04) is less than 0.05. Hence, there is significant relationship between the age of the respondents and their participation in decision making regarding children.

Table 8.12 Husband from same profession and decisions making regarding children

Profession of the husband	Decisions regarding children			Total
	Higher level	Medium level	Lower level	
Same	11	122	14	147
Different	4	95	4	103
Total	15	217	18	250

P-value of Chi-square= 0.368 of 2 d.f at 0.05% level.

The P-value of Chi-square (0.368) is greater than 0.05. Hence, there is no significant relationship between the decisions regarding children of the respondents and profession of the husband.

Table 8.13 Number of children and respondents participation in decision making regarding children

No of children	Decisions regarding children			Total
	Higher level	Medium level	Lower level	
1	6	95	6	107
2	7	94	8	109
3	2	28	4	34
Total	15	217	18	250

P-value of Chi-square= 0.831 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.831) is greater than 0.05. Hence, there is no significant relationship between number of children and decisions regarding children of the respondents.

Table 8.14 Respondents participation in decision making regarding their professional matters

Sl.No	Decisions on professional matters	Primarily by the respondent	Primarily by husband	Both
1	Attending meetings/conferences	106(42.4)	7(2.8)	137(54.8)
2	Attending courses	85(34)	20(8)	145(58)
3	Paper presentations	99(39.6)	29(11.6)	122(48.8)
4	Publications	92(36.8)	28(11.2)	130(52)
5	Official trips	73(29.2)	28(11.2)	149(59.6)

The table 8.14 on respondents' participation in decision regarding professional career reveals that joint decision of spouses is on increase. Important decisions related to the profession are taken normally by the individual concerned. In the case of women professional the men who are related to their role has a greater role. The decisions like attending meetings (54.8%), participation in courses (58%), paper presentations (48.8%), publications (52%) and official trips (59.6%) are mainly taken by wife and husband jointly because all these academic programs should be scheduled according to the due preference to family needs too. In almost all decisions more than one fourth of the respondents take their personal decisions.

Table 8.15 Respondents level of decision making regarding their professional matters

SL.No	Level of decision making in professional career	Frequency	Percentage
1	Higher Level	91	36.4
2	Medium Level	147	58.8
3	Lower Level	12	4.8
	Total	250	100

Table 8.15 on level of decision making in professional career shows that more than three out of ten (36.4%) have higher level of participation in decision making in professional career. Almost 6 out of ten (58.8%) have medium level of decision making in professional career. One out of twenty (4.8%) have lower level of decision making in professional career.

A moderate level of decision making power is evident in this area among women medical practitioners. Coordination of both family and work is necessary. Avoid family matters for career growth never favours a person with family interests. In such critical situations, joint decision of husband and wife is far better than individual decision. It will help to maintain work-family balance.

Research Hypothesis 1: Women medical practitioners enjoy decision making power.

It is clear from the table on participation of women in decision making in various spheres shows that women enjoy decision making power. Majority of decesions are taken by husband and wife jointly.

Table 8.16. Respondents age and decision making regarding their Professional matters

Age	Decision making			Total
	Higher level	Medium level	Lower level	
Up to 30	23	56	3	82
30-40	44	61	5	110
Above 40	24	30	4	58
Total	91	147	12	250

P-value of Chi-square= 0.37 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.37) is greater than 0.05. Hence, there is no significant relationship between the age of the respondents and their decision making in professional career.

Table 8.17 Profession of the husband and participation in Decision making regarding professional matters

Husband from same profession	Decision making in professional matters			Total
	Higher level	Medium level	Lower level	
Same	52	87	8	147
Different	39	60	4	103
Total	91	147	12	250

P-value of Chi-square= 0.603 of 2 d.f at 0.05% level.

The P-value of Chi-square (0.603) is greater than 0.05. Hence, there is no significant relationship between the decision making in professional career of the respondents and profession of the husband.

Table 8.18 Respondents number of children and participation in decision making regarding professional career

No of children	Decision making in professional career			Total
	Higher level	Medium level	Lower level	
1	33	70	4	107
2	41	63	5	109
3	17	14	3	34
Total	91	147	12	250

P-value of Chi-square= 0.153 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.153) is greater than 0.05. Hence, there is no significant relationship between number of children and decision making in professional career of the respondents.

Table 8.19 Correlation of respondents' participation in various types of decision making

	Decision making in child care	**Decision making in professional career**	**Decision making in health and reproductive health**	**Decision making in financial matters**	**Decision making in household management**
Decision making in child care	1.000	0.803	1.000	0.909	0.996
Decision making in professional career	0.803	1.000	0.802	0.480	0.854
Decision making in health and reproductive health	1.000	0.802	1.000	0.909	0.996
Decision making in financial matters	0.909	0.480	0.909	1.000	0.867
Decision making in household management	0.996	0.854	0.996	0.867	1.000

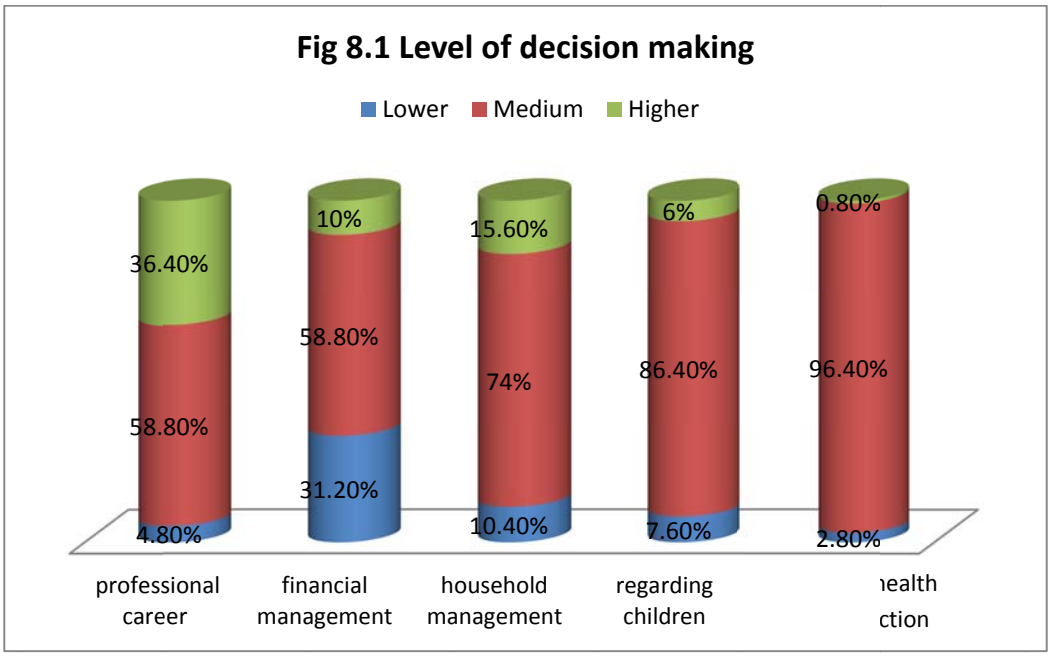
Significant at 0.05 level

Karl Pearson's Correlation was applied to find out the relationship between respondents' participation in different areas of decision making.

Research Hypothesis: Decision making in different areas are significantly related.

The null hypothesis for testing the above research hypothesis is that there is no significant correlation between decision making of respondents in different areas. Results given in the above table shows that correlation between decision making in different areas was positive and significant at 0.05 level. Hence reject the null hypothesis and accept the research hypothesis. Positive correlation indicates that as decision making in one area increases, the other

level is also increasing. That is respondents having high decision making in financial matters will have high decision making in household management.



Though women participate only moderate level in various spheres of decision making process, they enjoy equal access and full participation of power in decision making process. Respondents' responsibility and commitment towards medical profession voluntarily keep away from too many responsibilities related to their household and mothers role. Women they themselves develop a strategy to maintain equilibrium between their professional role and family role. Women give much priority to her medical profession by sharing the family responsibilities with their spouse.

Chapter - IX

SOCIAL NETWORK AND SUPPORT SYSTEM

Personal relationships with other human beings are crucial to a person's well being (Durkheim 1897/1951). The association between personal relationships on the one hand and well being on the other is significant. A person seeks and receives lot of help from others in emotional, instrumental, informative forms which may not be available from impersonal sources but may be readily available from family. The relationship with family, neighbors and friends are very important for the wellbeing of an individual as it serves specialized functions (Mart van der Poel 1993). In modern society a wide variety of specialized support is needed particularly for working women.

Family, friends and neighbors serve the different types of support. The nuclear family is probably, still the most important source of support, because it combines emotional involvement among its members and can have face to face contact. In modern society a wide variety of specialized support is needed but unlike earlier time family is not the absolute source of such support.

Neighborhood provides short term day to day support such as borrowing things, looking after the house when the family members are out of station etc. Friends are specialists in providing emotional support mostly when a crisis arises. They also provide with social companionship. Close kin members

functions as major source of emotional, financial, companionship, instrumental, informational support and health care.

The improvements in education and employment of women, along with urbanization have their effect especially on working women in their social contact. Close relationships with family, neighbors and friends make women feel a part of and integrate into a fairly large group of relationships. It gives them feeling that they have somebody to trust upon and rely for help in times of need. These social linkages gradually help the women in coping with the changing circumstances. It is very difficult to imagine one's life without such interpersonal relationships and they function as a booster for an individual's overall wellbeing. Hence the significance of network relationship and support system need to be examined in their different aspects.

Personal wellbeing is positively influenced by the number of personal relationships, or in other words the size of the personal network. The people in the personal networks can be considered as potential providers of support who are activated by a need for help. The more intimate members provide small services and emotional aid than other network members. Social proximity appears to be a more important determinant of getting help than physical closeness.

Women's networks are incorporated in the larger proportion. Unemployed women maintain close ties to more kin and maintain more diverse kin ties. Women's role is considered as "kin keepers", persons who keep

members of the extended family in touch with one another. Men fix things; women fix relationships and keep households and networks going.

Since not all personal relationships provide the same kind of and same amount of support, it is useful to make some distinctions. The criteria most commonly employed to distinguish between personal relationships is the role relationship. The role relationship categories most frequently used and considered most important are family, neighbors, and friends (Litwak & Szelenyi, 1969, Arling, 1976; Knipscheer, 1980; La Gaipa, 1981). Close kin consists of partner, children, parents and siblings and extended kin (Parsons, 1964; Lopata, 1978; Fischer, 1982a; Leigh, 1982). Other role relationships which can be taken into account are colleagues, acquaintances and fellow members of organizations (Lowenthal & Robinson, 1976; Schulz, 1978; Fischer, 1982a; Creech & Baabchuk, 1985; Felling, Fiselier & Van der poel, 1991).

Membership of a kin group and marriage are permanent and it goes with certain normative obligations and positive concern. This makes family relations particularly well suited to serve functions which require long-term involvement such as the care of people with chronic illness. The most important quality of neighbor relations in modern society, with mobility making community membership transient, is the geographical proximity and accessibility. Therefore, neighbours are the main source of fulfilling minor, short-term tasks, and in case of emergencies. In contrast with these two, friends can be chosen voluntarily and specialists in furnishing emotional support.

Because of this freedom of choice, friends are usually bound together by mutual interests and a mutual feeling of affection.

The nature of network of medical practitioners with kith and kin sometimes turns into a different nature based on their profession. They discuss their health issues and may include physical examination and prescription in family gatherings and always receive preferential treatment. Generally medical professionals have to maintain large personal networks outside the kin. The very nature of their job demands it. Short term and long term networks maintained with patients and their relatives. Sometimes it would develop from temporary to permanent type of networks. Some specializations like gynecology demand a periodic type of network. It may extend to next generation. As a service sector, it demands coordination of a number of professionals ranging from nurses, the more significant category to technicians like radiologist, dialysis and scanning and so on.

Another most important one is with persons from medical and pharmaceutical companies who are the link in between. There exists negative impressions and issues on these while introducing or recommending their products. Apart from professional links a large variety of service providing agencies like laundry, home delivery, stitching etc. form a support network giving more aid than a housemaid.

Fischer & Philips (1982) found that people with higher education (especially post graduates) are more likely to be isolated from kin. They are much involved with non-kin than were otherwise similar respondents of lesser

social standing. The number of non-kin relations in the network studies by Marselen (1987) who steadily increase with education.

People in the service class have larger networks than unskilled manual workers. The network size also increases with the level of education, and is smaller for urbanites than for people living in rural areas.

The number of friends in the personal network decreases with age. The number of friends in the personal network increases with the level of education because both the number of good friends available and the inclination to talk about personal problems increase with it. Both these tendencies could well be the result of better developed social skills among the higher educated (Keith 1986). The number of friends in the network is high for the higher educated.

Table 9.1Respondents Network Relations

Maintain good relations with	Frequency	Percent
Relatives	250	100
Colleagues	232	92.8
Friends	238	95.2
Neighbors	241	96.4

Table 9.1 reveals that respondents maintain good relations with various categories of people. Almost all of the respondents keep good relations with their relatives. 92.8 percent maintain good relation with their colleagues and

95.2 percent maintain good relations with their friends and 96.4 percent maintain good relation with their neighbors.

Table 9.2 Respondents pattern of relations

Relation	Frequency				Total
	1-5	6-10	11-15	16-20	
Family members	34	63	108	45	250
%	13.6	25.2	43.2	18	100
Colleagues	44	86	99	21	250
%	17.6	34.4	39.6	8.4	100
Friends	72	102	35	41	250
%	28.8	40.8	14	16.4	100
Neighbors	78	137	30	5	250
%	31.2	54.8	12	2	100

Table 9.2 on the pattern of relations shows that the respondents maintain a good number of relations with various categories of people related with them. 43.2 percent have close relations with about11-15 persons from relatives from both sides. 39.6 percent have close relations with 11-15 of their colleagues. 40.8 percent have close relations with about 16-20 friends. 54.8 percent have close relations with about 6-10 of their neighborhood families. Better neighborhood relations are the fashion of contemporary society and they are closely linked through various residents associations formed with the purpose to hold the community closer.

Table 9.3 Respondents ties with different kinds of relations.

Sl. No	Sectors	Frequency
1	Family members	1760
2	Colleagues	1275
3	Friends	1480
4	Neighbors	1012

Table on 9.3 respondents' ties with different kinds of relations reveals that they maintain close relation with about 1760 persons from their family circle. The second large number of persons who are comes in contact with from the colleagues (1275) followed by friends (1480) and neighbors (1012).

Table 9.4 Respondents type and Sources of Support

Sl. No	Types of support	Mother	Father	Sister	Brother	In-laws	Friends	Neighbors
1	Emotional	181 (72.4)	154 (61.6)	168 (67.2)	158 (63.2)	113 (45.2)	158 (63.2)	41 (16.4)
2	Economical/ Financial	110 (44)	127 (50.8)	112 (44.8)	143 (57.2)	83 (33.2)	115 (46)	4 (1.6)
3	Companionship	150 (60)	112 (44.8)	153 (61.2)	123 (49.2)	103 (41.2)	153 (61.2)	12 (4.8)
4	Informational	158 (63.2)	144 (57.6)	177 (70.8)	176 (70.4)	151 (60.4)	169 (67.6)	80 (32)
5	Institutional	136 (54.4)	98 (39.2)	153 (61.2)	121 (48.4)	47 (18.8)	168 (67.2)	7 (2.8)

The table 9.4 on Respondents type and sources of support shows that seven out of ten (72.4%) receive emotional support from their mother and it is only 45 percent from their in-laws. Friends and other close family members such as brother, sister and father extend support about two thirds. Again with respect to financial support family members and friends support them. Companionship is mostly with mother (60%), sister and friends (60% and above). They also enjoy informational and institutional support from the relatives, friends and neighbors.

Table 9.5 Frequency and Ways of contact

Ways used for it / Frequency of contact	Direct contacts	Over phone	Social medias	Others
Daily	33(13.2)	64(25.6)	116(46.4)	16(6.4)
Weekly	55(22)	79(31.6)	54(21.6)	29(11.6)
Monthly	62(24.8)	30(12)	11(4.4)	31(12.4)
Only when needed	100(40)	77(30.8)	69(27.6)	174(69.6)
Total	250(100)	250(100)	250(100)	250(100)

Table 9.5 on respondents' frequency and way of daily contacts shows that it is comparatively more through social media than through direct contacts and contacts through phone. Direct contacts were least on a daily basis but increased when it is based weekly or monthly. Direct and phone contacts are more when needed. Many of them even couldn't attend family functions comes in week days and incidents like death.

Attending functions

Attending functions plays an important role in social life. The functions are the occasion for social coherence and intimacy. The social functions are of many types. Ceremonies related to child birth, deaths, wedding, birthdays etc are mostly the functions. Gatherings and family get together are very common today. All these are celebrates in the family groups, friend circles, colleagues and neighborhood. According to the social status and position each achieved through education and employment, influence the recognition and participation in these functions. Educated and employed women have the privilege to attend functions outside their immediate circle. They value it as a social recognition. Generally, professions like medical doctor prevent them from participating in such functions especially unexpected ones. Women, who need preparations to attend functions, largely neglect such occasions due to busy nature of their work.

Table 9.6 Respondents participation in social functions.

Attending functions		Always	Sometimes	Never	Total
Functions with prior information	Family	134(53.6%)	106(42.4%)	10(4%)	250 (100%)
	Friends	112(44.8%)	110(44%)	28(11.2%)	250 (100%)
	Neighborhood	123(49.2%)	108(43.2%)	19(7.6%)	250 (100%)
Sudden/unexpected occurrence	Family	10(4%)	175(70%)	65(26%)	250 (100%)
	Friends	9(3.6%)	56(22.4%)	185(74%)	250 (100%)
	Neighborhood	9(3.6%)	75(30%)	166(66.4%)	250 (100%)

Table on 9.6 participation in social functions by the respondents shows that about five out of ten (53.6%) always able to attend their family functions if informed early. One in every ten (11.2%) never able to attend functions invited by their friends. About half (49.2%) of them always find time to attend such functions in the neighborhood. The sudden incidents like death and related rites, puberty related rites etc found problem to arrange their attendance. Such functions attended in the family by one fourths (26%), three fourths (74%) in their friends circle and about two thirds in the neighborhood relations.

Use of Social Media

Implications of social media may vary according to the people who engage with it. An educated group of people use it differently than an uneducated group of people. The quality and quantity may also change according to it. Just as a means of communication and passing and sharing of information, it has wider applications among professionals like medical practitioners. They can make use of its numerous advantages like simplicity, low cost, speed connectivity etc. other than these common virtues, they use it to receive and send advanced medical knowledge and information. They can video conference, ask for expert advice or references by using it. Today social media are widely used to maintain personal relations with family and friends

Table 9.7 Types of social media used by the respondents

Sl. No	Social Medias	Frequency of respondents	
		Using	Not using
1	Whatsapp	249(99.6)	1(0.4)
2	Facebook	211(84.4)	39(15.6)
3	Mail	210(84)	40(16)
4	Instagram	95(38)	155(62)
5	Twitter	31(12.4)	219(87.6)
6	Blog	13(15.2)	237(94.8)

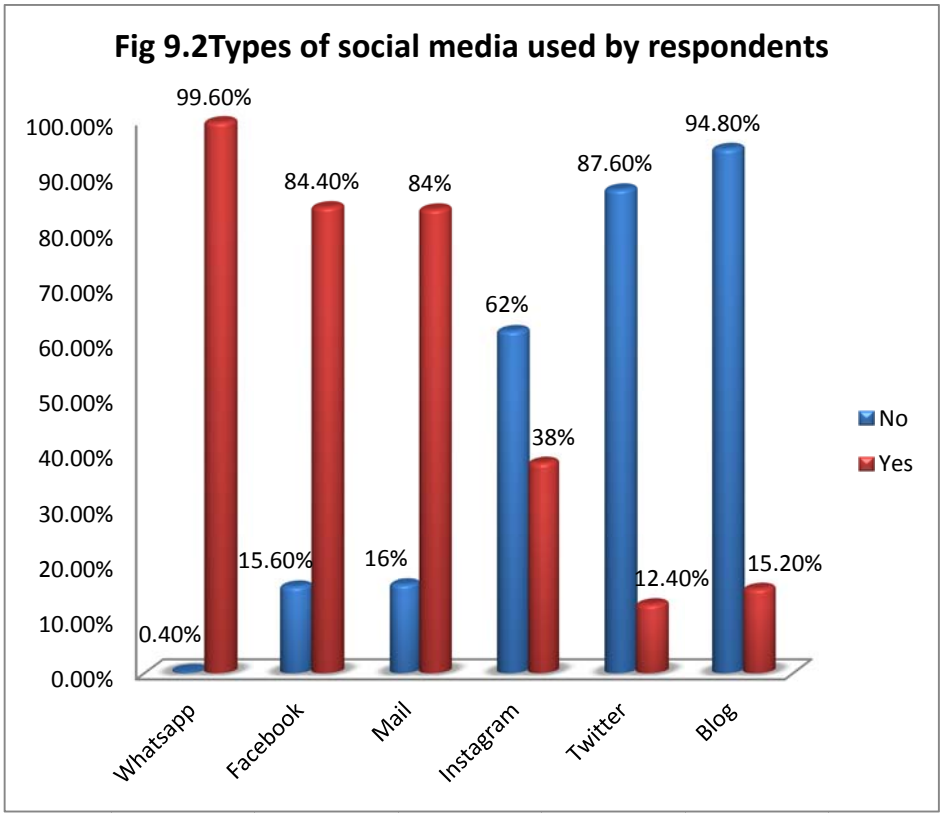


Table 9.7 on the social media use of the respondents reveals that except one respondent, all others use whatsapp as a network media. A large majority (84%) have face book account and mail account. Account in other media like Instagram, Twitter and Blog are popular among a minority. Even though they find difficulty to contact personally with the network members, they use available sources like modern information and technology for maintaining relations.

MEMBERSHIP IN ASSOCIATIONS

Quite another important area of network and support of employees is their membership in various associations ranging from professional to personal. For the women medical practitioners, membership and participation in their professional associations are very significant. Membership in professional associations help women to discuss and tackle common work related issues and enlighten employers about problems hindering their productivity. Personal clubs assist in enhancing their private lives and may provide a source for stress relief which in turn helps them in family and work arena.

Table 9.8 Nature and participation in associations of the respondents

Association	Just membership	Participation in meetings/ activities	Active participation	Executive member/ office bearer	Total
Professional	27(10.8%)	98(39%)	91(36.4%)	34(13.6%)	250 (100)
Religious	35(14%)	115(46%)	69(27.6%)	29(11.6%)	250 (100)
Cultural/ social	60 (24%)	130(52%)	27(10.8%)	33(13.2%)	250 (100)

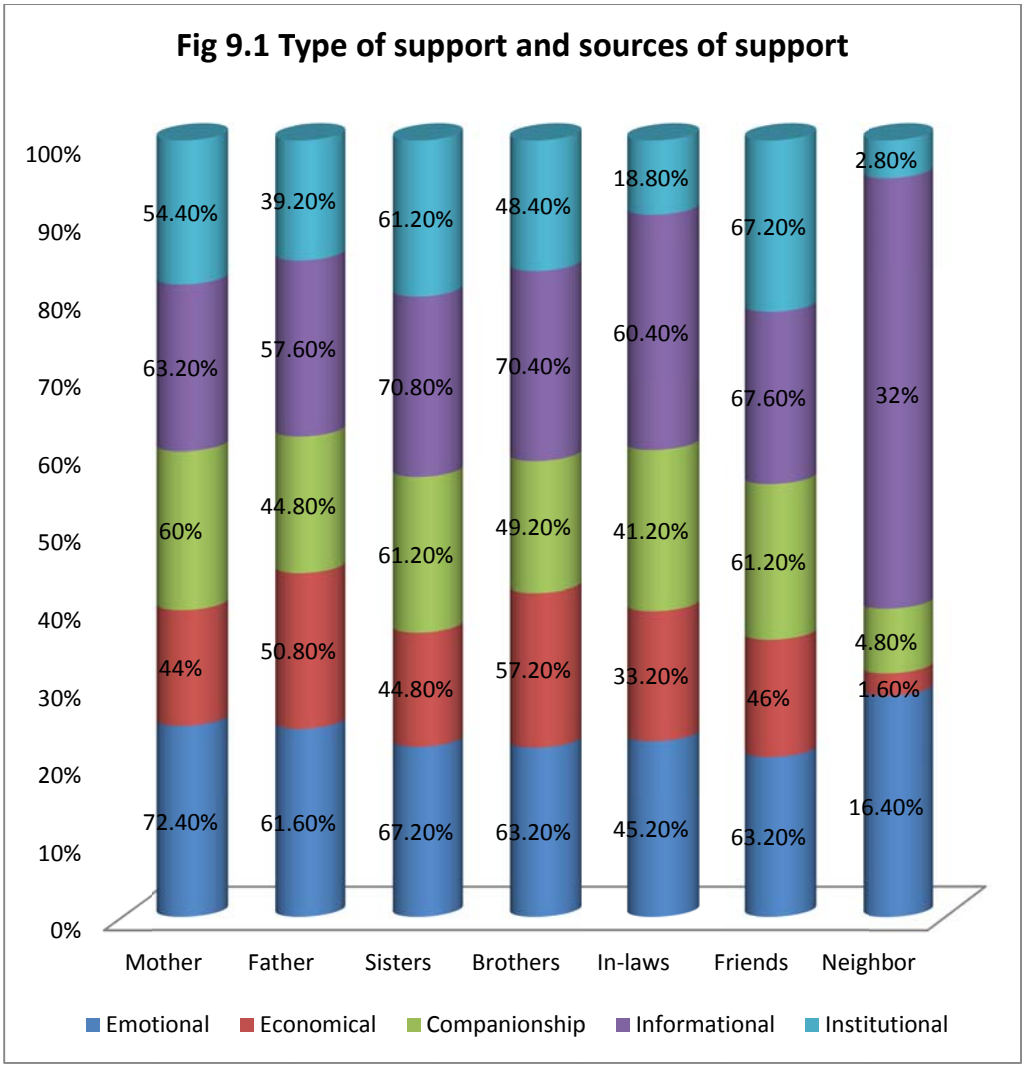


Table 9.8 on the nature and participation in associations respondents shows that almost all are members of different associations. About one third (36.4%) are active participants in professional association. There are different associations ranging from local to national with respect to professional association. Many are part of women's wing of their professional association. All are part of voluntary associations functioning in relation to religion. Nearly half (46%) of them participate in meetings and activities of the religious association and cultural/social (52%) association.

Chapter - X

LEVEL OF SELF ESTEEM

Blumberg (1984) argues that the level of economic power is the key factor determining the status of women in the world's societies. Where economic power of women is high, they are able to channelize this power into relatively high status; conversely, where the economic power is low, their overall social status is almost invariably low. In other words, enhanced female economic power is proposed as the prime factor in reducing gender inequality. Increased income and its control by women give them self-confidence, voice and veto in household decisions and control of their life options. They then gain the strength to translate this power into high status. It opens into a positive regard and respect for them on the part of men, it means an overall capacity to manage their own lives in ways relatively free from direct male control.

Evaluative dimension of the self that includes feelings of worthiness, pride and discouragement are all closely associated with self consciousness. Self-esteem is a disposition that a person has which represents their judgments of their own worthiness. It creates as a consequence of the implicit judgment that every person has of their ability to face life's challenges, to understand and solve problems, and their right to achieve happiness and be given respect. Self-esteem is feeling of worthiness, self-respect and pride. Qualification as a medical practitioner itself directs a person to high status and position, social

acceptance and demand. High earnings, social respect, high family support are some factors that increase the quotient of self esteem.

Low self-esteem in extreme cases leads to suicidal ideation and behavior. Self-imposed isolation, feelings of rejection, defection, insignificance and detachment and increased dissatisfaction with current social relationships are its after effects. A lack of social support from peers or family tends to create or exacerbate stress on an individual, which can lead to an inability to adjust to current circumstances. Heavy self criticism and dissatisfaction, hypersensitivity, chronic indecision and an exaggerated fear of mistakes all results in low self-esteem. Low self esteem severely effects fruitful execution of a medical practitioner's duties indirectly causing patients to suffer.

Table 10.1 Self Esteem of the Respondents

Sl. No	Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	I am very responsible to myself and to others	1(0.4)	13(5.2)	42(16.8)	141(56.4)	53(21.2)
2	I show assertive behavior whenever necessary	1(0.4)	4(1.6)	37(14.8)	184(73.6)	24(9.6)
3	I am well aware about my strengths and weaknesses(positives/ negatives	1(0.4)	4(1.6)	15(6)	175(70)	55(22)
4	I can able to control my impulses/emotions	5(2)	39(15.6)	65(26)	131(52.4)	10(4)
5	I am very empathetic	1(0.4)	3(1.2)	47(18.8)	158(63.2)	41(16.4)
6	I am loyal to others	2(0.8)	0(0)	18(7.2)	176(70.4)	54(21.6)
7	I am very selective in developing interpersonal relationships	2(0.8)	13(5.2)	61(24.4)	152(60.8)	22(8.8)
8	I am very care about myself	3(1.2)	11(4.4)	45(18)	155(62)	36(14.4)

9	I feel I am very important	4(1.6)	36(14.4)	72(28.8)	84(33.6)	54(21.6)
10	I am not too stubborn and too flexible	10(4)	22(8.8)	62(24.8)	133(53.2)	23(9.2)
11	I am well aware about my rights and duties	1(0.4)	5(2)	19(7.6)	172(68.8)	53(21.2)
12	I have problem solving skill	3(1.2)	44(17.6)	71(28.4)	109(43.6)	23(9.2)
13	I have decision making skill	2(0.8)	28(11.2)	56(22.4)	130(52)	34(13.6)
14	I have critical thinking	1(0.4)	17(6.8)	75(30)	120(48)	37(14.8)
15	I do positive self talk	5(2)	23(9.2)	57(22.8)	123(49.2)	3.7(14.8)

The table 10.1 on self esteem of the respondents shows that nearly more than half (56.4%) strongly agree that they are very responsible persons. Nearly two thirds (73.6%) show assertive behavior whenever necessary and seventy percent (70%) are aware of their strengths and weaknesses. Nearly half of the respondents are able to control their impulses/emotions. About two thirds (63.2%) show empathetic attitude. About seventy percent (70.4%) show loyalty to others. About sixty percent (60.8%) are selective in developing interpersonal relationships. One of the most important qualities of self esteem is feeling self worthy and more than sixty percent (62%) care about themselves. One third (33.6%) of women feel they are very important persons and more than half (53.2%) evaluate themselves as not too stubborn or too flexible. A little more than two thirds (68.8%) are well aware about their rights and duties. More than forty percent (43.6%) have problem solving skills. Decision making skill, a significant element of empowerment and self esteem which possessed by half (52%). Nearly half (48%) of them have critical thinking skill and do positive

self talk (49.2%). This analysis clearly reveals that women medical practitioners have an internal compass of what is right and wrong.

Table 10.2 Level of Self-Esteem of the Respondents

SL.No	Level of Self-Esteem	Frequency	Percentage
1	Higher Level	180	72
2	Medium Level	49	19.6
3	Lower Level	21	8.4
	Total	250	100

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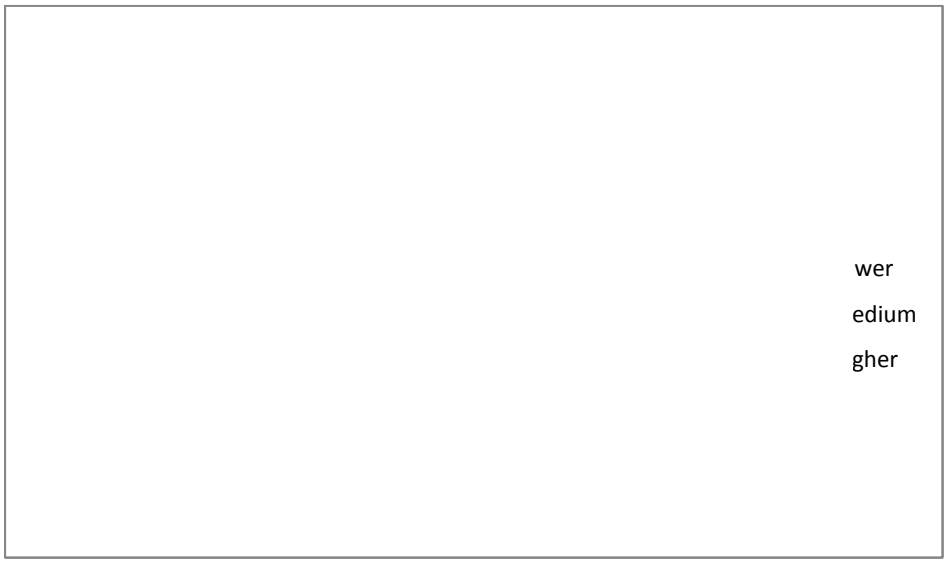

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With regard to level of self-esteem seven out of ten (72%) have higher level of self-esteem. Nearly two out of ten (19.6%) have medium level of self-esteem, while others (8.4%) have lower level of self-esteem.

Hypothesis 2: Self esteem will be high among women medical practitioners.

From the Table 2, it is clear that the level of self esteem is high among the women medical practitioners. Self esteem or self confidence helps them to grow personally and professionally.

Table 10.3 Age of the respondents and their self esteem

Age category	Self esteem			Total
	Higher level	Medium level	Lower level	
Up to 30	53	19	10	82
30-40	83	19	8	110
Above 40	44	11	3	58
Total	180	49	21	250

P-value of Chi-square= 0.805 of 8 d.f at 0.05% level.

Table 10.3 shows that the P-value of Chi-square (0.805) is greater than 0.05. Hence, there is no significant relationship between the age of the respondents and their self esteem.

Table 10.4 Profession of the husband and Self esteem

Profession of the husband	Self esteem			Total
	Higher level	Medium level	Lower level	
Same profession	72	23	8	103
Different profession	108	26	13	147
Total	180	49	21	250

P-value of Chi-square= 0.606 of 2 d.f at 0.05% level.

The P-value of Chi-square (0.606) is greater than 0.05. Hence, there is no significant relationship between self esteem of the respondents and husband from same profession.

Table 10.5 Education qualification of the respondents and their self esteem

Education qualification	Self esteem			Total
	Higher level	Medium level	Lower level	
MBBS only	100	31	13	144
MD	80	18	8	106
Total	180	49	21	250

P-value of Chi-square= 0.92 of 4 d.f at 0.05% level.

Table 10.5 shows that the P-value of Chi-square (0.92) is greater than 0.05. Hence, there is no significant relationship between the education qualification of respondents and their self esteem.

Table 10.6 Age at marriage of the respondents and their self esteem

Education qualification	Self esteem			Total
	Higher level	Medium level	Lower level	
Up to 25	113	30	13	156
Above 25	67	19	8	94
Total	180	49	21	250

P-value of Chi-square= 0.730 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.73) is greater than 0.05. Hence, there is no significant relationship between age at marriage of respondents and their self esteem.

Table 10.7 Respondents Self Esteem and Management of household activities

Self esteem	Management of household activities			Total
	Higher level	Medium level	Lower level	
Higher	49	101	30	180
Medium	16	19	14	49
Lower	7	10	4	21
Total	72	130	48	250

P-value of Chi-square= 0.264 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.264) is greater than 0.05. Hence, there is no significance relationship between the self esteem of the respondents and their management of household activities.

Table 10.8 Respondents Self Esteem and Support to professional career

Self esteem	Support to professional career			Total
	Higher	Medium	Lower	
Higher level	158	12	10	180
Medium level	26	18	5	49
Lower leveler	11	7	3	21
Total	195	37	18	250

P-value of Chi-square= 0.000 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.000) is less than 0.05. Hence, there is significant relationship between the self esteem of the respondents and their support to professional career.

Hypothesis 3: Respondents level of self esteem and support received for professional career are significantly related.

From the Table 10.8, it is clear that the respondents who have high self esteem are getting more support to their professional career. Self esteem makes successful relationships. It plays a vital role for building personal and familial support system. Women in this study are able to understand the situations where they need real support and assistance as well as they knows they are surrounded by a set of people who are willing to offer assistance and help.

Table 10.9 Marital satisfaction and self-esteem of the respondents

Marital satisfaction	**Self esteem**			**Total**
	Higher	**Medium**	**Lower**	
Higher	146	28	11	185
Medium	27	17	9	53
Lower	7	4	1	12
Total	180	49	21	250

P-value of Chi-square= 0.000 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.000) is less than 0.05. Hence, there is significant relationship between self esteem of the respondents and their marital satisfaction.

Table 10.10 Self esteem and various Independent variables

Variables	Chi-square value	d.f	P value
Occupational designation	13.301	8	0.102
Medical background	18.859	20	0.531
Years of service	9.373	8	0.312

When analysing the Table 10.10 on relationship between respondents level of self esteem with variables like occupational designation, medical background of the family and years of service clearly shows the P value of Chi square is greater than 0.05. Hence there is no significant relationship between respondents' level of self -esteem and above said independent variables.

Table 10.11 Respondents Self Esteem and various dependent variables.

Marital satisfaction	Self esteem			Total
	Higher	Medium	Lower	
Higher	146	28	11	185
Medium	27	17	9	53
Lower	7	4	1	12
Total	180	49	21	250

When analyzing Table 10.11 on the relationship between respondents level of self esteem with dependent variables like religious belief and activities of the respondent, management of household activities and leisure time activities shows the P value of Chi square is greater than 0.05. Hence there is no significant relationship between respondents' level of self -esteem and

above said dependent variables. But the relationship between their self esteem with marital satisfaction and support received for profession shows the P value of Chi square is less than 0.05. Hence there is significant relationship between their self esteem and these dependent variables.

Chapter - XI

DUAL ROLE PERFORMANCE

For years, women are pondering on their equality with men, especially in the occupational sector all over the world. Industrialization turned family centered production to factory centered production, resulting in more women coming out to work and occupied almost every field of work and become financially independent. Still their socio-economic status and empowerment is under discussion. The family and work lives of women and its challenges are multidimensional and inseparable and cannot be studied in isolation.

As the values of the society changes, the life of individual also changes. The new roles or reinterpreted roles emerged makes the society more complex. The individuals, according to their skill and potential try to balance these roles. This difference makes conflict in the individual and social life. The analysis takes into account the two full time engagements of domestic and occupational roles of married women. They are likely to suffer, in response to their extended commitments.

Each individual is different from one another, so the skills employed in balancing work and family are also different. The multiple role conflict is constituted basically with the difficulties experienced by the employed women, in simultaneously being employed and a responsible family member in any society. The extent of problems faced by employed women in fulfilling the expectations of any role with the other role creates role conflict. The Spillover theory of Edwards and Rothbard (2000) refers to the effects of work and family

on each other, and is described in terms of affect (mood and satisfaction), values (importance of work and family), and skills. There are two interpretations of spillover, firstly the positive association between family and work satisfaction and family and work values and secondly the transference in entirety of skills and behaviors between domains such as when fatigue from work is exhibited at home or when family demands interfere with work schedule. Work to family conflict occurs when experience at workplace affects the family life and family to work conflict occurs when experience in the family affects the work life. Multiple role conflict experienced by working women in fulfilling the expectations of any role along with the other role is discussed in this chapter.

Work hindrance on family life

The study examined the nature of the interface between the workplace in the family, which is the keystone of an employed woman's life. It has both negative and positive interference. Parenting is a large task within itself, and when mother has career can cause a double burden, or work–family conflict. Strain begins to develop when the demands of their family are conflicting with the demands from their job. When face double burden like this, it affects decisions made within a career and in a family. 75% of all working women are in their childbearing prime. When the conflict arise between one's family and work, the unpaid work that is being performed in the home may be cut down, because of certain health effects, or as a solution to handle with greater demands from the workplace. Social outings and visits, and family dinners are

two of the first things that get affected on due to the work/family conflict. In a study by Ari Vaananen, May Kevin, et al(2004) found that if a man place higher importance on their family were more likely to stay home from work in order to meet extreme family demands.

Table 11.1 Respondents work hindrance on family

Sl. No	Statements	Strongly disagree	Moderately disagree	Neutral	Moderately agree	Strongly agree
1	There is no time left at the end of the day to do the things I'd like at home (e.g., chores and leisure activities)	9(3.6)	72(28.8)	64(25.6)	77(30.8)	28(11.2)
2	My family misses out because of my work commitments	10(4)	67(26.8)	66(26.4)	90(36)	17(6.8)
3	My work has a negative impact on my family life	46(18.4)	126(50.4)	48(19.2)	27(10.8)	3(1.2)
4	The time I must devote to my job keeps me from participating equally in household responsibilities and activities.	7(2.8)	75(30)	79(31.6)	81(32.4)	8(3.2)
5	I have to miss family activities due to the amount of time I must spend on work responsibilities	12(4.8)	83(33.2)	43(17.2)	99(39.6)	13(5.2)
6	I am often so emotionally drained when I get home from work that it prevents me from contributing to my family	18(7.2)	82(32.8)	78(31.2)	60(24)	12(4.8)
7	Due to all the pressures at work, sometimes when I come home I am too stressed to do the things I enjoy.	15(6)	83(33.2)	68(27.2)	72(28.8)	12(4.8)

The Table11.1 on work hindrance on family life reveals that four out of ten (42%) agree that no time left at the end of the day to do the things they had like at home. Again four out of ten (43%) agree with the statement that their family misses out because of their work commitments. About seven out of ten (69%) disagree with the statement that their work has a negative impact on their family life. About one third (36%) agree that they cannot participate equally in household responsibilities. One third (33.6) agree that pressure at work place made too stress to do the things they enjoy at home. Nearly four out of ten agreed that work do not affect their family, while others said, one or other way their work affect their family. This finding is consistent with the findings of Rakesh Chadda and Mamta Sood (2010) that women struggle to juggle career and family responsibilities.

Table 11.2 Level of work hindrance on family life of Respondents

SL.No	Level of work hindrance on family life	Frequency	Percentage
1	Higher Level	95	37.6
2	Medium Level	61	24.4
3	Lower Level	94	38
	Total	250	100

The Table 11.2 on the level of work hindrance on family life shows that nearly four out of ten (38%) experience higher level of work hindrance on family life. More than two out of ten (24.4%) experience medium level of work hindrance on family life. Nearly four out of ten (37.6%) experience lower level

of work hindrance on family life. It is consistent with the findings of the studies conducted by Bushra Begum (2008) and Binsu (2014) that there are higher conflicts faced by women at work due to family constraints.

Women are more responsible to their profession. Women sacrifice their emotional attachment to family and show high level of commitment and dedication to their noble profession.

Table 11.3 Age of the respondents and their work hindrance on family

Age	Work hindrance on family life			Total
	Higher level	Medium level	Lower level	
Up to 30	31	20	31	82
30-40	45	24	41	110
Above 40	19	17	22	58
Total	95	61	94	250

P-value of Chi-square= 0.972 of 8 d.f at 0.05% level.

The P-value of Chi-square (0.972) is greater than 0.05. Hence, there is no significant relationship between the age of the respondents and their work hindrance on family life.

ROLE CONFLICT-Family hindrance on work

Membership in a particular family, especially for women, is not only an identity as a person but also a responsibility to be a part of it. Profound influence of family is there on belief, thought and action of every individual. It is definite that as a basic institution of society family has an inseparable hold

over the economic activities of the people. It is more present in agrarian mode of society and also visible directly or indirectly in our modern societies dominated by nonagricultural activities. It is a cultural obligation of women in general with any official position or status, needs to satisfy the role as a mother and a housewife. Islam permits women to take up outside employment with this condition of assuring to fulfill the role as a wife and mother.

It is quite natural that when club two equally important roles in one individual, the mechanical equilibrium cannot workout in the network of relations and related issues. A complete problem free balancing is ideal, in reality mutual adjustments and compensation required to lubricate the tough situation.

Table 11.4 Respondents family hindrance on work

Sl. No	Statements	Strongly disagree	Moderately disagree	Neutral	Moderately agree	Strogly agree
1	My work performance suffers because of my personal and family commitments	31(12.4)	149(59.6)	39(15.6)	29(11.6)	2(0.8)
2	Family related concerns or responsibilities often distract me at work	33(13.2)	118(47.2)	65(26)	32(12.8)	2(0.8)
3	If I did not have a family I'd be a better employee	93(37.2)	91(36.4)	27(10.8)	31(12.4)	8(3.2)
4	My family has a negative impact on my day to day work duties	62(24.8)	145(58)	31(12.4)	12(4.8)	0(0)
5	It is difficult to concentrate at work because I am so exhausted by family responsibilities	56(22.4)	155(62)	33(13.2)	6(2.4)	0(0)
6	The time I spend on family responsibilities often interfere with my work responsibilities.	46(18.4)	135(54)	55(22)	14(5.6)	0(0)
7	I have to miss work activities due to the amount of time I must spend on family responsibilities.	39(15.6)	147(58.8)	30(12)	34(13.6)	0(0)
8	Due to stress at home, I am often preoccupied	46(18.4)	150(60)	40(16)	14(5.6)	0(0)

	with family matters at work.					
9	Because I am often stressed from family responsibilities, I have a hard time concentrating on my work	50(20)	161(64.4)	31(12.4)	8(3.2)	0(0)
10	Tension and anxiety from my family life often weakens my ability to do my job.	52(20.8)	155(62)	36(14.4)	7(2.8)	0(0)

The Table 11.4 on family hindrance on work shows the respondents views on whether their family hinders their work performance. More than seventy percent (72%) of the women openly disagree that their work performance never suffers due to personal or family commitments. A great majority (83.6%) openly disagree that family never affect employee role. Five out of ten moderately disagree with the statement that the time they spend on family responsibilities often interfere with their work responsibilities and none came with strong agreement with this statement. This may be due to their time management skill that they can manage both the roles. About six out of ten moderately disagree and about two out of ten strongly disagree and none strongly agreed with following five statements. Nearly six out of ten (58%) moderately disagree with the statement that it is difficult to concentrate at work because exhausted by family responsibilities. About six out of ten (58%) moderately disagree with the statement that they miss work activities due to the

amount of time must spend on family responsibilities. Six out of ten (60%) moderately disagree that due to stress at home they often preoccupied with family matters at work. About two thirds (64.4%) moderately disagree with the statement that because of stress from family responsibilities they have a hard time concentrating on work and more than sixty (62%) disagree that the tension and anxiety from family life often weakens their ability to do their job. They find difficulties in work place, if they concentrate more on family affairs as well as improper time management like too much time in family affairs also cause their role performance in their profession. Women also openly agreed that if any tension or anxiety related to family sphere also affect their work.

Table 11.5. Level of family hindrance on work of Respondents

SL.No	Level of family hindrance on work	Frequency	Percentage
1	Higher Level	20	8
2	Medium Level	39	15.6
3	Lower Level	191	76.4
	Total	250	100

The Table 11.5 on level of family hindrance on work reveals that about one out of ten (8%) have higher level of family hindrance on work. One out of ten (15.6%) have medium level of family hindrance on work. More than three fourth (76.4%) have lower level of family hindrance on work. This finding is consistent with the definition of Greenhaus and colleagues (2003) on work-life

balance and Nigerian female doctors experience of difficulty in combining multiple roles (Adisa, Mordi and Mordi 2014).

Hypothesis 7 Uneven prioritization of any one sphere causes role conflict in other.

From the table 1 to 4 it is clear that work hindrance on family is more than family hindrance on work. So the hypothesis that uneven prioritization of any one sphere causes role conflict in other. So the hypothesis accepted.

Table 11.6 Age of the respondents and their family hindrance on work

Age	Family hindrance on work			Total
	Higher level	Mediate level	Lower level	
Up to 30	8	14	60	82
30-40	8	16	86	110
Above 40	4	9	45	58
Total	20	39	191	250

. P-value of Chi-square= 0.682 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.682) is greater than 0.05. Hence, there is no significant relationship between the age of the respondents and their family hindrance on work.

Support to professional career

Work-life balance better be maintained by the support received by women from man and machine. Support from man includes, all who are related

with. It is from the family, workplace and other arenas of life. Husband, parents, in-laws, children, siblings all are the sources of support. It may vary to each person. All other sources can adjust except husband because it would be a trouble making source hence significant one. Along with those who are near and dear others like servant or other service providers are also significant in the life of women professionals. Some of the problems can be avoided to a certain extent if help is available on the domestic front in the form of servants. For working women, domestic servants are not a luxury or a status symbol, rather a necessity because they help in ironing out the responsibilities of a working housewife by sharing household chores. Studies show that when women get adequate help at home, their effectiveness increases to a great extent, since they can devote more time and attention to the job.

Support from machine includes all the technological devices used to ease work both in the house and workplace.

Table 11.7 Respondents work and familial support received for their profession.

Sl. no	Statement	Strongly disagree	Moderately disagree	Neutral	Moderately agree	Strongly agree
1	I gave top priority to my family	3(1.2)	6(2.4)	52 (20.8)	116(46.4)	73 (29.2)
2	I take decisions beneficial to my family at the expense of my career	3(1.2)	16(6.4)	64 (25.6)	115 (46)	52 (20.4)
3	I compromise on career growth to accommodate the needs of family.	12 (4.8)	21 (8.4)	61 (24.4)	120 (48)	36 (14.4)
4	My husband supports me in my career	1 (0.4)	0 (0)	19 (7.6)	66 (26.4)	164 (65.6)
5	He considers my career as equally important	1 (0.4)	1 (0.4)	19 (7.6)	81 (32.4)	147 (58.8)
6	I discuss career issues with him	1 (0.4)	0 (0)	19 (7.6)	73 (29.2)	157 (62.8)
7	He encourages in career achievement	1 (0.4)	1 (0.4)	25 (10)	69 (27.6)	152 (60.8)
8	My job enables me to attend to my family as I would like to do	22 (8.8)	23 (9.2)	46 (18.4)	113 (45.2)	41 (16.4)
9	My parents are very supportive in my career life	1 (0.4)	5 (2)	8 (3.2)	53 (21.2)	181 (72.4)
10	My parents-in-law are very supportive in my career life	10 (4)	3 (1.2)	32 (12.8)	105 (42)	100 (40)
11	I have a very good working atmosphere	1 (0.4)	8 (3.2)	45 (18)	143 (57.2)	53 (21.2)
12	I got support from my colleagues	0 (0)	2 (0.8)	41 (16.4)	153 (61.2)	54 (21.6)
13	I have a comfortable schedule	12 (4.8)	26 (10.4)	35 (14)	142 (56.8)	35 (14)
14	I can take leave when I need it	22 (8.8)	38 (15.2)	54 (21.6)	115 (46)	21 (8.4)
15	People work around are very adjustive	2 (0.8)	24 (9.6)	57 (22.8)	132 (52.8)	35 (14)

The table 11.7 on work and familial support received by the respondents depicts that the women gained more support from their family than the work field. Three fourths (75.8%) agree that they place top priority to family. Two in every three (66.4%) usually take decisions beneficial to family by compromising or adjusting their career (62%) to accommodate needs. Except one (.4%) all others get support from husbands and about two thirds (65.6%)

strongly agree that their spouse support them. More than six out of ten (62.8%) strongly agree that they discuss career issues with their husbands and get encouragement (60.8%) in the career life. More than seventy (72.4%) strongly agree about the support from their parents, whereas only four out of ten (40%) supported by their in-laws. About one fifth (21.6%) strongly agree that they are supported by their colleagues, more than one tenth (14%) strongly agree that they have a comfortable work schedule and less than one tenth (8.4%) strongly agree that they can avail leave when they need it.

Table 11.8. Level of work and familial support received by the respondents for their profession

SL.No	Level of support to professional career	Frequency	Percentage
1	Higher Level	195	78
2	Medium Level	37	14.8
3	Lower Level	18	7.2
	Total	250	100

The Table 11.8 on the level of support received by the women in their professional career reveals that about eight out of ten (78%) receive higher level of support to professional career. More than one out of ten (14.8%) receive medium level of support to professional career. hardly out of ten (7.2%) have lower level of support to professional career.

Table 11.9 Husband from same profession and Support to professional career

Profession of Husband	Support to professional career			Total
	Higher level	Medium level	Lower level	
Same profession	110	25	12	147
Different profession	85	12	6	103
Total	195	37	18	250

P-value of Chi-square= 0.703 of 2 d.f at 0.05% level.

The P-value of Chi-square (0.703) is greater than 0.05. Hence, there is no significance relationship between support to professional career of the respondents and husband from same profession.

Hypothesis 8. Women with same professional husband receive more support in their professional career.

It is clear from the Table 9, that there is no significant relationship between support to professional career of the respondents and profession of husband, so the hypothesis is rejected.

Fig 11.1 Work hindrance on family and family hindrance on work

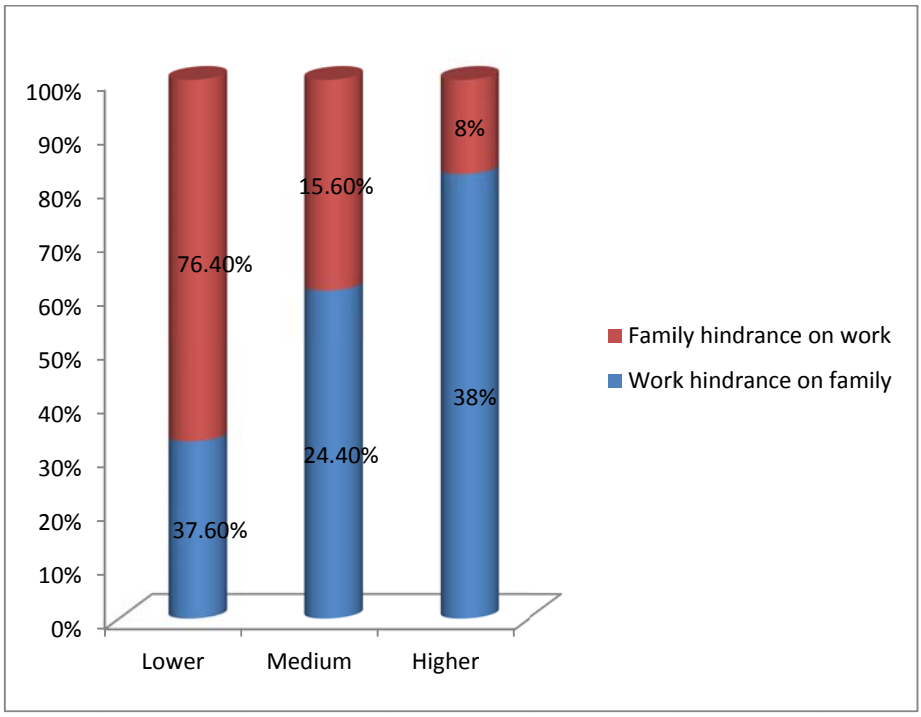


Table 11.10 Support to professional career and various independent variables

Variables	Chi-square value	d.f	P value
Age	2.125	4	0.713
Educational specialization	0.473	2	0.790
Age at marriage	0.727	2	0.695
Occupational designation	3.606	4	0.462

Table 11.10 shows the relation of support to professional career with different independent variables. Almost all have a value of above 0.05 hence there is no significant relationship between support to professional career and

independent variables like age, educational specialization, age at marriage and occupational designation.

11.11 Correlation of various dependent variables

	Self esteem	Marital satisfaction	Support to professional career	Work hindrance on family	Family hindrance on work	Management of household activities
Self esteem	1.000	0.174	0.126	0.374	-0.711	-0.069
Marital satisfaction	0.174	1.000	0.070	0.336	-0.739	0.982
Support to professional career	0.126	0.070	1.000	0.436	-0.662	-0.137
Work hindrance on family	0.374	0.336	0.436	1.000	0.386	-0.951
Family hindrance on work	-0.711	-0.739	-0.662	0.386	1.000	-0.652
Management of household activities	-0.069	0.982	-0.137	-0.951	-.652	1.000

Significant at 0.05 level

Research Hypothesis: Marital satisfaction and management of household activities are significantly related

Work hindrance on family and management of household activities are significantly related.

The null hypothesis for testing the above research hypothesis is that there is no significant correlation between marital satisfaction and management of household activities. Result given in the above table shows that correlation between marital satisfaction and management of household activities (0.982) was highly positive and significant at 0.05 levels. Hence reject the null hypothesis and accept the research hypothesis. Positive correlation indicates

that as marital satisfaction increases, the management of household activities also increases. That is respondents who have high marital satisfaction will have greater participation in management of household activities.

The other null hypothesis is that there is no significant correlation between work hindrance on family and management of household activities. The result shows that correlation between work hindrance on family and management of household activities (-0.951) was highly negative and significant at 0.05 levels. Hence reject the null hypothesis and accept the research hypothesis. Negative correlation indicates that as work hindrance on family increases, the management of household activities decreases. That is respondents having high work hindrance on family will have lower involvement in management of household activities.

Time spend in work sphere, Household activities and childcare

One of the most challenging aspects in life is time management. In the current fast changing environment, time management is very important in both personal and professional life.. "Time" being the most finite and scarce resource, needs to be planned and managed. Managing ones time does not mean the quantity of time utilized but how well it is utilized.

Durbin(1997) refers to time management as process of structuring and organizing time to result in better productivity and also to ensure a high quality of living for individuals. Thus the key to time management is to gain control of one's time a working smarter and not harder as 'time management is more

concerned with thinking than doing. Working women are more efficient in managing the time in comparison to non married working married women.

Figuring out how to grow a medical profession, attending official seminars, and meetings as many patients as possible and handling administrative responsibilities at clinic can be a challenge. It produce stress and also cause the Doctor to compromise by either limiting face time with patients or having to curtail time spent with family and friends. Effective time management can help physicians tackle this problem and establish a work-life balance. Managing time is integral to medical practice as it could mean better healthcare delivery and increased monetary benefit, helping the physician to do job better. This section deals about the time spend by the married women medical practitioners in family sphere and work sphere.

11.12 Time Spent by Respondents in Work sphere

Sl.No	Time in hours	Frequency	Percentage	Mean hour	Range
1	Up to 8 Hours	60	24.0	6.8	5-8 hrs
2	8-10 Hours	112	44.8	8.39	8-10 hrs
3	10-12 Hours	78	31.2	10.11	10-12 hrs
	Total	250	100		

The table No 11.12 on Time spend by the respondents in work sphere shows that about one fourth(24.0%) spend up to eight hours in work place , mean hour is 6.8 ranging from 5-8 hrs. A less than half (44.8%) between eight and ten hours, mean hour is 8.39 ranging from 8-10 hrs. A little more than thirty (31.2%) spend between 10-12 hrs, mean hour is10.11, ranging from 10-

12 hrs. It is clear from the table that a great majority work long hours in the hospitals, clinics etc.

11.13 Time spent by respondents for household activities

Sl.No	Time in hours	Frequency	Percentage	Mean	Range
1	Up to 2 Hours	129	51.6	1.43	0-2
2	2-4 Hours	109	43.6	3.4	2-4 hrs
3	4-6 Hours	12	4.8	4.3	4-6 hrs
	Total	250	100		

The table 11.13 on Time spend by the respondents for household activities shows that about half (51.6 %) spend up to two hours for child care , mean hour is 1.43 ranging from .5-2 hrs. About four out of ten (43.6 %) between two and four hours, mean hour is 3.4 ranging from 2-4 hrs. About one out of twenty (4.8 %) spend between 4-6 hrs, mean hour is 4.3, ranging from 4-6 hrs. It is clear from the above table that a great majority spend minimum time for the household work. Effective support system from familial and non-familial ties, modern technological gadgets helps the women to pre plan the work and space time. Due to this situation they may develop stress which turns adversely on her quality as professional and life satisfaction.

Table 11.14 Time spend by respondents for child care

Sl.No	Time in Hours	Frequency	Percentage	Mean	Range
1	Up to 2 Hours	98	39.2	1.87	0-2
2	2-4 Hours	117	46.8	3.9	2-4 hrs
3	4-6 Hours	35	14	4.6	4-6 hrs
	Total	250	100		

The table No11.14 on Time spend by the respondents for child care shows that about four out of ten (39.2%) spend up to two hours for child care , mean hour is 1.87 ranging from 0-2 hrs. A less than half (46.8%) between two and four hours, mean hour is 3.9 ranging from 2 to 4 hrs. A little more than one out of ten (14%) spend between 4-6 hrs, mean hour is 4.6, ranging from 4-6 hrs. It is clear from the table that as they are busy with professional duties, time used for child care activities are minimum. The respondents with grown up children normally need to spend minimum time in this sphere.

Women in this study meaningfully classified the total time of 24 hours into different categories. Women spend minimum hours for certain activities like household and child care which she gets support or assistance from familial or non-familial members. Most of the women in this study also very techno friendly and perform many activities especially home chore with the help of modern gadgets. Time saved by the women from these activities is efficiently utilizing it in their work place where she cannot relay fully others. Women medical practitioners are very efficient in managing the time. A

considerable proportion of women do not compromise their valuable time for unnecessary needs. When anaysising the time spend for different activities by medical practitioners clearly reveals that women give prime importance to their profession.

Technological support

Highly educated and paid women can own expensive and time consuming devices to ease their domestic works. In this study there included highly sophisticated and costly modern kitchen devices more than that of daily needed devices like washing machine, mixer grinder etc which are common in average households in Kerala.

Vasanth Kumar (1964), has found that strains of work at home and office coupled with lack of household amenities and vanishing domestic help, have contributed to the experience of role conflict among working women. Technology plays a vital role in the life of educated working women. Modern household gadgets help the working women to save time and reduce role conflict.

Table 11.15. Respondents usage of kitchen devices

Sl.No	Items used in the kitchen	Using	Not using
1	Dish washer	63 (25.2)	187 (74.8)
2	Microwave oven	158 (63.2)	92 (36.8)
3	Kitchen hob	119 (47.6)	131(52.4)
4	Cooking range	139 (55.6)	111(44.4)

Table11.14 on use of kitchen devices by the respondents reveals that a good proportion of women are using highly sophisticated, expensive and luxurious gadgets. One fourth of them (25.2) use dish washer, about two thirds use microwave oven, and nearly half use kitchen hob (47.6) and cooking range(55.6) at their home. The common devices like refrigerator, mixer grinder, washing machine etc not included in the tool purposefully because these are common in an average household in Kerala.

Technology is very powerful nothing is as fast as technology at improving life. It can affect life both positively and negatively. New technology always changes our life very much and takes it to a new level. It is like the new way of thinking or doing the normal things differently, better and much faster with less hassle and at a much affordable rate.

Computers, laptops, smart phones etc. make it easy for human beings of today to exchange information, make faster decisions, interact socially, and get entertainment, process financial transactions efficiently by online, mange homes and other existing technology. In the 20th C, technology plays an

important role in the constitution of human nature and identity. Humans have always shaped and extended themselves by virtue of technical tools and artifacts. This has made it much more efficient to travel because cheap air tickets can be purchased at a press of a button, an uber cab can come to collect at our own time no more waiting and stay any where we likes with more comfort and less investment. There is a cheap way of connecting with friends and family through social media and now don't have to remember people's birthday because social media can always remind it.

Technology unlocks life that was unimaginable and is the reflection of people's imagination on solving existing problems. Transformation of imagined idea into technology even reflects as online delivery of ideas, things and services. There was a time when the shopping experience belonged exclusively on the high street. Now there are no boundaries that the growth of online shopping has changed everything. It widened the horizon of economic activities of man in its real sense. Online banking and payment rather another aspect should be worth mentioning. Now technology, sometimes break the compartmentalizing the work and life by easily with a click or press of a button without interfering the present status. Now technology is to rise, to fresh up, to have food, travel, office, leisure, entertainment, banking etc.

Digital literacy and the use of digital tools are inevitable in our wired world. Even those who have less formal education can be stars in the digital world with the support of different apps. Medical professionals with all their favorable elements turn it into their success. Do not have rush and busy, there

are so many smaller steps we can take to broaden the spectrum of doctor-patient communication channels. The medical futurist believes that patients would love to know that their doctors can be reached at the tap of their fingers. There are digital health apps or devices for daily measurement of vital signs such as blood pressure or glucose. It is pretty clear that technology plays a big role in the medical world as it is essential for helping people treat illness and has a massive impact on doctors and their ability to do their jobs. In our modern era, technology think of microscopes and MRI scans, for instance-has become an inherent part of scientific investigation and diagnosis-technology influence human nature and human existence.

Typical medical duties include patient contact, administrative duties, charting, teaching, meeting and community outreach activities. And with the addition of mobile technology work time can easily creep into life time. Time outside of work can include wellness needs such as sleep, nutrition, exercise, spiritual pursuits and interaction with friends and family. Some factors are hard to change, there are marvelous technological responses, which could ease the burden on medical practitioners and help decrease stress. Technology facilitates women to reduce stress and anxiety and excel min their profession.

Chapter XII

AWARENESS, ATTITUDE AND PERCEPTION ON VARIOUS ISSUES

After getting higher education, employment and economic independence, women began to realize that they are equal to their men in society in all respects. Naturally, perception and attitudes of the women are likely to change. The awareness, ideas and values of the working women are shaping their perception and point of view.

Medical practitioners are a category who is privileged to have an attitude at a higher level. It helps to act or react at cognitive level. How we perform our thinking is our attitude and it influence our action. Our action is just a display of our perception and our belief. In other words, what we act or react is directly influenced by our way of thinking, our values and beliefs.

Social commitment and sociability is greatly expected from medical practitioners due to a number of reasons. Education is not only meant for individual progress and nourishment but it should inculcate a sense of responsibility to think and act for the benefit of the society because of the social cost behind their enrichment. It is the duty of those who attain heights, to serve the society. Sometimes the responses of such category of people on general or concerned field should benefit the entire society. To raise the voice against the vices of society or to regain the rights of the deprived or to protect the poor and helpless and starving and who are denied human rights and even

those rights and justice guaranteed by the constitution and enjoyed by the privileged.

Those in the medical profession can be instrumental in improving general health and welfare through the advice and instructions they provide to patients regarding health, sanitation and hygiene. Very often people unaware of their anemic conditions give birth to unhealthy children. This causes entire regions to have unhealthy populations. A good and committed doctor can rectify this problem by advising simple solutions to the people like taking iron supplemented food thereby ensuring healthy progeny. This beneficial role of a doctor is applicable in the case of prevention of communicable diseases like leprosy and tuberculosis. Women medical practitioners play a vital role in the welfare of women and children. Awareness of doctors regarding public health, community medicine helps them to render their service for the welfare of the society without any inhibitions and prejudice.

Knowledge and awareness about constitutional Rights, legislative measures and welfare polices always help any employer in general and doctors particularly to do their service with confidence and courage. Therefore irrespective of sex, all professionals in health sector must have knowledge and awareness regarding the legislations, Acts, Welfare policies and programmes etc, Knowledge and awareness have strong influence on one's attitude and perception. Hence this section deals on the awareness, attitude and perception of women medical practitioners.

Table 12.1Awareness on employee benefits

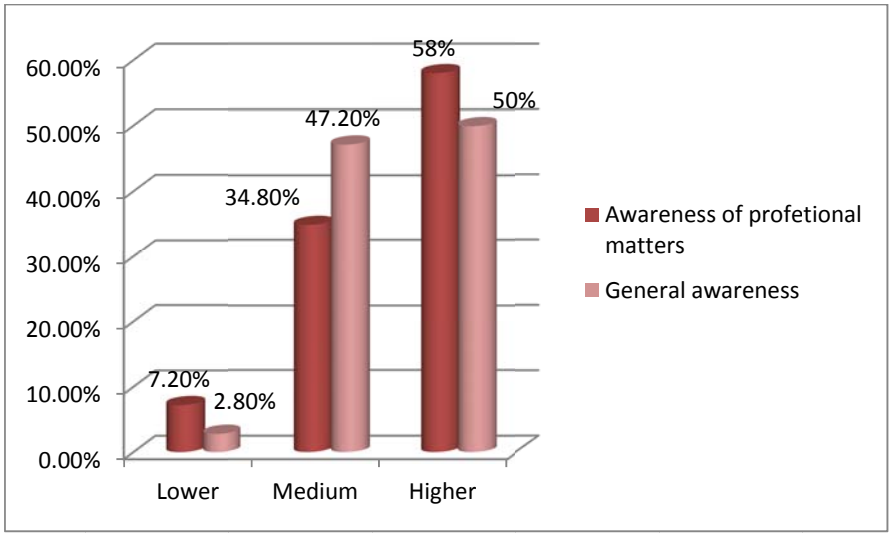
Sl.No	Career benefits	Fully aware	Partially	Not at all
1	Working hours	230(92)	20(8)	0(0)
2	Promotion rules	139(55.6)	89(35.6)	22(8.8)
3	Minimum salary	161(64.4)	84(33.6)	5(2)
4	Bonus and other service benefits/incentives	108(43.2)	121(48.4)	21(8.4)
5	Insurance and employment protection Legislations	86(34.4)	122(48.8)	42(16.8)

Table 12.1 on Respondents awareness on employment related legislations and incentives reveals that except a few, almost all (92.0%) are fully aware about the rules related to working hours. Only a little more than half (55.6) are fully aware about promotion rules. Nearly two thirds (64.4%) fully aware about rules related salary. An equal proportion of the respondents are either fully aware (43.2%) or partially aware (48.4%) about the bonus and other incentives. A little more than one third (34.4%) only well aware about, insurance and employment protection legislations.

Table 12.2 Level of awareness on employee benefits of Respondents

SL.No	Level of awareness	Frequency	Percentage
1	Higher Level	145	58
2	Medium Level	87	34.8
3	Lower Level	18	7.2
	Total	250	100

Fig.12.1 Respondents awareness in professional matters and general ideas



The table 12.2 on level of awareness nearly 6 out of ten (58%) have higher level of awareness. Three out of ten (34.8%) have medium level of awareness. One out of ten (7.2%) have lower level of awareness. Though women are very responsible in their profession, awareness regarding the employment legislations and benefits are only moderate level**.**

Table 12.3 Respondents awareness towards important Acts

Sl. No	Acts	Fully aware	Partially aware	Not at all
1	Right to Information Act	93(37.2)	131(52.4)	26(10.4)
2	Human Rights	122(48.8)	121(48.4)	7(2.8)
3	Right to children	135(54)	109(43.6)	6(2.4)
4	Right to women	139(55.6)	108(43.2)	3(1.2)
5	Traffic rules	135(54)	113(45.2)	2(0.8)
6	Women welfare Acts/Polices	85(34)	157(62.8)	8(3.2)
7	Consumer rights	164(65.6)	86(34.4)	0(0)

Table 12.3 on general awareness of the respondents reveals that more than one third (37.2%) fully aware about the Right to Information Act, and about half (48.8%) are aware about human rights. More than half (54%) are aware about the Act related to children's Rights and Acts about women's rights (55.6%). Only about one third (34.0%) are fully aware about women's welfare policies. About two thirds (65.6%) are fully aware of the consumer rights

Table 12.4 Level of awareness towards important acts

1	Higher Level	125	50
2	Medium Level	118	47.2
3	Lower Level	7	2.8
	Total	250	100

With regard to general awareness 5 out of ten (50%) have higher level of general awareness. Nearly 5 out of ten (47.2%) have medium level of general awareness. One out of ten (2.8%) have lower level of general awareness.

Table 12.5 Responses in social issues

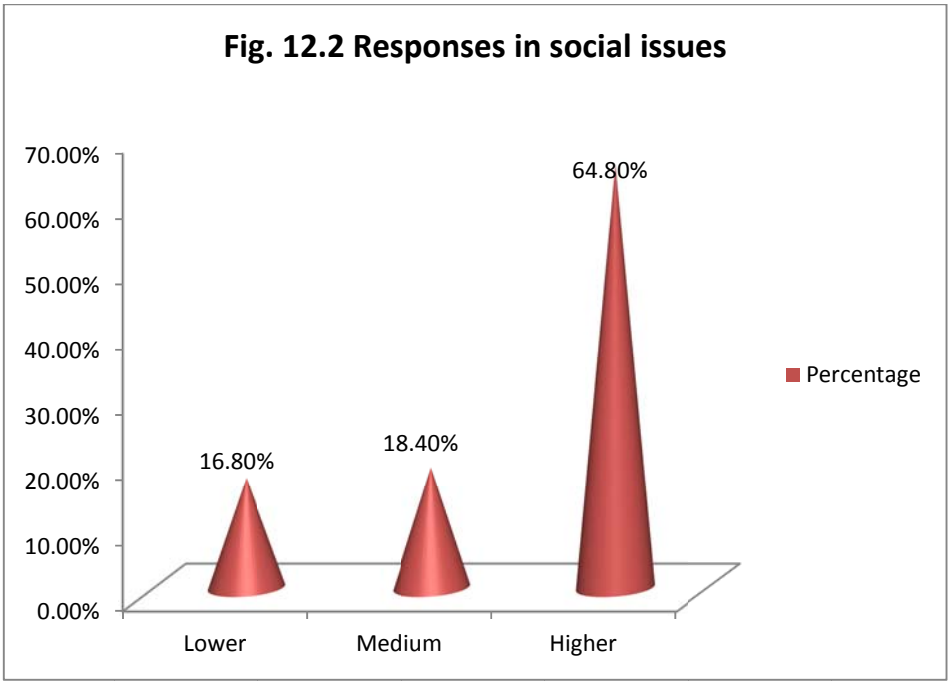
Sl.no	Issues	Agree	Neutral	Disagree
1	Even girl child is not safe in our society	194(77.6)	46(18.4)	11(6)
2	Legal support enjoyed by women in our society	69(27.6)	137(54.8)	44(17.6)
3	Position of women justifiable in our society	62(24.8)	123(49.2)	65(65)
4	Women should have rights to choose their husbands	242(96.8)	7(2.8)	1(0.4)
5	Women should make their own decisions in life	192(76.8)	53(21.2)	5(2)
6	Women should have equal say in deciding number of children	233(93.2)	15(6)	2(0.8)
7	Men should reject perspective of wives due to insufficient dowry	0	29(11.6)	221(88.4)
8	Equal job opportunities	229(91.6)	18(7.2)	3(1.2)
9	Unfair treatment of women	215(86)	28(11.2)	7(2.8)
10	Women should have equal say in household spending	230(92)	18(7.2)	2(0.8)
11	Women only should take care of their households.	13(5.2)	46(18.4)	191(76.4)
12	Women should be more environment friendly	215(86)	32(12.8)	3(1.2)

Table 12.5 on responses of respondents on social issues shows that a great majority (96.8%) of the respondents agree that the women should have

the right to choose their husbands. More than three fourths (76.8%) of the respondents also agree that women should make their own decisions in life. Most of the respondents (93.2%) have favorable attitude towards the equal say in deciding the number of children as well as in household spending. More than three fourths (76.4%) of the respondents are disagreeing the statement that woman alone should take care of the household. No respondent was in support of men rejecting of spouse due to insufficient dowry. Except a few, all of them (91.6%) favour to equal job opportunities. A great majority (86%) support that women should be more eco friendly. This strong responses of Muslim women medical practitioners towards various social issues is consistent with the study findings of Jibsin and Naseema(2017).

Table 12.6 Level of responses in social issues of Respondents

SL.No	Level of responses in social issues	Frequency	Percentage
1	Higher Level	162	64.8
2	Medium Level	46	18.4
3	Lower Level	42	16.8
	Total	250	100



With regard to level of responses in social issues 6 out of ten (64.8%) have higher level of responses in social issues. Two out of ten (18.4%) have medium level of responses in social issues, while two out of ten (16.8%) have lower level of responses in social issues.

Table 12.7 Responses in social issues and self esteem

Responses in social issues	Self esteem			Total
	Higher	Medium	Lower	
Higher	120	27	15	162
Medium	30	12	4	46
Lower	30	10	2	42
Total	180	49	21	250

P-value of Chi-square= 0.021 of 4 d.f at 0.05% level.

The P-value of Chi-square (0.021) is less than 0.05. Hence, there is significant relationship between the self esteem of the respondents and their responses in social issues. Women who have high level of self esteem are strong response on social issues.

Table 12.8 Responses in social issues and various independent variables

Variables	Chi-square value	d.f	P value
Age	0.912	4	0.923
Educational specialization	0.261	2	0.878
Age at marriage	0.735	2	0.693
Husband from same profession	0.333	2	0.847
Occupational designation	1.646	4	0.800
Medical background	8.230	4	0.084
Years of service	6.583	4	0.160

Table 12.8 on responses in social issues and various independent variables shows that almost all chi square values are greater than table value 0.05, so there is no significant relationship between these variables.

Table 12.9 Correlation of different dependent variables

	Network and support	**Religious practices**	**Responses in social issues**	**Self esteem**	**Marital satisfaction**
Network and support	1.000	0.275	0.977	0.997	0.999
Religious practices	0.275	1.000	0.474	0.350	0.311
Responses in social issues	0.977	0.474	1.000	0.133	0.984
Self esteem	0.997	0.350	0.133	1.000	0.174
Marital satisfaction	0.999	0.311	0.984	0.174	1.000

Significant at 0.05 level

Research Hypothesis: Marital satisfaction and network and support are significantly related.

The null hypothesis for testing the above research hypothesis is that there is no significant correlation between marital satisfaction and network and support. Result given in the above table shows that correlation between marital satisfaction and network and support (0.999) was highly positive and significant at 0.05 levels. Hence reject the null hypothesis and accept the research hypothesis. Positive correlation indicates that as network and support increases, the marital satisfaction also increases. That is respondents having high network and support will have high marital satisfaction.

Also we conclude that the table shows that, respondents having high network and support will have high self esteem (0.997), but it doesn't seen that the increase in religious activities (0.350) and responses in social issues (0.133).

Chapter- XIII

FOCUSED GROUP DISCUSSION

It is the face to face interaction of people from similar background having different views and experiences to discuss a specific topic of interest. The discussion is guided and controlled by a moderator or facilitator. The moderator introduces the topic to the group and motivates each participant to get involved. Through this method several perspectives about the same topic can be collected. The moderator has to develop an agenda for discussion including key questions and its replies.

Two discussions were conducted. The first group discussion was conducted in Changaramkulam, Malappuram District. The theme for the discussion was the Muslim women medical practitioners and the issues of work& family balance. The second one was conducted at Mala, Thrissur district. It focused on the reflections of socio-cultural conditions on the work life balance among Muslim women medical practitioners.

FGD No.1

Discussion was conducted in Changaramkulam, Malappuram District.

Participants: 5 male members and 3 female local members of CIGI (Centre for Information and Guidance India), an important voluntary organization functioning in Kerala, for the promotion of education and career development in the community.

Theme for Discussion:Muslim women medical practitioners and the issues of work family balance.

P1. At present, Muslim women do not face any problem to balance their family and profession with the support of both the husband's and the wife's family members.

P2. Patriarchy, a male dominated system of society, place women as inferior by denying their educational and employment opportunities.

P3. Things are far better, but a complete problem free atmosphere is yet to come.

P4. There were instances of bold women broke the conventional challenges.

P2. Women need courage to break traditionalism to attain their goals.

P1. Not the situations but the way to hurdle forward is more important.

P5. The problem under study points out towards the need to support women to fulfill their aspirations as a medical practitioner.

P6. The power of a woman to attain such a competent qualification should definitely be given inner strength to continue in her profession. She is equipped for that.

P7. Religious stigmas are still there to cage her in the house.

P6. Actually it is not the religion, but those subjective interpretations are really the villains.

P7. Islam considers both men and women alike by providing equality in every aspect of life.

P8. Family as the most important institution of the society and it has to be maintained for the sake of humanity. It is the responsibility of both husband and wife.

P1. Most probably, the spouse of women medical practitioners are with equal or higher professional status. It may create more problems especially with child care duties.

95. In such families the features of medical profession like long working hours, night duties, emergency cases etc create problems.

P3. Technology and outside service agencies help women in such a situation. They can monitor the children at home or help in doing home works during free time or after coming back home..

P5. Better network with the family and neighborhood help women to take support whenever needed.

P1. It is the responsibility of the community to keep the women charged with their areas of work so that they can remain satisfied and have work family balance.

P6. If the worries of women with regard to her home chores are shared by others, most probably with husband, they can concentrate more in work which will refresh her and develop a positive energy in her life.

FGD No.2

Discussion was conducted in Mala, Thrissur District.

Participants: 4 male members and 3 female members of Friday Club, one of the cultural organization formed with the objective of promoting collective social activities in the community.

Theme for Discussion: The reflections of socio-cultural conditions on the work life balance among Muslim women medical practitioners.

P1. Male domination and elements of patriarchy are not as strong as earlier in our society.

P2. I agree that patriarchy is diminishing in authority steadily.

P3. Women are getting more opportunities for better education and employment.

P4. The basic nature of women enriched with the qualities of dedication, care, love etc. are suitable for the profession of medical practitioner.

P5. Women are not at all secure in our society. Night duty is not safe for women. While travelling in odd hours they have to depend upon husband or other male members in the family.

P3. Women with small children face severe problems. Usually they extend their maternity leave. This makes big gap in their service and would influence their professional expertise.

P4. Women cannot give away her familial responsibilities.

P6. There are many taboos existing in the community against women's occupation.

P7. Educational rights are enjoyed by women in the community. But the medical practice especially after marriage is a big problem for them.

P3. Education makes them capable to take right decisions at right time.

P6. Without any gender quota, girl students are less in medical colleges.

P2. If woman has the will power to continue her job after marriage, she can find positive ways for that with the support of existing social system.

P1. Cultural stigmas always bind women to stick to their stereo typical roles.

P4. Presently there are many taboos inside the community against women's freedom and participation.

P5. Women's representation in the medical professions including nursing was neglected till recently.

P3. It is because of the nature of this area.

P2. Peculiar socio-economic, cultural atmosphere of Kerala empowered Muslim girls to achieve heights of their goals.

P3. Families are now in the path of transformation. New trends are anti family by taking decisions to avoid children for the convenience of the couple.

P5. I object that view. Unlike other professions, medical practitioners are not in that wrong way. They are much concerned about the presence of children in the family.

P1. Child care is not a big issue today. It is less risky with the modern technology.

P3. A careful utilization of available recourses ranging from men and materials should facilitate women medical practitioners to reduce their issues and balance their family with professional aspirations.

CASE STUDIES

Case I

Age-60 yrs

A few more patients had been waiting for their turn to meet the doctor even though it was very late for the morning session at the super specialty clinic run by doctor with four supporting staffs, when the researcher reached who was given appointment at 01.00 p.m. Permission for special appointment was granted because doctor is the grandmother of researcher's son's friend. With the help of high tech equipment, the doctor was engaged in diagnosing the patients and prescribing medication. After a while, researcher was received with a smile and without any hesitation she started to share her story before researcher asked anything. She is very active in her service even at the age of 62. She was compelled to resign from government service immediately after she joined in her late twenties. She flew to Saudi Arabia with her engineer husband and two little kids. Medical practice was difficult as she had to manage her kids alone. But she always used opportunities to keep in touch with her profession. When the children grew up, they returned and settled in their native place. Then she started this clinic in her home. It was her childhood dream to become a doctor. Her educated and employed father promoted his daughters' education and three of them are doctors. They were given due support by the family. She completed her MD and DGO before her service entry. Now she feels very happy and is active in profession as she is able to help the poor patients by providing treatment at a reasonable rate. After half an

hour conversation, she rushed for her noon prayer. Then only I noticed that she uses walker and needs others help to move. She briefed the stroke and its recovery that made her internally more strong and powerful. Her daughters were housewives and have settled abroad. She is leading happy life with her grandson and husband wholeads a retirement life.

Case II

Age-66 yrs

The researcher met her in the pain and palliative care centre run by an NGO with a prior appointment. She is too busy even at this age so couldn't meet her though it was given a try. She provided free service in three more centers along with her private practice at the clinic near her home. She has secured a number of additional qualifications even in new generation area like Cosmetology after her MD in general medicine. She is a retired civil surgeon but continue her profession with the support of her doctor husband and dentist daughter to continue in this field. As a brilliant student, she entered into this field without a prior plan. The starting years of her career provided her too much stress while balancing profession and family with the little kids. She struggled to overcome the situation with the support and help of her parents. Government service facilitated various opportunities to sharpen her profession with the official positions. Most of her service period was in health centers and hospitals with limited facilities but she was ingreat demand among the poor and needy especially in the backward and coastal areas which shaped her profession and personality. She believes it as the precious moments of her life.

She has many experiences to share on legal abortions she made, facts and realities behind each cases and she expressed her worries about the society especially new generation.

Case III

Age-34 yrs

"Shallow waters wake moist din" this saying came in mind when the researcher met this young, calm, smart and vibrant doctor. Daily she travels more than forty kilometers from her home town to reach the rural clinic where she is working. It doesn't diminish her spirit to be a doctor the dream she furnished from her studentship and she believes it holds her more responsible. She experienced the model of a doctor and the way to deal with the patients who approach her from her father since her childhood. As a doctor he never hesitated to treat patients even if they came late at night. She remembers their long waiting for her father when they had planned to go outing or when they had to attend functions. She knew the sacrifices behind this profession, still decided to follow it as she was attracted by the respect received.Even though she cannot spare much time for the family after travel and duty, she receives great support from them. Her in-laws gave her ample support to raise her two children. As a doctor in a rural hospital, she treats all categories of patients and prescribes medicine without bothering her specialization as a pediatrician.

Case IV

Age-67 yrs

The unique identity as “the writer among doctors” was secured by her with the talent in expressing her views and experiences as a popular medical practitioner. It made her achieve recognition at the national level too. She is a retired government Medical College Gynecology Professor. She had a vision to be a doctor since childhood. For the fulfillment of this dream, she vehemently opposed the family’s decision to marry her off. After great struggle and also by considering her academic brilliance she was allowed to continue her studies. To protect family’s interest her younger sister’s marriage wasarranged before hers. e. It was not easy for her to achieve her goal as she had to fight from an orthodox background. Her first marriage after her studieswas a failure. Now with a very busy doctor husband she is happy and settled. She finds time for both writing and consulting. Both her sons haven’t chosen their parent’s profession and became engineers. Both husband and wife are practicing in their house not only with the intention of money making and utilizing retirement life meaningfully but also for maintaining relations with those who had trust in them for decades. Now she spends more time as a writer and devotes time to communicate with the patients. Nowadays people are very busy. No one has time to share their emotions and feelings. Many couples received a tension free treatment from her though most of them were much worried when they first approached her due to lack of kids. She finds time to hear them even though

she is busy with her family, profession andwritings and its related activities and official positions.

Case V

Age-40 yrs

Different from all others who talk much about the support from family especially from husband, she doesn't reveal anything about her husband. Profession, family, husband and children have conflicted each other many times in her life. She selected her partner from the same field by expecting his support. During her studentship, as the field demands, she never compensated her studies to enjoy life. She worked hard to achieve her dream career. She secured specialization in ENT. When problems began to rise, she never thought of compromising her profession which she achieved because of hard work and competition. She thought that it was easy to get a doctor as husband with her qualification as a doctor. He also demanded it during proposal. Now she feels that her qualification is more worth than her husband because she worked hard to get her degree but not much invested to get him as husband. Her decision to continue her profession created family issues and finally resulted in their separation. Criticism is raised from the family members but she considers it as a challenge. It made her bolder and motivated her to prove her credibility. Now she is living with her two school going children in a rented house near to those who asked her that how can she live without the support of a man. Decisions of those who have educational and professional competency is depicted as over smartness in our society. She tries to question the notion through her life.

Chapter - XIV

SUMMARY AND CONCLUSION

Work family balance is an inter-role phenomenon (Marks and Mac Dermid 1996). It is defined as “satisfaction and good functioning at work and at home with minimum of role conflict (Campbell-clark 2000). A diversion from the bias of the dominating focus on the negative outcomes of the work-family interface, a growing body of research is focusing on how work and family can benefit each other (Lauring and Selmer 2010). It can be possible to transfer gains obtained in one domain to enhance functioning in the other. And this mutuality also helps to compromise the drawbacks or missing emerge in any sphere. One facilitated to work outside by support gained in the home. Value of social support is not measurable for a working woman. All her personal social support is positively associated with work-family balance.

Behavior and attitudes of family members aimed at assisting day to day household activities are the instrumental support extends towards the employee. Relieving the employee from household tasks by accommodating the employees’ requirements helps to preserve energy for work. Emotional support includes the expression of feelings by the professional women to ease her mental tension and stress. Flexible work arrangements allow individuals to integrate work and family responsibilities with less conflict.

Working women irrespective of type of employment have to adjust between the family obligations and their work commitments. With the passage of time, women all over the globe are competing for their equal position with men, especially in the occupational sector. Industrialization has brought a continuing shift from family centered to factory centered production, resulting in a flow of women coming out of the traditional setup of a family to work. Women have occupied almost every field of work and have become economically independent.

The working woman has to perform dual duties and face a crisis of adjustment. She is torn between dual commitments. A woman who chooses or is compelled to work is also expected to run her household and bear the major responsibility of child rearing. The existing norms and values compel her to take all the responsibilities. A working woman has multi-faceted commitments. At her place of work she has to bear the responsibilities associated with the specific set of duties she has to perform. Both work overload and involvement in the job has a strong effect on work family balance

In spite of this, there is large number of women who are entering the employment sector and in the process becoming a major contributor of family income. This has increased the desire for women to enter the occupational sectors which were considered to be traditionally in the male domain. In the health sector presence of women was there particularly in the nursing field as it did not call for great challenges in educational requirements. Over the years a significant number of women have entered into the health sector as doctors.

Medical profession is a challenging one as it deals with life and death situation, and is not bound by time constraint. This may be the reason why women were hesitant to join the health sector as a doctor. Though women are entering the field as doctors they have to surpass greater obstacles and make more adjustments than their male counterparts.

Studies on both national and international level about male medical practitioners and their careers and family life are in plenty. A cross sectional study on Marital and parental satisfaction of married Physicians with children (Carole and Lillien 1999), show how married physicians optimally combine work and family to seek improvement and productivity and remain qualified physicians. But limited studies have been made on women medical practitioners and their work-life balance especially on religious basis. Hence this study intends to focus on work family balance of Muslim women medical practitioners.

A detailed conceptual frame work was set forth for this study. The major objective of this study is to understand the work-life balance among Muslim Women Medical Practitioners**.** The specific objectives are to find out the socio-economic status, know the level of belief and religious participation of the respondents**,** identify the role structure of the respondents within the household and identify the utilization of leisure time, identify the marital satisfaction level, find out the level of decision making in both personal and professional affairs, know the nature of social network and sources and kinds of social support received by these women, identify the level of self-esteem, understand

the dual role performance among these women and the favorable aspects to support them and know the awareness, attitude and perception of these women towards social issues regarding women.

The present study is confined to the study of 250 Muslim women medical practitioners in Kerala. The area of study includes almost all districts among which maximum participation from Malappuram (27.2%), Thrissur and Kozhikode (15.2% from both.) and minimum from Pathanamthitta and Kannur (.4%). A detailed questionnaire based on the objectives of the study was prepared and applied for the collection of data. An exploratory-descriptive research design was considered appropriate to study the nature of work-family balance. Focus group interaction and case studies are also conducted for detailed data.

Socio-Economic Profile

About one third of the respondents were from the younger age group of up to 30 and a little less than one half from the middle age group of 30-40. Nearly one quarter falls in the elder age group that is 40 and above. The mean age of the respondents in the present study is 35.6. A medical student, contrast to other branches, takes longer period for completing education and then to settle down. This finding is consistent with the study among women in medicine conducted by Pandey and Geetha Chaturvedi(1978) that the respondents included in their study were above 30 years of age.

Nearly half of the respondents are first born child in their family and thus they enjoyed the privilege to receive more support and concern from the family members especially in educational matters.

The geographical specification of the place of birth plays a vital role in boosting one's career opportunities. There is a belief that urban background provides more opportunities and avenues for medical career since childhood as compared to rural areas. Orientation and bridge courses offered by various coaching centers provide the aspirants opportunities and in building confidence. About sixty percent respondents were born in urban areas, while others are from rural area. It is creditable that considerable proportions are from rural area and they succeed despite greater obstacles.

The institution of joint family has deep roots in Indian tradition and culture. Industrialization, urbanization and westernization lead to growing trend of individualistic way of life and rise to nuclear family system. This has been emphasized by eminent Sociologists like Goode (1963) and Parsons (1961). Studies also indicate that working women prefer to live in nuclear family. Women doctors in India who live in extended family system enjoy the benefits that accrue from such a system and are able to pursue their busy profession with less conflict. The present study shows that a little more than two thirds are living in nuclear family setup and rests of them are in extended/joint family. It is consistent with the findings of the study Debnath (2015) which found that women from nuclear families enjoy greater decision making power, freedom of movement in various spheres and enjoy the freedom to have a career.

Usually women prefer to work near to their house so that they can lessen the issues related with daily travelling, work and family balance, time management, mode of travelling they depend with etc. Distance to work place is an important aspect and many compelled to stay away from the family to continue her profession. Distance has an impact on the quality of life and work. Normally at the morning women workers use their precious time for daily travelling. Time used for journey may turn productive by utilizing it for maintaining contacts, reading and other official responses. But for women doctors it would be a hardship over their dual role performance. Medical professionals prefer to reside near their workplace. Three out of ten work within one kilometer distance from their present residence. Only a little less than one forth need to travel more than ten kilometers daily to reach their work place.

The nature of work and type of residence are closely related. It can be elicited that practicing women doctors and those who are in medical colleges are not willing to go to various places of posting as they are a little hesitant to break the existing living arrangement. Out of the total respondents seven among ten are living in their own residence, while a few reside in quarters offered by the organisation they are working for. It also reveals that a good majority are able to own a house at a younger age.

With regard to the occupational designation, more than one fourth of them are senior consultants having 15 and above years of experience. Nearly

one fourth have 8 to 15 years of experience and about half of the respondents are juniors with less than 8 years of medical practice.

In India traditionally men enjoy a better social status than women. It is obvious that husbands are treated as superior to their wives. They are supposed to be more qualified to maintain their superiority in the house. Most of their partners have equal or higher qualification in the present study. Husbands of the respondents must be helping and motivating their wives in enhancing and keeping up their career. It is only spouses who are equally qualified who understand the burden of their wives and take efforts to ensure that they have equal opportunities and atmosphere for uplifting career.

This study reveals the fact that most of the husbands encouraged and motivated their wives to enhance their career by going for higher education and specialized training. Generally doctors prefer to marry a partner from the same profession. This study shows that women doctors have the freedom of deciding a partner from same profession. Nearly six out of ten husbands are in this profession. It is consistent with the study of Tanika (2016) and American Medical Association (2019) that women have power to decide and plan her marriage and career.

In a developing country the role of government in the health sector is very much necessary. At the same time, one cannot deny the increasing role of private sector in the medical field. Hence there is a discrepancy in salaries offered by the government and private sector. This study includes doctors both from government and private practitioners. They are not ready to reveal the

true earnings. Doctors who are working in government sector do not reveal their earnings from private practitioners are not ready to reveal their true earnings. We cannot completely deny that government doctors are not engaged in private practice. About sixty percent earns up to Rs.50000 as salary and a small proportion earn above one lakh and rest of them belong to the income category between Rs.50000 and One lakh. In this study it was also found that doctors both from government and private sectors are not ready to reveal the true earnings. Doctors who are working in government sector do not reveal their earnings from private practices. Private practitioners are also not ready to reveal their true earnings.

Except a small proportion all others use vehicle for travelling. Among them who use vehicle, two out of every five use car and one fifth depend on public transport system. One's punctuality and performance in work depend upon distance to travel, mode of conveyance and time management etc. A little more than three fourths drive to the place of work.

In medical field working hours are not fixed in general especially with regards to big hospitals. Each role consist different activities and it requires definite amount of time in a day. In the present study majority have a working time of maximum eight hours per day. As the field demands, despite having a fixed number of working hours doctor end up working much more than that as they attend to emergency cases that come even after work hours.

Nearly sixty percent hold post-graduation degree with specialization and rest hold only MBBS degree. Respondents who have minimum qualification

are trying for post-graduation and preparing for entrance examination. Post-graduation qualification is somewhat mandatory in this era of specialization. Cultural bonds and other family responsibilities provide limited space to avail this option for a few.

As the qualification and specialization increases the person become more competent in their respective field. And it in turn makes their professional life more demanding and this reason has impact on personal life or family responsibilities.

More than one fourths of the respondents were specialized in gynecology. Gynecology deals with women and reproductive health. This area of specialization is dominated by women doctors. Even in our society women prefer to discuss their reproductive health problem with women doctors. In this study only a small proportion are gynecologists.

Family life in general and children in particular are highly salient factors in producing role conflict. A little more than two thirds have two and more children. The number and age of children are directly related to role conflict in working women (Bhatty and Bhatty 1971, Singh 1972, Sachdev 1974,). The number of children is obviously relevant because fewer children mean less work (Hoffman 1963).

The professionals encourage their children to follow their profession by highlighting its merits among them or the children themselves may be inspired by their parents' profession. Hence children of doctors become doctors and children of engineers become engineers in our society. Studies reveal that even

though the medical field is full of tension and stress, the children of doctor parents are directed towards or choosing this noble profession. A little more than one third of the respondents' parents are also from medical background. Rest of them is the pioneers in their family without medical background.

In a society age at marriage indicates position of women. Education influences age at marriage of the individuals. Early marriages both for men and women are the norm for the Muslim community all over the world. Kerala is not an exception from this. But the present study shows a very positive indication that the mean age at marriage is 25.2 years and almost all of the respondents got married at 24 or above the age of 24. Unlike other professional courses MBBS demands more serious approach by the students. Almost all the respondents married after the completion of their course. It proves that, they showed commitment to complete their studies with the support of their family. 28.4 is the mean age at marriage for husbands.

Marriage and being a parent has profoundly influenced by persons education and employment. The mean age at first delivery in this study is 26.1. Both age at marriage and age at first delivery in this study reflect the studies conducted in advanced societies of the world.

Nearly sixty percent of the respondents completed their post-graduation and specialization only after marriage in the present study. It reveals that women have power to decide and plan her marriage and career. A little less than half of the respondents have five years of practice and more than one fourth completed fifteen and above years of experience. 9 out of 10 have

service break. Most of them had break mainly for delivery and maternal care. A little more than one fourth took leave for completing their studies. Women professionals struggle between productive and reproductive roles of pregnancy, lactation and bringing up infants adversely affect their service and efficiency in work. Women in this study give equal importance for her career and family

Religious Beliefs and Participation

Islam, as a holistic religion provides prime importance to acquiring knowledge. There is no disparity for men and women in this religion. Women, equally with men enjoy the rights of education and employment with some conditions. These conditions are not to restrict their freedom, but to shield her from worldly discrepancies. The most basic aspect of a believer is to follow the instructions given to all from most personal to social or public life. Five basic tenants of Islam, regular notions of worship should be followed by all Muslims which in turn help to mould his life as an ardent believer.

The participation in religious activities of respondents reveals that a great majority maintains their religious belief and follows religious obligations even in a busy professional schedule. More than three fourths are regular in their prayers. Four out of ten visit religious centers. A little less than three fourths follows religious dress code and about eight out of ten are following religious food code. A little less than half attend religious functions and nine out of ten fast during Ramadan. More than two thirds are regular in reciting Quran and little more than eight out of ten are inculcating religious values among their children. Again eight out of ten are following important customs

and practices of Islam. A little more than four out of ten completed her Hajj or Umrah. The result of last statement about the problem in attending some medical cases as a Muslim and difficulty to follow religious beliefs shows that there is no remarkable or significant relation exists between the religious belief and profession of the respondents.

The level of participation in religious activities shows higher among six out of ten. Nearly two out of ten have medium level of participation in religious activities, whereas two out of ten have lower level of participation in religious activities. This result is consistent with the study of Farr Curlin and associates that the religious characteristics of US physicians are also high. There is no significant relationship between the age of the respondents and profession of husband on their religious belief and participation in religious activities. As age increases participation also increases. Charity is a part of our personal life and value. It is not only religious obligation but also a socio-cultural nature of humanity. In the present study a good proportion of respondents take part in charity activities. Among them, almost all offer financial support to the poor and needy. Nearly half offer free medical service and attend bed ridden patients personally or as part of palliative care societies and other voluntary organizations. Usually there is inverse relationship between religious belief and the conditions of education, social position and employment but this study shows that women doctors irrespective of position, income etc are actively involved in religious activities.

Compared to other professions medical practitioners are more religious because of nature of their job. Doctors are always dealing with life and death and such situations would make them more religious and keep near to God. Sometimes they seem as representatives of god for those patients. Doctors direct the patients to be a believer in God and ask Him anything. Work ethics is an important factor for the doctors. Morally bound doctors are found to be less unscrupulous and more ethical in their practice.

Every thought and action of a believer should be in accordance with the religious instructions. The important mile stone of life like education, employment and marriage is governed by the belief system. Religion plays an important role in molding the personality. Than just a belief system, religion helps for fulfillment and saturation in life.

Role Structure within the Household

Household duties of women are bound with a number of roles she is entrusted to perform at home. Among them role as wife and mother are more prominent. These roles are biologically built, culturally practiced and socially accepted. There present many traditionally developed concepts of a housewife. An ideal housewife magically engages with all activities of the house and fulfills the needs of every members of the family. Home was her world and no life outside it. Not much change happened with the changing role of women. Things not turned in favour of her when she started to share the economic burden of the family with men in the family. It happened as an additional burden for her to keep both responsibilities at a time. In this changing scenario

of work and empowerment of women, the household duties are still her responsibility (Martinez and Palerna 2009 and Fernandez and Angeles Quroga 2016).

An attempt is made to analyse the participation in household activities of working house wives and examine whether there is any alteration in role performance as result of education and more particularly due to the employment of wives. Cultural and biological nature of man puts some unique roles and responsibilities to both men and women. Certain roles are attached only to women, no one can replace it.

Effective management of household duties is not a problem for professional women if she gets support from the members of the family, domestic helpers and home appliances. The husbands of working wives should share the responsibilities to enable them to cope with the new demands. But many of them are not willing to take up responsibilities even when they are free because of their traditional values and convictions. So this investigation had special focus on this aspect.

Though the individual participation of husbands in household task is negligible, a good proportion of husbands share many household duties with their wives.

As to the mode of participation, it is better shared. Women medical practitioners sometimes need to attend emergency medical cases even at their home at odd times. The husbands inclined to participate in household duties do so mostly in the physical absence of the wife or when she cannot attend the

task. It means they have accepted a new normative system governing the role situation. This result consistent with the result of the study conducted by Madhava (2001) that there is change in the traditional system and an increase in the participation of husband in the household duties. Indian culture ascribes the domestic duties should be unshared for women. Usually the son is never asked to help the mother in the kitchen. But nowadays when a boy get married to a working girl, he is well aware of the fact that the wife will work outside the home and that she will not be able to perform her traditional role due to added obligations and responsibilities. As he is aware, he extends his helping hand in domestic responsibilities.

From the following analysis, a trend of change in the traditional division of labour in house work is noticed. The activity, which men share at large, like ironing, provides better relaxation to women. Since the men take this responsibility women get time to relax. Most of the employed men spend time with friends in the club or other organizations, and many come home very late, whereas women have to rush to their houses, directly from the work place, to assume all the duties of a house wife. This drains out all their energy. If husbands are ready to share the household responsibilities, along with their wives it will reduce her burden for her.

With regard to level of participation of household activities four out of ten have higher level participation. Five out of ten have medium and one out of ten has lower level of participation in household activities. Women doctors manage their household duties by effective time management and support

system. A considerable proportion of doctors are well aware about the duties and responsibilities related to their profession. Therefore they make lot of adjustments in their family sphere. Women who involve more on family sphere experience work stress.

The socialization process is still the responsibility of the family even in the urban setting. Though nurseries and educational institutions have relieved the family from some of its functions related to children, the basic function of early socialization still rests with the parents. Bearing and rearing of children is both biological and social obligation for women. Their growth and development demands lot of mother's energy, time and strength.

Feeding, sending children to school, helping in their studies, training and disciplining are important areas for role preference by the family members. At the school going age they require constant care and guidance. It involves tasks like dressing them up, arranging books, helping them to do their homework, taking them to the school as well as ensuring that they leave the house in time for the school. Participation in child care reveals clearly collective child rearing practice. Feeding or packing food mostly rests with women in comparison to other two categories. The women were dominant in areas like assisting in doing homework and arranging books and uniforms is about half of the families. Taking them to school has the least female participation and as an important help, half of them performed by husband and it was their highest participation rather half of them performed by some other persons rather than parents. Only a little more than one third involve in task of

giving bath and dressing. This result of spousal support with house work contradict with the results of study conducted by Silvia Adam (2008)

Most traditional tasks associated with child care are shared. Two third of them jointly perform the task of attending during illness and telling stories and entertaining them. The least shared task is assisting in doing homework. A notable aspect is that more than half share the task of bathing and dressing up of children. This result was consistent with the result of the study of Kapur (2005).

With regard to level of participation in child care activities nearly four out of ten have higher level of participation in child care activities. Four out of ten have medium level of participation in child care activities. Nearly two out of ten have lower level of participation in child care activities. . Nearly two out of ten have lower level of participation in child care activities. Collective child rearing practices help nearly about sixty percent of women to involve actively in their professional duties and responsibilities. Here, women performing and fulfilling their mother's role with the constant support of their spouse and family members.

Dual career women are confronting issues regarding management of household activities. As an outside employee they have assigned duties and timing. Mostly it is manageable for them. The household duties are repetitive and cyclical, hence management is tiresome. Management is a skill and it is well among those who have that skill along with some supporting factors. Husband, family, servants, technology etc. are the factors which help them to

manage their work and family. A great majority have the confidence that they can manage the household duties to great extent. More than two out of ten manage their household even without servant. Half of them follow preplanned menu system and more than one among every ten even manage without modern kitchen devices. Except twelve percent all others prepare more easy or simple or time saving type food to great and some extent. Four out of ten not at all depend up on any instant food. More than eight among ten follow effective time management a little more than one fourth have great extent while others only to some extent. With regard to level of management of household activities nearly 3 out of ten have higher level; five out of ten have medium level, whereas nearly 2 out of ten have lower level of management of household activities. The result of this analysis that the women medical practitioners can manage their household duties reflects the studies conducted by Hemlata and Suryanaraynam (1983) and Gove and Zeiss(1987).

Working women, in general, while struggling to balance both work and family divert their leisure activity into some of the related ones which would ease their professional and familial burden. Medical practitioners in their shuttle life between work (sometimes include extra private practice) and family may not get enough time and space to freshen up with leisure activities. There is a marked difference between the quality and quantity of leisure among different categories. Generally women spend their leisure time watching cinema, serial, small talk etc. when take the case of educated women all these shows a different pattern. According to the nature of education they have, they

select their leisure. If she is in a profession, again visible changes reflect in the leisure. They purposefully or not related towards her field of work. The activities and the persons comes in relation to her leisure like listening music for music therapy, tending a medicinal herb garden, chatting with friends about trends in medicine, reading medical related books etc. . Though these women do not get much time for leisure and recreation, a well proportion of women meaningfully utilize their leisure to refresh their mind and body. It is also a type of strategy followed by the medical practitioners to maintain work-family equilibrium.

Marital Satisfaction

Family and work are two major domains of life. If conflicts occur between these two domains, it adversely affects the life. Studies prove that comparatively women experience higher level of conflict between work role and family role than men because men give more importance and commitment to their profession.

Marriage involves the most intimate type of emotional relationship between husband and wife. Relatively large body of literature studied the impact of work satisfaction on marital adjustment of married working women. Fariba, et, al (2013) studied the relationship between marital satisfaction and job satisfaction among employees and found that a significant relationship between marital satisfaction and job satisfaction. Marital satisfaction factors indicate that women's job affect marital satisfaction (Shaieghian,et,al 2009)

Marital satisfaction is the foundation of marital life and family solidarity .It is an essential element of successful family life and personal growth. The fulfillment and positive development will be possible only when the relationship between couples is coherent and satisfactory. Personality of the partners, nature of job, child rearing responsibilities, sexual satisfaction and communication patterns are the major factors which influence marital satisfaction.

An increase in marital satisfaction was significantly related to an increase in job satisfaction (Rogers and Mary 2003). A great majority of women have high level of marital satisfaction. In general persons who have high education, employment and social status have high expectations in their marital life. There are chances for marital conflict among doctors when there develops a gap between these expectations and reality among the spouses. This study shows that a great majority of women have high level of marital satisfaction. This result is inconsistent with the findings of various cross sectional studies have pointed to high level of work family conflict and low level of marital satisfaction among professionals (Alisha 2011, Lilu, Yang Wang, Jiana Wang and Lie Wang 2012). This study again reveals the fact that women medical practitioners in spite of their demanding profession have high level of marital satisfaction. This contributes to their career enhancement. When assess the relationship between marital satisfaction and age, self-esteem and profession of the husband, It shows that except the profession of husband. All other variables are not related marital satisfaction.

This study has proved the hypothesis that doctor couples have more marital satisfaction than doctors with other professional career.

Decision Making

As the basic social institution, family plays an important role in our social life. The family functions on the important decisions on various aspects. These decisions are influential on the development of its members. There has a pattern of decision making in our society where male dominate the key positions of decision making.

Right decisions at right time and space are important in one's life decision to select course is not the final for a women medical practitioner in her life. She has to take a number of decisions followed by her studies and most important one among them is to continue as a professional.

Family is inevitable for social life. It includes numerous decisions at different stage, situation and sphere. A person with due regard in family decisions become confident enough to face with similar situations outside the family, most probably in her work field.

It has implications of empowerment too. Working women with enough space in her house can only shine in her respective professional field. The power and appeal through decision making gained by women from family role help them to develop courage and confidence. It serves as an authoritative guide to help women navigate the workplace and their everyday life with greater success and impact.

The present study focuses on five major areas of decision making in family like household management, decisions on personal matters, financial decisions, decisions on professional aspects and decisions regarding children.

Decision making in household management reveals that many of the traditional concepts of authority regarding household management shows a transformation. Most of the decisions are taken by husband and wife jointly. Men slightly predominates in areas such as repairing and painting of house, arranging assistance from outside agencies like help from plumber or electrician and taking unwell family members to the hospital whereas women predominate areas like arranging and decorating house, deciding family menu and employing servants. This finding is dissimilar with the findings of Jan and Akhtar (2008) that women generally possess low decision making power in familial matters.

Purchasing of provisions required for the kitchen is mostly a joint activity and about seven out of ten purchase household things jointly. Husband enjoys very limited power to decide the daily menu of the families. As a traditional female responsibility three out of ten continue to enjoy this decision. Arranging and decorating house is regarded as a sole female responsibility. In this study also women predominate in these activities. Another traditional role of women in deciding about the care of sick family member is mostly a joint responsibility. Independent decisions of husbands predominate in some specific areas where women are unable to attend due to their busy work schedule at outside.

Nearly two out of ten have higher level of participation, seven out of ten have medium level of participation in decision making in household management. Since they have to do responsible work related to their profession, they keep themselves away from the household management responsibilities. It is neither escapism from responsibility nor powerlessness.

Decisions regarding one's body or reproductive health are one of the major and crucial decisions among family decisions.

Respondents' role in decisions in personal matters shows that almost all decisions regarding reproductive health are taken by husband and wife jointly. The study reveals the fact that women have strong voice on reproductive health decisions and most of the decesions regarding one's body and reproductive health are taken husband and wife jointly. One major reason for this change may be the nature of their profession. Power enjoyed in decision making regarding her body or sexual decisions made her strong enough and lead to empowerment which seems to be very rational and modern. This is a real empowerment enjoyed by these women and this power is gained only through their education and professional career.

Decisions regarding financial matters show women's better participation and is regarded as another most important indicator of empowerment of women. Financial management includes family budget, expenditure, bank transactions, and payment of bill. Wages /salary, payment of fee etc are usually handled by husband. Except a few areas, all other areas of financial decisions are taken jointly by husband and wife. Online purchasing, e-payment, Net

banking etc provided opportunities for educated and employed women to enter in to the areas where once it was men's domain. In the areas of savings, bank transactions, purchasing of clothes and household appliances and money spend for gifts, luxury items and family trips are made after joint decision by husband and wife. Participation of women in financial matters is considered as one of the significant sign of empowerment. The money matters of big business magnates, film and sports stars are dealt with manager or personal staff is not regarded as their powerlessness. Rather an internal arrangement by them to feel cool to perform them well.

When assessing the overall level of women's participation in financial decisions reveals that about sixty percent of women enjoy decision making power. Joint decisions of husband and wife make a large number of women fall into moderate level. Women's vital role in certain specific area of decisions made a small proportion to enjoy higher level of freedom in decisions. This study reveals the fact that women are equally considered by men in financial decisions

The decision regarding child care shows her role in one of the most important traditional roles of women as mothers. But the decisions related to it are not at all feminine in character. The traditional role of a mother is increasing with varied responsibilities being attached with child care. This is an important area of decision making as it involves decision relating to age at which schooling has to be started for the child, the type of school, the medium of instruction, higher studies etc.

The areas of decisions of childcare cover areas other than of decisions regarding educational activities such as giving pocket money, visiting friends, participation in sports, games and arts, discipline and giving punishment or reward etc.

It highlights the role of women in decision making along with their husbands. It positively indicates that their role as joint decision maker with husband is on increase. A notable increase in to the role of a punishment giver is a step to the male dominated area. The permission to visit friends' houses is rather another new area that shows steady increase.

With regard to level of participation in decision making regarding children shows that most of the decisions are taken by husband and wife jointly. Hence a great majority of them fall into medium level of participation. Decisions on children were also men's area where women had very limited space particularly in traditional patriarchal family. Educational advancements, employment opportunities, decent income made women to share and contribute their valuable views along with their men.

The decision regarding professional career reveals that joint decision of spouses is on increase. Important decisions related to the profession are taken normally by the individual concerned. In the case of women professional the males related to her has a greater role. The decisions like attending meetings, participation in courses, paper presentations, publications and official trips are mainly taken by wife and husband jointly because all these academic programs should be scheduled according to the due preference to family needs too. In

almost all decisions more than one fourth of the respondents have their personal decisions.

With regard to level of decision making in professional career three out of ten have higher level of participation in decision making in professional career. Almost six out of ten have medium level of decision making in professional career. One out of ten has lower level of decision making in professional career.

The results of participation in decision making in five areas shows that maximum participation fall into medium level. This reflects the results of the study conducted by Benjamin, (1962); Patki and Nikhade (1999).

This study not proved the hypothesis that decision making power will be high among women medical practitioners because here we can identify only a moderate level of participation in decision making.

Network and Support

Life is a combination of a number of mutually interrelated and supported elements. When these support system in a coordination synchronize the life turned become beautiful. The personal merits or achievements alone cannot make one successful. The individual qualities or virtues can be best reflected or expresses through the network relations.

Muslim women medical practitioners have maintained good network relations so that they can turn it into support whenever necessary. The very feeling that there is someone to help and support gives a feeling of relaxation

and it reflects in their productivity and quality. They can make use of it as a part of daily arrangement or for when occasions arise unexpectedly.

It is commonly said that the emotions whether glad or sad should be shared to make it maximum beneficiary for the persons. Sharing is encouraged only among those who are relying upon them. It is not possible to create work family balance in a vacuum. It is well maintained by the individual efforts made by each individual. The level of work family balance may different for different persons depending on the individual concerned. Those who have the skill of effective utilization of existing positive conditions would be benefited from it.

Muslim women medical practitioners have good interpersonal relationship with their kith and kin. . Almost all of the respondents keep touch with their relatives, friends and neighbors, while ninety percent maintain regular contact with their colleagues.

Respondents' tie with different kinds of relations reveals that they maintain close relation with about 1760 from their family circle. The second large number of persons who are comes in contact with from the colleagues (1275) followed by friends (1480) and neighbors (1012).

Respondents' type and sources of support shows that seven out of ten receive emotional support from their mother (Wellman, 1992; E Yamada, 2005) and less than half from their in-laws. Friends and other close family members such as brother, sister and father extent support about two thirds. Again with respect to financial support family members and friends support

them. Companionship is mostly with mother, sister and friends. They also enjoy informational and institutional support from the relatives, friends and neighbors.

Women have greater proximity to their nearest friend in fact, it is the availability of friends rather than gender that is important to neighboring support (Kempston, 1998). Neighbors are the main source of help with minor, short term tasks and in case of emergencies (Van der Poel 1993). Frequency of contact is a function of social closeness (intimate, active. Latent), spatial closeness (some neighborhood metropolitan area) and kinship closeness (immediate verses extended kin). Immediate kin diminishes less with greater distances than does contact with extended kin (Adams 1990; Klatzky, 1971; Leigh 1982; Gaunt 1998).

Daily contacts are relatively more through social media and telephones than personal face to face contacts. With regard to weekly contacts a considerable proportion of women contact their network members over phone, followed by weekly visits. Nearly one fourth visits their kith and kin at least once in a month. About forty percent agreed that they visit their relatives if any emergency, while others said they contact their network members either through phone or through social media immediately if any need arise.

Earlier studies on support system and work-life balance proved that support is a dominant predictor of work-life balance. This study also reveals that women medical practitioners maintain good personal network and tap support from their significant network members whenever it is necessary. With

regard to the type of support and sources of support shows that husbands provide support for career issues. Parents particularly mother and sister provide emotional and task support. This study clearly shows that women are kin keepers. It is consistent with study finding of (Moore, 1990, Wellman and Wellman, 1992) Women tend to be the kin keepers of families. Women's happiness is related to frequency of contact with relatives, consistent with the kin keeper role. Friends are another important members who provide emotional and companionship. This support network helps them to achieve their personal and professional goals and give a source of support to manage their work role and family role.

Attending functions plays an important role in social life. The functions are the occasion for social coherence and intimacy. Functions related to various life events such as house warming, marriage, child birth, birthdays, naming ceremony, deaths, etc are the common functions celebrated in Indian society in general and in Kerala particularly. Gatherings and family get together are very common today. Functions and celebrations may be related to kinship and friendship. Celebrations and feast may occur among family members, friends, colleagues and neighborhood. According to the social status and position each achieved through education and employment, influence the recognition and participation in these functions. Educated and employed women privileged to attend functions outside their immediate circle. They value it as a social recognition. Generally, professions like medical doctor prevent them from participate in such functions especially unexpected ones. Women, who need

preparations to attend in functions, largely neglect such occasions due to busy nature of their work.

Participation in family gatherings and functions by the respondents shows that about five out of ten are able to attend their family functions always if informed early. One in every ten was never able to attend functions invited by their friends. About half of them always find time to attend such functions in the neighborhood. The unexpected life stage events such as death and related rites, puberty related rites etc found problem to arrange their attendance. Such functions attended in the family by one fourths, three fourths in their friends circle and about two thirds in the neighborhood relations.

Implications of social media may vary according to the people who engaged with it. An educated group of people use it differently as compared to an uneducated group of people. The quality and quantity of engagement may also change according to it. Though primarily it is a means of communication and passing and sharing of information, it has wider applications among professionals like medical practitioners. They can make use of its numerous advantages like simplicity, low cost, speed connectivity etc. above those common virtues, they use to receive and send advanced medical knowledge and information. They can video conference, ask for expert advice or references by using it. Today social media are widely by used busy professionals to maintain personal relations with family and friends too.

Except one respondent, all others use Whatsapp as a network media. A large majority have face book account and mail account. Account in other

media like Instagram, Twitter and Blog are popular only among a minority. Even though they find difficulty to contact personally with the network members, most of them maintain relations with the help of digital media. Both personal and official contacts are maintained by these women with social media. It helps them to enrich themselves with the usage of available resources in the field of information technology. Updating as a person as well as a professional is now easy with this. It can be regarded as empowerment and they literally become smart by using smart phones. More than a device for communication, it functions as a complete device with a number of applications and offers which creates a virtual world. It turned the society into global village but at the same time isolate individuals from their immediate surroundings. Married women professionals regard technology as a way to be smart moms by using mobiles to keep in contact with her children at home while she is at her duty and enquire about their whereabouts and well-being(Rego, 2011; Melissa 2010). This study also reveals the fact that technology has made it possible to be present both at home and at work (Trauth, Quesenberry and Morgan, 2006; Neena, Donna 2013).

Quite another important area of network and support of employees is their membership in various associations ranging from professional to personal. For the women medical practitioners, membership and participation in their professional associations are very significant. It boosts their confidence and managerial capacity.

Nature and participation in associations of the respondents shows that almost all are members of different associations. About one third has active participation in professional association ranging from local to national level. Many are part of women's wing of their professional association. All are part of different voluntary associations and nearly half of them participate in meetings and activities of the religious association and cultural/social association.

Self Esteem

The development of self and self-esteem are more important for every individual. It is the social surroundings which helps the person to develop self. The way society value a person is significant. It is persons perception about his/her image in the society. It is a guiding force and inner strength for all. There are both positive or constructive and negative or destructive elements in life. Both of them present in every individuals. The way we interact with these conditions determine well being. The emphasis given to positive elements helps to grow and emphasis on negative elements leads to destruction. It is the self esteem of a person which helps his/her selection of choice in the life. The positive incentives which boost to build self-esteem are education, employment, marital satisfaction, social support etc.

Muslim women medical practitioners are present with so many positive aspects which move them towards self-esteem. As a person most of them reached their life goal set by them since early childhood i.e to become a doctor. The quality of education they attained also a fact. They become physically and

mentally matured when external into marital life after their studies. This again give them choice of selection. It results in their self-esteem, positive life, marital and professional satisfaction. The positive regard from the society as a doctor a high paid and prestigious position rather enhances their self-esteem. So the very presence of self-esteem helps them to see life as smoothly running. They are equipped to face the unexpected developments in the family life and situation in an easy and tension free manner. This particular state of life leads them to balance or equate the work and family. Network and support from persons and machines also a stage setter of work-family balance. According to the specialization and position of women's profession increases, the expectation of their participation in household activities decreases. Family as a system finds alternative means and sources of fulfillment of its needs.

With a high self-esteem she feels good about herself by absorbing positive messages about other women from different cultures and relationships. Qualification as a medical practitioner itself directs a person to high status and position, social acceptance and demand. High earnings, social respect and increased family support etc. are positive inputs of this.

The self-esteem of the respondents shows that nearly six out of ten strongly agree that they are a very responsible person. More than seven out of ten show assertive behavior whenever necessary and aware about their strengths and weaknesses. Nearly half of the respondents are able to control their impulses/emotions. About two thirds shows empathetic attitude. More than seven out of ten shows loyalty to others. More than six out of ten are

selective in developing interpersonal relationships. One of the most important categories in self-esteem is feeling self-worthy and more than sixty percent care about themselves. One third of the women feel they are very important persons and more than half evaluates them as not too stubborn and too flexible. About seven out of ten are well aware about their rights and duties. More than four in every ten have problem solving skill. Decision making skill is a significant element of empowerment and self-esteem, owned by half of them. Nearly half of them have critical thinking and positive self-talk.

With regard to the self-esteem of medical practitioners clearly indicates that a great majority have higher level of self-esteem. Employment and income serve as a resource for boosting women's confidence and self esteem, and it lead to a sense emotional wellbeing, economic independence, and autonomy and widen their personal and social net work. Women in this study strongly believe that medicine as a noble profession and it commands respect in the society. This thought and awareness enhances the level of confidence and boosts their self esteem.

The hypothesis accepted that the level of self-esteem will be high among women medical practitioners.

Dual Role Performance

Society is "a web of social relationships" (Mac Iver). The most basic social relationships can be exists in its small unit of family. When society moving towards more and more complex state, the individuals undergone with drastic changes in their social environment and relationship. One most

important change is the changing role of individuals in the family and society, especially the role of working women in the family. The new or re-arranged roles are balanced with the skill and potential acquired by the persons. They are equipped with the inner strength.

As the values of the society changes, the life of individual also changes. New roles or re-interpreted roles that emerged make the society more complex. The individuals, according to their skill and potential try to balance these roles. This difference causes conflict in the individual and social life. The analysis takes into account the two full time engagements of domestic and occupational roles of married women. They are likely to suffer, in response to their extended commitments. In this chapter multiple role conflict experienced by working women in fulfilling the expectations of any role along with the other role is discussed.

The study examined the nature of the interface between the workplace and in the family, which is the keystone of an employed woman's life. It has both negative and positive interference. Parenting is a large task within itself, and when the mother has a career it can cause a double burden, or work-family conflict. Strain begins to develop when the demands of their family are conflicting with the demands from their job. When faced with a double burden like this, it affects decisions made within a career and in a family. Three fourths of all working women are in their childbearing prime. When the conflict arise between one's family and work, the woman compromises in the unpaid work performed in the home simply because it is not contract bound, unlike the

contractual work done at the workplace. Social outings, visits, and family dinners are few of the first things that get affected due to the work/family conflict.

Work hindrance on family life reveals that four out of ten agree that no time is left at the end of the day to do the things they like at home. Again four out of ten agree with the statement that their family misses out because of their work commitments. About seventy percent of the women agreed that their work stress cause negative impact on family domain such as long hours in work-place, attending patients at odd hours, attending night duties etc. women try to maintain a balance between these two ideas and try to avoid inter-role conflict. This finding is consistent with the findings of RakeshChadda and MamtaSood (2010) that women struggle to juggle career and family responsibilities.

With regard to level of work hindrance on family life, more than half openly agreed that their work affect their family life. This finding is consistent with the study of Greenhaus and colleagues (2003) on work-life balance. A similar study about Nigerian female doctors experiencing difficulty in combining multiple roles also revealed the same findings (Adisa, Mordi and Mordi 2014).

It is quite natural that when there is clubbing of two equally important roles in one individual, the mechanical equilibrium cannot workout in the network of relations and related issues. A complete problem free balancing is

ideal, in reality mutual adjustments and compromises are required to lubricate the tough situation.

This study clearly shows that though women face family hindrance they take great effort to see to it that it does not negatively affect their profession, because they believe that the medical profession is more noble and dedicated service for the humanity than any other profession.

With regard to level of family hindrance on work, studies show except a small proportion, all others experience lower level of family hindrance on work. This result is contrast to the study of Hammer (2001) that in his study the family to work hindrance is high. A good proportion of women said that they are very conscious about their profession and it should not suffer due to personal or family commitments. A considerable proportion of women said if they spend long hours with their family it affects their work performance. The nature of their work is different from other professional work. Therefore in this study found that women adopt good time management skill and they themselves develop a strategy to balance these two roles. Even though women give first priority to their medical profession, they are aware about their family responsibilities A considerable proportion of women said that taking too many responsibilities in familial level may cause stress and strain and in turn affect their ability to do their medical duties. Another significant point noted in this study is more than half of the women give prime importance for the growth and success of their profession.

Work-life balance is the maintenance of a balance between responsibilities at work and at family. To lead a comfortable living with self-satisfaction, women are working hard to get a balance between their personal and work life. The support systems play a significant role in work life balance. The support from their spouse, parents, in-laws, friends, neighbors and colleagues help them to manage their family role and professional role. Women in this study maintain good interpersonal relationships and healthy support system. Among the supporters, husband plays a pre-dominant position, followed by parents and friends. With regard to the types of support and sources of support reveals that except one all others get support from husbands and about two thirds strongly agree that their spouse support them. More than six out of ten strongly agree that they discuss career issues with their husbands and get encouragement in the career life. More than seventy strongly agree about the support from their parents, whereas only four out of ten were supported by their in-laws. About one fifth strongly agree that they are supported by their colleagues, fourteen percent strongly agree that they have a comfortable work schedule and less than nine percent strongly agree that they can avail leave when they need it.

With regard to level of support received by the women in their professional career clearly shows that women receive higher level of support to professional career. Net work members play a significant role. Primary consanguineous kin occupy a prime place among supporters. Role of husband is inevitable in it.

This study proved the hypothesis that women medical practitioners get support from their male counterparts to fulfill their household role and mother's role.

The hypothesis that increased specialization demands more from the professional which in turn creates lag in the domestic role performance is rejected in this study. As the specialization increases the demand for them and responsibility increases but they need to handle only the emergency cases that come under their area.

Highly educated and employed women can own expensive and time consuming devices to ease their domestic works. In this study there included assessment of use of highly sophisticated and costly modern kitchen devices more than that of daily needed devices like washing machine, mixer grinder etc which are common in average households in Kerala.

Technology is very potent and nothing is as fast as technology at improving life. It can affect life both positively and negatively. New technology always influences our life very much and takes it to a new level. It is like the new way of thinking or doing the normal things differently, better and much faster with less hassle and at a much affordable rate.

Computers, laptops, smart phones etc. make it easy for human beings of today to exchange information, make faster decisions, interact socially, and get entertainment, process financial transactions efficiently by online, manage homes and other existing technology. In the 20thcentury, technology plays an important role in the constitution of human nature and identity. Humans have always shaped and extended themselves by virtue of technical tools and

artifacts. This has made it much more efficient to travel because economical air tickets can be purchased at a press of a button, an Uber cab can come to collect at our own pleasure with loss of no time and no more waiting. Professionals have the choice to stay any where they like with more comfort and less investment due to mushrooming of hospitality services. There is now economical and efficient way of connecting with friends and family through social media with small conveniences like not having to remember people's birthday because social media can always remind it. This study also reveals the fact that technology has made it possible for the professional to be present both at home and at work (Quesenberry, Trauth and Morgan; Neena, Donna 2013).

Awareness, Attitude and Perception

Social perception deals with how people think about and make sense of other people, how they form impressions, draw conclusions and try to explain other people's behavior, structural issues etc. There are number factors that influence one's perception other than education and employment such as perceivers' factor, attitudes, moods, motives, self-concept, interest, cognitive structure, expectations, situational factors time, work setting, social setting etc. After getting higher education, employment and economic independence, women began to realize that they are definitely equal to their men in society. Naturally, perception and attitudes of the women are likely to change. The awareness, ideas and values of the working women are shaping their perception and opinion.

Medical practitioners are a category who is privileged to have an attitude at a higher level. It helps to act or react at cognitive level. How we perform, our thinking is our attitude and it influences our action. Our action is just a display of our perception and our belief. In other words, what we act or react is directly influenced by our way of thinking, our values and beliefs.

With regard to the perception and attitude of women on professional aspects and general aspects reveals that except a few, all others are aware of the nature of their work, policies related to their work, rules and regulations regarding their salary, promotion, medical ethics etc. as to the level of awareness shows that about half of the women have moderate level of awareness. Almost all are aware about the rules on working time.. More than half of them are aware about the promotion rules. Majority are aware about minimum salary rules, insurance protection and other benefits of the employee. A good proportion of women are very assertive and they have their own view or opinion regarding various social issues. Another notable point among these women are, a good proportion of women have optimistic and positive attitude. They are ready to fight if any discrimination and injustice happened in the society. They all agreed that women should have liberty to choose their career, partner etc.

Most of the respondents have favorable attitude towards the equal say in deciding the number of children as well as in household spending. More than three fourths of the respondents disagree to the concept that woman alone should take care of the household. No respondent support men rejecting

perspective of wives due to insufficient dowry. Except a few, all of them favor equal job opportunities. A great majority support that women should be more eco-friendly. This openness in sharing the views of Muslim women medical practitioners is consistent with the study findings of Jibin and Naseema(2017).

With regard to level of responses in social issues shows that about sixty percent of women are very assertive in their responses about social issues. Women in this study are well aware about their dual roles. Balancing out the needs of these roles is of a great importance. When a woman encounters a problem in of those areas, she would be challenged in the other one as well. Hence women develop their own ability or skill and accept their household and mother's role without much stress or pressure and perform her professional role in a more successful and satisfied way with a more positive image. We can term these women as empowered though they seek the support of their spouse and family members, and understand their strength and weaknesses and develop a skill or ability to manage them.

Concept formulation

The study is a comprehensive assessment of the work-family balance; extent of participation in decision making, level of self-esteem and marital satisfaction, network and support system and empowerment. Better work-family balance and empowerment was acquired by these women with the support received from her family particularly from spouse, domestic help and technology.

In this study it is seen that women develop a new mind set to expand and grow as a great doctor. Women understand their role and responsibility, value their relationship, realize their potential, proud about their accomplishments, unique in their expressions and broaden their horizons. Women are transforming their life from less honored, age-old and tradition ridden handicaps to highly honored egalitarian society. This empowerment can be termed as **self-discovered empowerment**. Hence Women in this study are termed as women with self-discovered empowerment.

Better work-family balance acquired by these women through the support received from her family, decision-making process, confidence and self esteem developed from their family role and professional field and happiness from their marital life.

Conclusion

Muslim women, especially in our patriarchal society, had been bound by several socio-cultural taboos consciously developed for their suppression by the male counterparts. Modernization liberated women from those inequalities and injustices and paved the way for the enrichment of those women who charged ahead with the power and spirit of transformation. Religion is no more a threat especially due to revised and reformed interpretation of rules and regarding these rules in the right view. Muslim women Medical Practitioners, with all the existing barriers, are moving towards fulfillment of their life goals supported with numerous positive conditions. The education and employment provide them wider opportunities of empowerment and all these develop high

self-esteem among them. When the men and materials turned supportive, they are able to easily deal the work and family and maintain a balance between the two. Sharing of household duties with husband made them more confident to engage qualitatively in their profession.

The passion towards their profession helps to keep hundred percent justice to their profession by the Muslim women medical practitioners. Effective and well-knit systems concretize and maintain such a status. Intimate relations, support from religion and so on are the favourable conditions that assist them and provide them more opportunities to excel in their work.

Sacrifices or compromises for achieving something great give extreme happiness at its end. She turns every achievement in her life as a stepping stone for her future success and reduces the distance and leads her into the zenith .As a mother and wife, she has to perform dual duties and face a crisis of adjustment. Being a professional woman she is also expected to run her household and bear the major responsibility of child rearing. The existing cultural norms and values compel her to make all the adjustments. If an earning woman attempts and succeeds in merging her working role with the general roles of mother and wife, she will be considered as a woman who is/has satisfied with her dual roles. For this she needs strong support from her husband, parents, children, siblings and perhaps others outside the immediate familial circle.

In the shuttle between two expressive roles, women medical practitioners achieve and retain marital satisfaction by maintaining emotional

attachment with the spouse and family members. This in turn benefits them to balance their career requirements with that of family. Participation in decision making power, which is a sign of empowerment, is shared by these women with their spouse. To make life easier and maintain equilibrium between work and family, nothing can replace a touch; a heart to heart talk and time spend together between the family members.

Suggestions

- Organize workshops, seminars etc for medical practitioners to manage their work stress and boost their self-esteem. So that they can reach great heights of their goal.
- An effective network group of women medical practitioners should be formed to share their views, ideas, grievances, challenges etc.
- A formal platform and help desk at the government level to give right direction and guidance to the women medical practitioners.
- Cultural and religious associations should extent more support to women to be confident to take up competent fields in medicine without gender bias and artificial religious restrictions.
- More conducive and legal service conditions in the private sector should facilitate the women medical practitioners to protect them from sacrifice the profession for the sake of family.

Scope for further research in this area

- More in-depth comparative studies regarding work-life balance of Muslim women medical practitioners and other professionals is needed.
- Scientific study on emotional and psychological challenges faced by these women while balancing work-family life.
- Studies regarding work- stress and stress management strategies particularly for women medical practitioners are needed.
- Studies regarding women's lower participation in decision making needed.
- More scientific studies on effective utilization of social and cultural support system of the Muslim medical practitioners needed.
- Qualitative studies on network and support system of women medical practitioners are necessary.
- Comparative studies about work-life balance between men medical practitioners and women medical practitioners are needed.
- Researches on emotional and physical wellbeing of Doctors are needed.
- Research on type of empowerment between professionals and non-professional women.
- Case studies on successful Doctors are necessary.

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PROFILE OF THE RESPONDENTS

AGE DISTRIBUTION OF RESPONDENTS

Sl.No.	Age	Frequency	Percent
1	Up to 30	82	32.8
2	30-40	110	44
3	40 & above	58	23.2
Total		250	100

PARITY OF BIRTH

Sl.No	Parity	frequency	Percent
1	First	120	48
2	Second	68	27.2
3	Third & above	62	24.8
Total		250	100

NATURE OF BIRTH PLACE

Sl. No	Type	Frequency	Percent
1	Urban	155	62
2	Rural	95	38
Total		250	100

TYPE OF FAMILY

Sl. No	Type	Frequency	Percent
1	Joint	95	32
2	Nuclear	155	68
Total		250	100

QUALIFICATION

Sl. No	Qualification	Frequency	Percent
1	MBBS only	144	57.6
2	MBBS & above	109	42.4
Total		250	100

Educational specialization			
Sl. No	**Areas of specialization**	**Frequency**	**Percent**
1	Gynecology	70	28
2	Pediatrics	18	7.2
3	ENT	8	3.2
4	Surgery	3	1.2
5	Anesthesia	5	2.0
6	others	2	0.8
7	MBBS only	144	57.6
	Total	250	100

YEARS OF SERVICE

Sl No	**Years of service**	**Frequency**	**Percentage**
1	Up to 8 years	123	49.2
2	8-15 years	60	24
3	More than 15 years	67	26.8
	Total		27

EDUCATIONAL QUALIFICATION OF THE HUSBAND

Sl.No	**Husbands' qualification**	**Frequency**	**Percentage**
1	Equal or more	230	92
2	Qualification Below	20	8
	Total	250	100

PROFESSION OF HUSBAND

Sl.No	**Husbands' profession**	**Frequency**	**Percentage**
1	Same profession	147	58.8
2	Different profession	103	41.2
	Total	250	100

MONTHLY SALARY RECEIVED

Sl. No	Amount	Frequency	Percentage
1	Up to 50,000	152	60.8
2	50,000-1,00,000	20	8
3	Above 1,00,000	78	31.2
	Total		

NUMBER OF CHILDREN

Sl. No	Amount	Frequency	Percentage
1	Single child	107	42.8
2	Two children	109	43.6
3	Three & more	34	13.6
	Total	250	100

DISTANCE TO WORK PLACE

Sl.No		Frequency	Percent
1	Within 1 km	79	31.6
2	1-5 km	66	26.4
3	5-10 km	47	18.8
4	More than 10 km	58	23.2
	Total	250	100

HOURS OF PROFESSIONALWORK

Sl. No	Hours	Frequency	Percentage
1	Up to 8 hours	60	24
2	8-10 hours	112	44.8
3	10-12 hours	78	31.2
	Total	250	100

ABOUT SERVICE BREAK

Sl.No	Break	Frequency	Percent
1	Yes	156	62.4
2	No	94	37.6
	Total	250	100.0

WORK FAMILY BALANCE-A STUDY AMONG MUSLIM WOMEN MEDICAL PRACTITIONERS IN KERALA

1. PERSONAL DATA

1. Name
2. Age
3. Place of residence
4. Present residence-own house/rented house/flat/quarters
5. Duration of present residence
6. Nature of birth place- urban/rural
7. Order of birth
8. Educational qualification
9. Professional specialization
10. Years of service
11. Occupational designation (junior/middle/senior)
12. Income
13. Working hours
14. 1. I have (please tick) A. Own Account
    B. Passport
    C. License
    D. Vehicle
    E. Mobile/Connection
    F. ATM/Credit Card

HOUSEHOLD PARTICULARS

Sl.no	Sex	Age	Relation with respondent	education	occupation	income	Work place

DETAILS OF PROFESSIONAL CAREER

1. Years of service …….
2. Do you had service break Yes/No
   If yes, period of break ……..,Please give reason……..

3. Distance to your place of work: within 1 km/2-5 km/5-10 km/more
4. Mode conveyance: walk/bus/taxi/self driving/own vehicle with driver
5. Part of charity services:Yes/No

If yes type of activity 1.Financial assistance 2.part of palliative care societies
3. Camp services 4. Visit bed ridden patients
5. Disaster areas

DETAILS OF OWNERSHIP OF PROPERTY

Sl.no	Items	Fully owned by me	Jointly	Not at all
1	House			
2	Flat			
3	Plot			
4	Shops or other buildings			
5	Land			

MARITAL DETAILS

1. Age at marriage : Husband……..Wife……..
2. Marriage with your consent (kabool): Yes/No
3. Age at first delivery :
4. Having child with your consent : Yes/No
5. Studies continued after marriage : Yes/ No

2. BELIEVES AND RELIGIOUS BELIEFS AND PARTICIPATION

1. Are you religious Yes/No/Sometimes
   a. If yes

Sl.No	Items	Yes	No	Sometimes
1	Regular in prayers			
2	Visit religious places			
3	Following religious dress code			
4	Following religious food code			
5	Attend religious functions			
6	Take fasting during Ramsan			
7	Reciting Quran			
8	Inculcating religious values to the children			
9	Following religious customs and practices.			
10	Went to Hajj or Umrah			
11	As a muslim women face problem in attending some cases			
12	Feel difficulty to follow some religious believes during duty			

3. ROLE STRUCTURE WITHIN THE HOUSEHOLD

PARTICIPATION IN HOUSEHOLD ACTIVITIES

S.No	Activities	Primarily by Self	Primarily by Husband	Jointly with Husband
1	Preparing food			
2	Cutting Vegetables			
3	Cleaning			
4	Putting Clothes in Washing Machine			
5	Putting Washed dress for drying			
6	Dish washing			
7	Arranging and Decorating the House			
8	Treating Guests			
9	Buying Household provisions			
10	Ironing			

PARTICIPATION IN CHILD CARE ACTIVITIES

Sl. No	Duties	Self	jointly	Others
1	Giving bath and dressing			
2	Feeding or packing food			
3	Arranging Books and Uniforms			
4	Assisting in doing Homework			
5	Attending during illness			
6	Taking them to School			
7	Telling stories and entertaining them			

MANAGEMENT OF HOUSEHOLD ACTIVITIES

Sl. No	Management of household activities	Great extent	To some extent	Not at all
1	I can manage it with my own skill			
2	I have servant to help me			
3	I have pre-planned menu system			
4	I am depending more on modern kitchen devices			
5	I prepare food more easy type food			
6	I purchase more instant food making items			
7	I have a good time management skill and apply in day today activities.			

LEISURE TIME ACTIVITIES

SL. No	I like to spend my leisure	Yes	Sometimes	No
1	Reading books			
2	Watching movie			
3	Engaging in social media			
4	Chatting with my friends			
5	With my husband			
6	With my children			
7	With my husband and children			
8	Going for shopping			
9	Going for parlor			
10	Going for health club			
11	Gardening			
12	Updating Knowledge			
13	Social welfare Activities			

4. MARITAL SATISFACTION

1.Strongly disagree 2. Moderately disagree 3. Neutral
4. Moderately agree 5. Strongly agree

Sl.No		1	2	3	4	5
1	My partner and I understand each other perfectly					
2	I am pleased with the personality characteristics and personal habits of my partner					
3	I am very happy with how we handle role responsibilities in our marriage					
4	My partner completely understands and sympathizes with my every mood					
5	Our relationship is a perfect success					
6	I am very happy about how we make decisions and resolve conflicts.					
7	I am happy about our financial position and the way we make financial decisions					
8	I have satisfy my needs by our relationship					
9	I am very happy with how we manage our leisure activities and the time we spend together					
10	I am very pleased about how we express affection and relate sexually.					
11	I am satisfied with the way we each handle our responsibilities as parents					
12	I have never regretted my relationship and with my partner, not even for a moment.					
13	I am satisfied about our relationship with my parents, in-laws, and friends					
14	I feel very good about how we each practice our religious beliefs and values					

5. DECISION MAKING

DECISION MAKING IN HOUSEHOLD MANAGEMENT

Sl. No	Statement	Primarily by the respondent	Primarily by husband	Both
1	Purchasing provisions required for the kitchen			
2	Deciding about the menu			
3	Employing servants			
4	Assistance from outside agencies			
5	Arranging and decorating house			
6	Repairing and painting			
7	Inviting friends			
8	Inviting relatives			
9	Visiting friends			
10	Visiting relatives			
11	Taking the sick family members to the hospital			
12	Decisions regarding family health			
DECISION MAKING IN HEALTH AND REPRODUCTIVE RIGHT				
1	Spacing of children			
2	Family planning			
3	Reproductive health			
4	Parity of children			
DECISION MAKING IN FINANCIAL MANAGEMENT				
1	Payment of bills (electric, phone, NET, water, rent)			
2	Savings			
3	Bank transactions			
4	Wages to servant			
5	Paying school fees			
6	Purchasing of clothes			
7	Buying household appliances			
8	Money spent for gifts			
9	Money spent for luxury items			
10	Money spend for family trips			
DECISION MAKING IN PROFESSIONAL CAREER				
1	Attending meetings/conferences			
2	Attending courses			
3	Paper presentations			
4	Publications			
5	Official trips			
DECISION MAKING REGARDING CHILD CARE				
1	Admission to school			
2	Higher studies			
3	Permitting them to go for movie/picnic and other entertainment			

4	Inviting their friends			
5	Allow them to stay in relatives house			
6	Punishment			
7	Amount of pocket money			
8	Arranging tuitions			
9	Allow them to visit friends			
10	Participation in sports, games and arts			

6. SOCIAL NETWORK AND SUPPORT SYSTEM

1. I have account in – Whatsap/Facebook/Mail/Twitter/Instagram/Blog/Others
2. Usually used it for- Personal/Official/Post or comment social issues/Others
3. I maintain good relations with-- Relatives/Friends/Colleagues/Neighbors/ Others

Ways I used for it	**Direct contacts**	**Over phone**	**Social medias**	**Others**
Frequency of contact				
Daily				
Weekly				
Monthly				
Only when needed				

DETAILS ABOUT NETWORK MEMBERS

Sl. No	**Name**	**Sex**	**Relation to the respondent**	**Age**	**Edu**	**Occ**	**Income**	**Religion**	**Caste**	**Place of resi**	**How often you meet**

TYPE OF SUPPORT AND SOURCES OF SUPPORT

S.No	**Types of support**	**Mother**	**father**	**Sisters**	**brothers**	**In-laws**	**Friends**	**Neighbours**
1	**Emotional**							
	Share happiness							
	Share sadness							
	Ease tension							

2	**Economical/financial**							
	Minor							
	Major							
	Emergency							
3	**Companionship**							
	Visits							
	Shopping							
	Outing							
4	Informational							
	Over phone							
	Direct							
	Other sources							
5	Institutional							
	School visit							
	Religious							
	Bank							

ATTENDING FUNCTIONS

Attending functions		**Always**	**Sometimes**	**Never**
Functions with prior information	Family			
	Friends			
	Neighborhood			
Sudden/unexpected Occurrence	Family			
	Friends			
	Neighborhood			

NATURE AND PARTICIPATION IN ASSOCIATIONS

Association	**Just Membership**	**Participation in Meetings/activities**	**Active Participation**	**Executive member/ Office bearer**
Professional				
Religious				
Cultural/ social				

7. SELF ESTEEM

1.Strongly agree 2 .Agree 3. Neutral 4. Disagree 5. Strongly disagree (Put tick mark)

Sl.No	**Statement**	**1**	**2**	**3**	**4**	**5**
1	I am very responsible to myself and to others					
2	I show assertive behavior whenever necessary					
3	I am well aware about my strengths and weaknesses(positives/negatives					
4	I can able to control my impulses/emotions					
5	I am very empathetic					
6	I am loyal to others					

7	I am very selective in developing interpersonal relationships					
8	I am very care about myself					
9	I feel I am very important					
10	I am not too stubborn and too flexible					
11	I am well aware about my rights and duties					
12	I have problem solving skill					
13	I have decision making skill					
14	I have critical thinking					
15	I do positive self talk					

8. **DUAL ROLE PERFORMANCE**

WORK HINDRANCE ON FAMILY LIFE

1.Strongly disagree 2. Moderately disagree 3. Neutral
4. Moderately agree 5. Strongly agree

Sl.No	**Statements**	**1**	**2**	**3**	**4**	**5**
1	There is no time left at the end of the day to do the things I'd like at home (e.g., chores and leisure activities)					
2	My family misses out because of my work commitments					
3	My work has a negative impact on my family life					
4	The time I must devote to my job keeps me from participating equally in household responsibilities and activities.					
5	I have to miss family activities due to the amount of time I must spend on work responsibilities					
6	I am often so emotionally drained when I get home from work that it prevents me from contributing to my family					
7	Due to all the pressures at work, sometimes when I come home I am too stressed to do the things I enjoy.					

FAMILY HINDRANCE ON WORK

1.Strongly disagree 2. Moderately disagree 3. Neutral
4. Moderately agree 5. Strongly agree

Sl.No	**Statements**	**1**	**2**	**3**	**4**	**5**
1	My work performance suffers because of my personal and family commitments					
2	Family related concerns or responsibilities often distract me at work					

3	If I did not have a family I'd be a better employee					
4	My family has a negative impact on my day to day work duties					
5	It is difficult to concentrate at work because I am so exhausted by family responsibilities					
6	The time I spend on family responsibilities often interfere with my work responsibilities.					
7	I have to miss work activities due to the amount of time I must spend on family responsibilities.					
8	Due to stress at home, I am often preoccupied with family matters at work.					
9	Because I am often stressed from family responsibilities, I have a hard time concentrating on my work					
10	Tension and anxiety from my family life often weakens my ability to do my job.					

SUPPORT TO MY PROFESSIONAL CAREER

1.Strongly disagree 2. Moderately disagree 3. Neutral
4. Moderately agree 5. Strongly agree

Sl. No	**Statement**	**1**	**2**	**3**	**4**	**5**
1	I gave top priority to my family					
2	I take decisions beneficial to my family at the expense of my career					
3	I compromise on career growth to accommodate the needs of family.					
4	My husband supports me in my career					
5	He considers my career as equally important					
6	I discuss career issues with him					
7	He encourages in career achievement					
8	My job enables me to attend to my family as I would like to do					
9	My parents are very supportive in my career life					
10	My parents-in-law are very supportive in my career life					
11	I have a very good working atmosphere					
12	I got support from my colleagues					
13	I have a comfortable schedule					
14	I can take leave when I need it					
15	People work around are very adjustive					

TIME USED PER DAY

Time used for professional work	Time used for household work	Time used for child care

Technological support in the household activities

Sl.no	Items you have at home	Yes	No
1	Dish washer		
2	Microwave oven		
3	Kitchen hob		
4	Cooking range		

9. Awareness Attitude and Perception and attitude

Sl. No.	Awareness in Professional field	Fully aware	Partially	Not at all
1	Working time			
2	Promotion rules			
3	Minimum salary			
4	Bonus and other service benefits/ incentives			
5	Insurance and employment protection Legislations			
	General awareness			
1	Right to Information Act			
2	Human Rights			
3	Right to children			
4	Right to women			
5	Traffic rules			
6	Women welfare Acts			
7	Consumer rights			

RESPONSES IN SOCIAL ISSUES

Sl. No.	Issues	Agree	Neutral	Disagree
1	Even girl child is not safe in our society			
2	Legal support enjoyed by women in our society			
3	Position of women justifiable in our society			
4	Women should have rights to choose their husbands			
5	Women should make their own decisions in life			

6	Women should have equal say in deciding number of children			
7	Men should reject perspective of wives due to insufficient dowry			
8	Equal job opportunities			
9	Unfair treatment of women			
10	Women should have equal say in household spending			
11	Women only should take care of their households.			
12	Women should be more environment friendly			