CHAPTER 3

REVIEW OF LITERATURES
Reviewing third world development strategies with an eye to the status of women adds a new and important perspective. Women's position, relative to men, can be viewed from many vantage points. In this chapter, some review of literatures is discussed. As it is very clear that earlier researches help in providing better direction in the present research work. It helps in understanding the several aspects of the current research topic and also gives absolute indications and directions to the research work so that investigator could go ahead towards some specific problems. It saves the researcher from repetition of researches already done is in correct direction or not. If the earlier researches are not totally related to the research work then is is very supportive and helpful to the investigator. The review of literatures helps in two ways, firstly it escape the researcher from unnecessary work and secondly it also helps in finding out innovations for solving the current problems. Earlier done researches also support to form research hypothesis, collecting the important facts and provide appropriate guidance and views to the current research work.

The researcher have been arranged some earlier done researches i.e. review of literatures according to variables under current research work as given in the following order;

1. Attitude towards sex selective abortion
2. Socio-economic status
3. Anxiety level
3.1 ATTITUDE TOWARDS SEX SELECTIVE ABORTION

Identification of some of the key social, particularly socioeconomic, reasons that explain the circumstances of women's excess mortality is crucial to the formulation of development policy. Such an approach can indicate how certain development policies may not only enhance the lives of women but, more important, save their very lives.

Gallup poll in 2001, asked, "Do you think abortions should be legal under any circumstances, legal only under certain circumstances or illegal in all circumstances and in what circumstances?" 32% of Canadians responded that they believe abortion should be legal in all circumstance, 52% that it should be legal in certain circumstances, and 14% that it should be legal in no circumstances.

In 2002 Ganatra B et al reported that the most common reason women report for having an abortion is to limit family size. Other common reasons are to increase the spacing between births or to protect their health in cases where underlying medical conditions would be worsened by pregnancy or childbirth. For example, women participating in large quantitative surveys in Rajasthan and Madhya Pradesh in 2001–2002 and Maharashtra in 1996–1998 reported having had an abortion because they had achieved their desired family size (41%, 59% and 45%, respectively), because their last child was too young (30%, 22% and 21%) and because they had health problems (22%, 20% and 5%). Among married adolescents obtaining abortions in Maharashtra, more than half (53%) reported having an abortion because their previous child was too young.
In 2002 Sen A et al observed that there are a number of reproductive strategies that Indian couples adopt as they attempt to ensure the birth and survival of at least one son. These include bearing children until the desired number of sons has been achieved and stopping once that number has been attained (through temporary or permanent contraception or abortion of later pregnancies) and the selective termination of female fetuses. In addition, gender disparities may arise in the allocation of health and nutrition resources, leading to excess morbidity and mortality of female infants and children.

In 2003, drug sellers/pharmacists (who represent an important source of abortion services since medical abortion became available for sale by prescription as well as abortions done by untrained providers. It is also likely that many abortions performed by registered providers in certified facilities are not reported because of deficiencies in data reporting systems and data collection practices.

In 2003, Jensen et al. reported that Sex selective abortion could also affect daughters’ well-being through a reduction in family size. Several studies have shown that in populations with strong son preferences, daughters have, on average, more siblings than sons as parents of daughters continue to have additional children to attain the desired number of sons.

In 2003, Retherford et al. studied on documented sharp increases in male female ratios at birth since the 1980s, especially in Northern and Western states, which are regions historically known for strong sex discrimination and son preferences. These studies have shown that increases in sex ratios at birth
correspond in time to the diffusion of prenatal sex determination technologies suggesting that sex selective abortion is likely to be a major contributing factor.

In 2004, World Health Organization report on the advertisement on abortion techniques "Invest 500 rupees (for a sex test) now, save 50,000 rupees (for a dowry) later”.

In 2004, Government of India further amended into the Pre-Conception and Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) (PCPNDT) Act in 2004 to deter and punish prenatal sex screening and sex selective abortion which was the old passed law, the Pre-natal Diagnostic Techniques Act (PNDT) in 1994. The impact of the law and its enforcement is unclear. United Nations Population Fund and India's National Human Rights Commission, in 2009, asked the Government of India to assess the impact of the law.

In 2004, Ramachadran et al concluded that the proportion of certified and legal abortion facilities accounts for only 24% of all private abortion facilities in the country. As regards for the reasons seeking abortion, the authors find that only 31% of the abortions fell strictly within the grounds permitted under the MTP Act; the rest were simply that the pregnancy was unwanted (71%), economic reasons (7%) and unwanted sex of the fetus (13%).

In 2005, A Pew Forum on Religion & Public Life reported that In India, the economic role of men, the costs associated with dowries, and a Hindu tradition which
indicates that funeral rites must be performed by a male relative have lead to a cultural preference for sons.

In 2005, Rogers, Lois reported that the number of deaths due to legal abortion between the years of 1991 and 1993 was 5, as compared to the 9 deaths caused by ectopic pregnancy during the same time frame in the United Kingdom.

In 2006, according to a Polling report, the preference for sons is reported in many areas of Asia, and the use of abortion as a deterrent to female birth has been reported in Mainland China, Taiwan, South Korea, and India.

In 2006 CBS News poll, which asked, "What is your personal feeling about abortion?", 27% of Americans said that abortion should be "permitted in all cases," 15% that it should be "permitted, but subject to greater restrictions than it is now," 33% that it should be "permitted only in cases such as rape, incest or to save the woman's life," 17% that it should "only be permitted to save the woman's life," and 5% that it should "never" be permitted.

In 2006, Mutharayappa et al. asserted that between 1985 and 2005 as many as 10 million female fetuses may have been selectively aborted. Dr Prabhat Jha, University of Toronto in 2006 estimated that prenatal sex determination and selective abortion account for 0.5 million missing daughters yearly. And the sex of the previous child was a determining factor in whether a female fetus was aborted. Fewer females are born as second and third children if the first child in a family is a daughter.
In 2007, International Institute for Population Sciences published that More than 1.2 billion people live in India, approximately 26% (328 million) of whom are women of reproductive age (15–49).

In 2007, Ebenstein et al. suggested that sex selective abortion is the main cause for the rising trend in sex ratios at birth is the fact that sex ratios rise steeply with birth order and are concentrated among mothers who have daughters in previous births. Changes in enumeration of daughters or misreporting of age are unlikely to explain this rising trend as similar increases in sex ratios at birth are also manifested among Indian populations living in the US, Canada, and the UK where birth registration is nearly complete and accurate.

In 2008, Shephard suggested that pre-natal sex selection could substitute for post-natal sex discrimination. The impacts of pre-natal sex selection on the well-being of daughters in India by analyzing changes in children’s nutritional status and mortality over the time since the diffusion of sex-selective abortion. Some researchers and policy makers have speculated that sex selective abortion would reduce the number of unwanted daughters and would therefore improve the outcomes of daughters who are ever born.

In 2008, the Department of Health undertook a review of the safety, effectiveness and acceptability of early medical abortions in non-traditional settings, such as primary care. The study concluded that there was no discernible difference between the pilot non-traditional sites and their comparator sites in terms of safety, effectiveness or acceptability.
In 2008, Ganatra et al commented on research focused on another phenomenon: an increase in the sex ratios (number of males per hundred females) in India. This imbalance has been attributed to the increasing sex-selective abortions, where by parents have been provided the opportunity to carry out discrimination against daughters even before birth.

In 2009 Lin et al. examine the effects of an increase in access to sex selective abortion in Taiwan on female mortality using variation in access generated by the legalization of abortion In 1985/1986. Their findings suggest some positive associations between sex selective abortion and increasing female survival.

In 2009, Lin et al. about the effect of sex-selective abortion on child outcomes (mainly mortality). Using data from India NFHS round 1-2, examined whether there is differential change over time in the outcomes of daughters versus sons between families with high versus low likelihood of using sex-selective abortion and finds inconclusive evidence of substitution effect on mortality.

In 2010, Barcellos et al., reported that son preferences in India and other East Asian countries have been documented extensively. A large number of studies have shown that parental preferences for sons are manifested in gender differences in intrahousehold allocation of resources and medical care which result in gender differentials in child’s outcomes such as nutrition, morbidity and mortality, and in the extreme cases, in female.
In 2011, the British Pregnancy Advisory Service (BPAS) sought a judicial review to challenge the Department of Health’s view that legislation required both sets of drugs to be taken in an approved place, 11 rather than permitting women to take the second set of drugs at home. The High Court rejected BPAS’ s claim whilst going on to say that there was scope within the legislation for the Secretary of State for Health to approve changes to where the drugs could be taken. The then Secretary of State said that such changes would not be introduced without adequate piloting and evaluation in the UK. BPAS has made clear its intention to continue to push for women to have the choice to take the second set of drugs at home. This will be monitored by the BMA.

In 2011, Simmons et al suggested that parents might also attempt to adjust excess fertility and undesired sex composition of children through selective allocation of resources that results in mortality of the less desired children. Alternatively, if parents continue to bear children until they achieve their desired number of sons, daughters will have, on average, a larger number of siblings than sons. Therefore, even if parents treat sons and daughters equally within a household, daughters are expected to grow up in larger families with fewer resources per child.

In 2012, According to Sample Registration System data, women in India have an average of 2.4 births in their lifetime. This key indicator of reproductive health, known as the total fertility rate, has declined from 3.6 in 1991. Women living in urban areas have fewer children (1.8) than their rural counterparts (2.6). Reproductive outcomes vary widely throughout India, reflecting the social, demographic and economic diversity of its states and differential access to health services across the country. For example, among the bigger states, the total fertility rate varies from 1.7 in Himachal Pradesh, Punjab, Tamil Nadu and West Bengal to 3.5 in Bihar. Fertility
is higher than the national average among women living in parts of the Central region (2.9 and 3.3 in Madhya Pradesh and Uttar Pradesh), Eastern region (2.8 and 3.5 in Jharkhand and Bihar and Northeastern region (3.0 to 3.8 in Arunachal Pradesh, Nagaland and Meghalaya).

In 2013, The Ministry of Health and Family Welfare collects and publishes statistics on the number of abortion procedures provided by certified facilities. The number of procedures recorded through this data collection system was 723,000 in 2001 and 642,000 in 2008. Provisional government figures estimate that 621,748 abortions were performed in 2011–2012, and the number increased slightly to 636,306 in 2012–2013, indicating an annual rate of about two abortions per 1,000 women aged 15–49 in 2013. However, these numbers greatly underestimate the actual incidence of abortion for several reasons. They exclude all abortions done by private-sector physicians who are trained in abortion service provision but who do not work in certified facilities, as well as abortions done by physicians or other cadres of formally trained health professionals who do not have specific training in abortion service provision but who nonetheless provide abortions.

In 2014, Kassebaum NJ et al reported that maternal mortality is a key indicator of women’s health and social status, and levels in India are unacceptably high. According to Sample Registration System data, the maternal mortality ratio declined 40% over the last decade, from 301 maternal deaths per 100,000 live births in 2001–2003 to 212 in 2007–2009 and 178 in 2010–2012. Given the numerous challenges faced in accurately measuring maternal deaths, it is likely that these data undercount some maternal deaths. Two recent indirect estimates of the maternal mortality ratio in India indicate a similar decline over time, but somewhat different overall levels,
possibly due to differences in defining maternal deaths: WHO estimates indicate the maternal mortality ratio fell from 370 in 2000 to 190 in 2013, while the Global Burden of Disease study estimates indicate the it fell from 382 in 2003 to 280 in 2013. In terms of numbers, it is estimated that 50,000–72,000 maternal deaths occurred in India in 2013, significantly fewer than the 100,000 maternal deaths estimated for 2003.

In 2014, Ahmed S et al reported that women seeking abortion in India come from all socioeconomic groups, live in both rural and urban areas, and belong to all age-groups. And because a majority of Indian women reside in rural locations and many are poor or low-income, a large proportion of abortions occur among women with these characteristics. However, when the distribution of women obtaining an abortion is compared with the distribution of all women, many studies find that women who are older, more affluent and from urban locations are more likely than other women to report having had an abortion. 26% of women residing in urban areas accounted for 48% of all reported abortions, and the 20% of women in the highest wealth bracket accounted for 44% of abortions. Even after controlling for other factors, this study found that more educated women, urban women, and women with greater autonomy or household wealth are more likely than rural and poorer women to report an induced abortion.

In 2014, BMA published a report on unless abortion is necessary to save a woman’s life or prevent grave permanent injury, doctors in England, Scotland and Wales have a right of conscientious objection under the Abortion Act. At the same time, patients have a right to receive objective and non-judgmental care. Doctors with a conscientious objection should inform patients of this as soon as possible, and make appropriate arrangements for referral.
3.2 SOCIO-ECONOMIC STATUS

A number of socio economic status scales have been developed by various researchers in the past few years, but most of them are not able to meet the parameters of current changes in the society in terms of economic and technological advancement. Review of some of Socio-economic status scale being used currently, through light on the efforts of various experts in measuring socio-economic status in past decades.

In 2001, Grundy et al. concluded that the combination that would seem most promising would be either occupational social class or education paired with the Townsend deprivation indicator or perhaps a combination household resource/Townsend deprivation indicator. We would suggest that using a combination of this type in studies of health inequalities and differentials in use of health care would improve our knowledge of the extent, possible causes and consequences of social inequalities in the older population.

In 2002, Robert H et al. published that socioeconomic status (SES) is one of the most widely studied constructs in the social sciences. Several ways of measuring SES have been proposed, but most include some quantification of family income, parental education, and occupational status. Research shows that SES is associated with a wide array of health, cognitive, and socioemotional outcomes in children, with effects beginning prior to birth and continuing into adulthood. A variety of mechanisms linking SES to child well-being have been proposed, with most involving differences in access to material and social resources or reactions to stress-inducing conditions by both the children themselves and their parents. For children, SES impacts well-being
at multiple levels, including both family and neighborhood. Its effects are moderated by children's own characteristics, family characteristics, and external support systems.

In 2002, Worrall et al. suggested that one approach has been to use wealth as a proxy for income or expenditure, where wealth is measured as household ownership of assets. Single assets have been used, e.g. whether the household owns a radio. More recently, researchers have begun to use indices made up of multiple assets (sometimes including housing materials), where the weights are derived using principal components analysis.

In 2003, Bornstein et al. reported that socioeconomic status (SES) is probably the most widely used contextual variable in education research. Increasingly, researchers examine educational processes, including academic achievement, in relation to socioeconomic background be an ongoing dispute about its conceptual meaning and empirical measurement in studies conducted with children and adolescents.

In 2005, Agawal OP et al, concluded that the socio economic status (SES) is an important determinant of health, nutritional status, mortality and morbidity of an individual. SES also influences the accessibility, affordability, acceptability and actual utilization of available health facilities.

In 2005, Sirin R concluded that family SES, which will largely determine the location of the child’s neighborhood and school, not only directly provides home resources but
also indirectly provides “social capital,” that is, supportive relationships among structural forces and individuals (i.e., parent–school collaborations) that promote the sharing of societal norms and values, which are necessary to success in school.

In 2006, Singh et al. developed a scale to measure socio-economic status. Caste, family, occupation, education, income possession, land (agriculture/residential), participation in social,political, religious and academic activities, house (own/rented), size of house ets. were the areas they identified to measure socio economic status.

In 2006, The Government of India in the National Family Health Survey (NFHS - II) had used the Standard of Living Index (SLI) scale which contains 11 items viz. house type, source of lighting, toilet facility, main fuel for cooking, source of drinking water, separate room for cooking, ownership of the house, ownership of agricultural land, ownership of irrigated land, ownership of livestock, ownership of durable goods for measuring the SES both urban and rural areas for the entire country.

In 2008, recommendation of Sixth Pay Commission helps to grow economy of India. Determinations of social position are a matter of social change. It varies with time, region, culture and paying capacity of people.

In 2008, Agarwal A et al. reported that there is a need for developing a uniform system of socioeconomic classification of the population universally based on the
income with scientific basis and should be applied with ease and simplicity in each sector or strata wise of population.

In 2009, Tendulkar et al studied in the country regarding the number of people living below the poverty line (BPL families). They vary from 42% and 26% in rural and urban India. They also differ based on the different committees that had been formed to look into the problem. There is a need to identify the actual beneficiaries who will be benefitted by the government programs/subsidies. One of the tools available to measure the problem is the identification of SES of the family by applying the SES scales.

In 2010, Worrall et al. published that occupation is clearly a determinant of SES, and SES may to some extent determine the employment opportunities available. However, like education, the effects of occupation (on the risk of malaria infection and to a lesser extent utilization of interventions) are difficult to separate from the effects of SES, and such separation may be artificial and of limited operational importance.

In 2011, Sobel J et al studies of the relationship between socioeconomic status (SES) and obesity reveals a strong inverse relationship among women in developed societies. The relationship is inconsistent for men and children in developed societies. In developing societies, however, a strong direct relationship exists between SES and obesity among men, women, and children. A review of social attitudes toward obesity and thinness reveals values congruent with the distribution of obesity by SES in different societies. Several variables may mediate the influence of attitudes toward
obesity and thinness among women in developed societies that result in the inverse relationship between SES and obesity. They include dietary restraint, physical activity, social mobility, and inheritance.

In 2012, Barthely et al. surveyed to examine socio-economic differences in health, nutrition and population indicators. A potential problem with the asset index approach is differences across surveys in the assets used; and that even those studies which use a common asset index cannot be readily compared, except insofar as they provide a relative measure of poverty.

In 2013, Dasgupta et al published the largest reduction in the female disadvantage in postneonatal Mortality is observed in poorer rural households who are less likely to practice sex selection. This result could be attributed to falling family sizes which frees up household resources which has allowed investments in daughters to increase. Overall, the results suggest that sex selection and postnatal gender discrimination are practiced by different socio-economic groups.

In 2014, International Society for Equity in Health reviewed an equity lens to examine the relationship between malaria and poverty. A definition of equity commonly used in the literature is “the absence of potentially remediable, systematic differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically”.
3.3 ANXIETY LEVEL

According to the dictionary definition, anxiety is a painful uneasiness of mind concerning some impending or anticipated ill. An anxiety reaction is a state of apprehensive without an apparent object, in which attempts are made to discharge internally generated tension and to reduce anxiety through increases bodily activity. The essential aspect of anxiety is that, it brings on an internal or subjective condition. It represents a danger or threat within the person himself rather than solely on external danger.

In 2000, Seghal et al studied that anxiety may have consequences for health status and precipitate conditions such as migraine, angina, aggravation of psoriasis, asthma, eczema and other disorders; disturbance of bowel movement resulting in constipation, diarrhea or irritable bowel syndrome, unstable maintenance of diabetes; vulnerability of hospital required infections; cognitive impairment which has implication for patient teacher and self care, altered appetite and eating habits, which affect the nutrional state, insomnia and restlessness, perhaps leading to reduced healing, lethargy, which may lead to low motivation and rejection of help and lowered pain threshold. It has also been regarded as a casual factor in the development of neurosis and other behavioral disorders. Angers seems to be playing a more crucial role in the causation of chronic disease than anxiety.

In 2000, Mishra et al examined the perception of anxiety level among male and female.
In 2002, Barbara et al compared high anxiety couples with low anxiety couples and found that high anxiety couples expressed higher level not only in anxiety and stress but also in anger, sadness and fatigue.

In 2003, Saipainish determined the prevalence of source of anxiety among educated couples.

In 2004, Kockar and Gencozi investigated the importance of different source of perceived social support, socio-tropic, automatic personality dipositions, achievement expectations in predictive anxiety symptoms of couples.

In 2007, Ramli BM reported that Mothers with ADHD children are more anxious, depressed and stressed. Odd ratios are 3.8, 6.4 and 6.4 respectively. ADHD children displayed difficult behaviours in almost all CBCL subscales than asthmatic children. Externalizing behaviour caused significant anxiety, depressive and stress levels, whereas internalizing behaviours caused significant in stress level but not to anxiety and depressive levels.

In 2009, Karande S reported that the mean age of mothers was 40.14 years (+/-SD 4.94, range 25.07-54.0), 73% belonged to upper or upper middle socioeconomic strata of society, 67% were graduates or postgraduates, 58% were full-time home-makers, and 33% lived in joint families. Levels of anxiety were absent in 24%, mild in 75%, and moderate in 1% of mothers. Their mean total anxiety score was 5.65 (+/-SD 4.75,
range 0-21), mean psychic anxiety score was 3.92 (+/-SD 3.11, range 0-13), and mean somatic anxiety score was 1.76 (+/-SD 2.05, range 0-10). Their common worries were related to child's poor school performance (95%), child's future (90%), child's behavior (51%), and visits to our clinic (31%).

In 2010, Erdem Y published that out of the mothers, 33.8% were between the ages 25-29, 41.7% of the subjects had a primary education, 89.4% were housewives, 64.9% had social security and 58.9% of subjects had low family incomes. Of the 151 subjects, 75.5% had planned their pregnancy, and 41.7% were primiparas. It was determined that maternal age, education, income; planned pregnancy, having complications of pregnancy, receiving antenatal care, type of labour, gestational age of the infant at birth, reasons for hospitalization of the infant and birth weight did not affect maternal anxiety levels. Maternal anxiety was significantly related to the infants' gender and duration of hospitalization, with statistically significant differences.

In 2011, Dreisbach S reported that “There is an intense, constant fear that is hard to describe,” A recent study of about 63,700 college students found that five times as many young adults are dealing with high levels of anxiety as in the late 1930. The signs of anxiety’s prevalence among women are everywhere: Ads for anti-anxiety drugs run frequently on TV shows often aimed at women; young female stars, like the actress Amanda Seyfried, confide their own experiences in the press; websites like findthelight.net attract thousands of users.
In 2013, Yilmiz H found that anxiety levels of mothers of daughters is higher than the anxiety level of mothers having sons. Anxiety levels in mothers of such children should be taken into account, and mothers should closely be followed and if necessary, psychologically supported.