Chapter 3

Review of Literature
Before embarking on exploration of a potentially explosive problem of reproductive health of women in Dibai area, it is pertinent to review the related studies on this aspect. In the present chapter, the reproductive health related studies under different groups, relevant analysis and the literature reviewed are classified and presented. In India, a number of studies are available that have tried to assess the reproductive health related problems of women in different regions. However, none of the study has been conducted to study the status and health of the women in Dibai region. To understand the social, cultural, and reproductive issues pertaining to the development of women and their role in the society, the literature review has been carried out by the researcher. Further, the aim here was to identify the research gap that became basis to formulate the objectives for the research.

3.1 Studies Pertaining to Determinants of Fertility

L Visaria (1999) explored N.F.H.S (1992-93) to understand the impact of determinants of fertility in the reproductive health. Such variations in fertility are generally examined and understood in terms of socio economic factors. Education, income, caste, place of residence, etc, and their impact on fertility is measured cross sectionally and over time. Researches on variables that can explain the maximum variance or on possible pathways that can explain the route to decline in fertility have continued to attract the attention of social scientists. It has also been recognised that socio-economic factor can affect fertility only through intermediate variables.

Intermediate variables are termed as the exposure to intercourse, to conception and carrying the pregnancy to full term such that it results in a live birth. The
analytical framework presented by Davis and Blake (1956) nearly 40 years ago listed 11 such intermediate variables.

The study noted that the variations in fertility are generally examined in terms of socio-economic factors such as education, income, caste, place of residence. These factors can affect fertility only through intermediate proximate variables such as proportion of females married, prevalence of contraceptive use, incidence of induced abortion and the fertility inhibiting effect on breastfeeding.

Before estimating the values of each of the proximate determinants of fertility for all the major states of India, we need to examine the available evidence on the level and the observed interstate variations in the marriage patterns, breastfeeding practices, and use of contraception, and of abortion, which affect fertility.

The objective of the study was to estimate the values of the proximate determinants of fertility for major states. The objective had been achieved after examining available evidence and interstate variations in these factors. The study has empirically shown that total fecundity rate (T F), the average number of live births expected among women during their entire reproductive period, was estimated to be 11.8 births.

**A K Nanda (2000)** studied socioeconomic determinants of health among women based on a study of households of rural areas of three north Indian states. The paper aims to understand women's illness, in context of social, economic, and demographic conditions. Results of the study throw insight to the spectrum of female health status in a poor society. In spite of limitations of morbidity data, preponderance of vaccine preventable and hygiene related diseases shows the primacy of economic deprivation leading to ill health among women. The age pattern of morbidity among women reveals that females disadvantage in health begin to intensify around the age of twenty coinciding with marriage and child
birth, and persisting till the onset of menopause. Educational attainments of women indicate that the number of years spent in school, has the potential to lower the prevalence rates of illness. Women’s morbidity is high both at lower and higher income levels, indicating the relative difficulties in establishing the link between poverty and ill health without taking recourse to household commodity ownership and use. Logistic regression shows that borrowing, presence of household industry, possession of pressure cooker, extended family system, exposure to the newspaper, and higher number of children within four years of age lead to improvement in women’s health whereas poor accommodation, ownership of sewing machine, larger household size, more membership, lesser share of females in the household increase their vulnerability.

P Singh (1999) studied and analyzed the data of post survey check by the Institute for Research in Medical Statistics (IRMS). The study observed that the total fertility rate (TFR) in the post survey check is of the same magnitude as in NFHS except for Rajasthan that comes out to be +.5. The results on awareness of modern methods of family planning in the post survey check and NFHS were similar except for the 'injection' methods for the states of Uttar Pradesh, Madhya Pradesh, Rajasthan, Gujarat, Haryana and Delhi. In the post survey check, it was much lower compared to the NFHS. It may be noted that even health personnel were ignorant of the 'injection' methods of family planning and it has not been included in the family planning programme.

In the post survey check as well as the NFHS, the percentage of female sterilization has been observed broadly of the same magnitude. Further, the percentage of eligible couples using any of the modern methods of family planning in the post-survey check as well as in the NFHS was also within acceptable margin of error.
On the antenatal services, and the immunization of pregnant mothers the results by two sources presented a consistent trend. The results on delivery management by the two sources also presented broadly a consistent pattern.

P Visaria and S I Rajan (1997) pointed that in the post 1970 period, fertility had declined mainly due to the strong push given to the family planning (sterilization) programme. However, women in younger age groups (below 35 yrs of age) had not lowered their fertility; in fact, their fertility had significantly increased. A sharp decline in fertility was observed among women aged above 35. Visaria and Rajan identified the gaps in NFHS data with respect to morbidity in antenatal and postnatal periods; circumstances during pregnancy, childbirth, and postpartum period; and the content of antenatal care received. The NFHS has also not addressed critical aspects such as, the extent to which women exercise choices in those matters without coercion.

3.2 Studies Pertaining to Gender of the Child

T Patel (2004) in her article stated that since the early 1980s, India has witnessed a sharp decline in juvenile sex ratio. The question was raised that why do women go for sex determination? Are they to be blamed for it? The study addressed the issue of sex determination. Commercialization of the medical profession as well as of human relations and large publicity in mass media, have also played a part making the sex determination tests and aborting the female foetus desirable. The situation is all the more complicated when ultrasound technology is not bannable, and sex determination test is punishable unless it is done with the intent of aborting a female foetus, proving which nearly impossible.

Patel argued that mothers got rejection who gave births to daughters, barring the first daughter in some cases. The tendency is increasing among the prospering middle and lower castes in several districts in UP and MP.
Medical Termination of Pregnancy (MTP) Act of 1971 has perhaps heightened an ethic of cost benefit arithmetic. Was MTP really introduced as a choice at a time when women in most of the developed nations of the world had achieved the right to abort? Patel asked if a mother can exercise agency to keep her daughters? What happens to those mothers who make such a decision? What happens to girls who survive? Mothers and at times other family members too go through a conflict within themselves. The exceedingly greater care and vigilance in raising daughters and raising their sexuality, in arranging for grooms, dowry and life long presentations and gifts, conducive in making girls an avoidable proposition. This speaks of 'Instrumental Rationality'.

S B Agnihotri (2003) explored the results of the first population census of the millennium. The study concluded that the census revealed a number of significant changes in sex ratio patterns in the country. Firstly, the sex ratio decline among children in 0-6 age group turns out to be sharper in the urban areas (32points) than in the rural. Second, the traditional north -south divide stands significantly modified and the 'northernisation' of sex ratio is rapidly taking the urban route. The sharp decline in the urban female/male ratios among children cannot be explained away by any of the three popular escape hatches of yesteryears, i.e., migration, undercount, or biologically ordained high sex ratios at birth. This decline clearly points to one factor, i.e., sex selective abortion or female foeticide that has gained currency during the 1980s and more sharply in the 1990s.

S Sudha and S I Rajan (2003) presented evidence from the census of India to show that abnormally masculine estimated sex ratio at birth (SRB) grew more prevalent between 1981 and 1991 and female disadvantage in child mortality risks persisted. Statistical analysis suggested that women's status indicators are associated with partial protection to daughters; women's work participation more so than female literacy. Male work participation and urbanization over the decade
are associated with decreasing female disadvantage in child mortality, suggesting that modernization may be associated with sub-situation of pre- for post-natal sex selection. Changes in cultural factors also suggest links to growing female disadvantage. That is, gender bias remains firm. The study illustrated how gender inequality operates in the domains of education, employment, and marriage allowing advancement for a small section of Indian women, but not transforming gender bias for the majority.

V Patel (2002) studied the causes of adverse juvenile sex ratio in Kerala. The paper argues that census 2001 has revealed deterioration in the juvenile male female sex ratio in Kerala. Hospital birth record can help establish sex ratios at birth and thus the prevalence of female foeticide. Gender differentials in favor of males with respect to some well being indicators has been noticed. It has been noticed that male children were more likely to be completely immunized in relation to female children, leading to adverse juvenile sex ratio.

L Sami (2002) studied female differentials in famine mortality in Madras and Punjab. For most of South Asia, gender differentials in instances of famine mortality have generally shown a pattern of relative survival advantage during crisis. Sami attempts to look at gender differentials during two 19th century famines from a public health perspective. The objective was to links between gender discrimination, status, and labour force participation during the colonial period. The reason for gender discrimination is cited as the availability of food and other entitlements also, which led to an overall limitation of female life chances. Male children are given more nutritious and fatly foods and delicacies while female children rarely partake of any luxuries. Girl is allowed to die unattended, where medical would be at once called in if the son were attacked.
3.3 Studies Pertaining to Sexual and Reproductive Health

K G Santhiya and S J Jejeebhoy (2003) synthesized the available evidence on the situation of married adolescent girls and shed light on situations and choices that differ from adult women. The paper explored factors that pose abstracts to good health, namely, their relative autonomy and ability to exert choices in their sexual and reproductive lives and care seeking behaviours experienced by them. Findings argued, for measures that delay, manage, and recognize the vulnerabilities of married adolescent females. There is need to raise awareness among parents teachers and community leaders. There is also a need to hold the government accountable for enforcing the legal age of marriage for girls. Authors emphasised that programmes to enhance married girls' autonomy within their marital homes and those that encourage education and generate livelihood opportunities need to be simultaneously developed.

S Mulay (1999) in his study stated that the main thrust of the article is to evaluate demographic transition in Maharashtra, especially during 12years from 1980-92, on the basis of data made available by two national surveys on fertility and mortality rates, and family health. The study shows that despite high contraceptive prevalence in Maharashtra, there is a very moderate decline in birth rate, in the state. Better reproductive health facilities leading to reduced fetal losses, lesser childlessness and reduced breast-feeding, can be said to be the main factor contributing in increase in fertility. In such situation, only strengthening of IEC component of the family welfare services can result in decline in fertility in Maharashtra.

T K Roy, V Jayachandran and S K Banerjee (1999) in their paper attempted to explore the economic rationality of fertility preferences of India. An attempt has
been made to examine the linkage separately among couples with varying levels of education, with supposition that a stronger negative association between economic condition and fertility will emerge among the more educated couples.

This study decided to ascertain the living standard of the household where a woman lived through an indexed termed as standard of living index (SLI). It incorporated information regarding household amenities which includes type of house, availability of electricity, source of water, nature of toilet facility, and possession of livestock and consumer durable goods. Finally, a summary index has been derived on the basis of accessibility of these items by assigning weights to each item according to its economic value and importance.

The other two variables, possession of land and occupation of women, which are relevant in deciding the economic condition, have been dealt with separately. The present investigation is restricted to only four states: Kerala, Punjab, Mharastra and Uttar Pradesh.

3.4 Studies Pertaining to Trends in Fertility Behaviour in Specific Regions

A Maharatna (2002) explored the aspects related to tribal fertility in India. The study analyzed tribal fertility in comparative perspective in late 19th and early 20th century. Data for the study was collected from censuses and other surveys. He argued that the results provide indication that India's tribal population as a whole in early this century had a lower fertility than that for mainstream Hindu population. Two socio-cultural factors have been analyzed that could have shaped a relatively low tribal fertility. First is the differences in marriage pattern between tribal and Hindus. Low fertility among tribal women has been attributed to their relatively late entry into marital union. At the same time, spousal age gap at marriage is generally much smaller among tribal population than that for Hindus. Apart from marriage pattern, the second socio-cultural difference is as
female status/autonomy and degree of patriarchy. These factors contribute to a differential fertility between tribal and Hindu societies. There is relatively higher female status and autonomy (i.e. less gender discrimination) among many Indian tribes. Thus, the age at marriage female work participation and work and its implications for reproductive behaviour, and spousal separation affect the fertility among tribal women.

N Lodha and L Kumawat (2002) conducted empirical study regarding the status of tribal women and fertility. The study was undertaken with two objectives. First, to assess the attitude of tribal women towards family size, methods, and source of information used. Second, to study the decision-making power related to fertility and control over fertility. Village Swaroopganj of Bhilwara district was chosen for the study. Random sampling technique and structured interview schedule were used for data collection. The author explored issues related to knowledge of family planning and its adoption of birth control methods and source of information, decision-making, and opinion about birth control measures. Lodha and Kumawat concluded that tribals are traditionally bound by customs. After having five to seven children very few of tribals go for family planning. There is need for strong motivational government policy for family planning. There is strong need for proper education to mould their traditional taboos and beliefs. There is urgent need of proper communication system and infra-structural facilities among tribal areas for imparting family planning and services. Efficient and easy to use family planning methods are essential in order to control the birth rate. Hence, low fertility and adoption of family planning methods can improve the status of women.

3.5 Studies pertaining to the Education of Girl Child

P Sengupta and J Guha (2002) studied the impact of household demand factors on the school participation and performance in four villages and two urban wards
of West Bengal. The aim of the study was to assess the relative importance of these factors on the schooling choice made for girl children. The results indicated that some of the strongest enabling factors with regard to girls’ school participation and grade attainment were household resource factors such as parental, specially maternal schooling, fathers' occupation, and family income. Urban residence, as expected, had a strong positive association, and significant cohort effects were observed with regard to the schooling outcomes. A girl child’s labour force participation significantly reduced the demand for schooling, and the amount of schooling obtained. Religion and caste factors emerged as important determinants of schooling, as well.

D Bhog (2002) in the article "Gender and curriculum" analyzed the national curriculum framework to look at how the core thrust of the framework might impart on the likely contact of future education. Bhog argues that despite its reiterations on equality, fundamental rights and quality education for all, the emphasis of the National Curriculum framework on Indian tradition and the collapsing of value education and religious education puts on hold the possibility of education emerging as an enabling tool for women's empowerment. The article revisits, briefly, the vision and policy framework of the new Education Policy framework of 1986 with regard to women's education, analyzing the effect of progressive policy rhetoric on the actual writing of school textbooks, particularly those relating to language teaching.

K S James and S B Nari (2005) studied the trends among Hindus and Muslims with respect to decline in fertility. The paper analyzed the proximate determinants of fertility among Hindus and Muslims as against the socio-economic differentials as causes for the differences between economic behavior. The objectives of the paper are two fold.
First, it examines the pattern of fertility decline among Hindus and Muslims in India particularly in the period of accelerated fertility transition in the country. Second, it further decomposes the fertility by the four proximate determinants based on the data available from the NFHS-1998-99 to see the impact of proximate determinants on fertility on Hindus and Muslims. This study finds that Muslims fertility in India follows nearly the same pace of transition as that of Hindus, particularly in the period of accelerated fertility decline in the country. The general perception that Muslims are averse to the use of contraception needs validation.

**L Baker (2001)** analyzed how medical and scientific discourses surrounding the Delcon Shield legitimized and authorized the punishment and control of women's bodies. Women who used, or were targeted as potentials users of, the Dalcon Shield intrauterine device were judged according to normative constructions of sex, hegemonic heterosexuality, and race. Eugenics and population control discourses were significant in classifying particular women as inferior and abnormal via pathologizing discourses and practices, the reproduction and sexual capacities of women, as a sexed group, were targeted and disciplined.

**A L Bureau (2001)** presented an overview of French contraceptive and abortion history with an emphasis on 19th/20th century legislation. The voluntary reduction of the French birth rate in the 19th century, which was linked to efforts to reduce infant mortality, is described. It is noted that abortion was made illegal in France in 1810. The battle between Pro and anti natalists since than reviewed, looking as contraceptive laws, the formation of movements, papal pronouncements, and other phenomena that has influenced the debate. It is argued that changes in contraception have led to transformations in male-female relationships, the situation of children, and women's role in society. Related technological advances are also reported.
3.6 Studies Pertaining to Reproductive Health of Adolescent Girls

N de Lange and L J Geldenhuys (2001) presented the findings of research undertaken to explore and describe the experience of adolescents terminating their pregnancies. Data were collected during individual interviews with adolescents who presented themselves for termination of their pregnancies at two hospitals in the Port Elizabeth-Uitenhage area. The transcribed interviews were analyzed using descriptive analysis. Guba's measures to ensure trustworthiness of qualitative data were applied. The results are presented and analyzed as they relate to the individual, the family, the school, and society. Recommendations were made from an ecosystematic perspective to improve the experiences of adolescents terminating their pregnancies.

J Bruce (2003) explored the adolescent agenda and argued that the concept originated in western cultures; for a long time. The nature of the adolescent sexuality centered on the behavior of unmarried sexually active adolescent. Alarming pressure on their sexuality and fertility has begun to be noticed. Concerns about their social condition, their universe are just beginning to be unveiled. Addressing these concerns need a multi-pronged approach that includes implementation of laws that delay marriage and help build skills for a better life. There is a need for community-based interventions that ensure social support and the development of HIV/STI prevention strategies specific to meeting the needs of this vulnerable section.

S J Hirsch and A C Nathonson (2001) in their paper discussed distinctions made by married Mexican women in the US and Mexico between withdrawal-coitus interrupts- and rhythms methods of contraception, as well as differences between women who use more modern ones. Findings are derived from an ethnographic study of gender and reproductive health in a Mexican transitional community. The primary method used was life histories, complemented by 15
months of participant observation. The sample consisted of 13 systematically selected pairs of women; one woman in each pair is lived in Atlanta, GA, and the other lived in sending community in Western Mexico. While research on fertility regulation frequently classifies rhythm and withdrawal, as traditional methods, this study showed that those who use these methods might base their classificatory system on other conceptions, including contraceptive methods. This research shows, therefore, that ideology and social context need to be taken into account when exploring how women interpret shared ideas about sexuality.

M R Khraif (2001) examined the prevalence of family planning practices in Saudi Arabia, in addition to presenting the characteristics of users and the determinants of contraceptive use among married women of reproductive age. The study utilized data from a 1999 comprehensive demographic survey. Results show that the level of use is low 19.5% in the country, but a little higher in urban areas. Contraceptive use is higher among the more educated and among those with children. A high standard of living also predicts higher contraceptive use. By using logistic analysis, it is found that husband’s education, wife’s education, age of first marriage, number of living children, number of dead children, place of residence, and family standard of living are significant determinants of contraceptive use. It becomes clear that contraceptive use is mainly for child spacing rather than limiting fertility.

S Chatto (2004) explored the varied Islamic ideologies and contradictions regarding the sensitive issues of contraceptive and abortion with respect to family planning in Kashmir.

She argued that Muslim women in Kashmir are perceived as passive objects of state – medical control, in the interdiscursive formations surrounding the concepts and techniques of the family planning clinic. The state-the central government- consider them as primary target groups for population control. They
are perceived to be ‘conservative, superstitious and fatalistic’ because of their illiteracy and religious beliefs. The doctors perceived them as ignorant and lacking in a sense of moral responsibility towards their bodies. They have, thus, to be initiated into the ethics of responsible sexuality.

In the dominant ideology of Kashmiri Muslim men, the women are illiterate, Jahil. They are considered weak and ignorant about Islam because a majority of them cannot read the text. For the jammat and such other political parties, since ‘family planning’ is being used as a viable symbol of protest against alleged political marginalization, it is the women who must first be constrained, and controlled and taught that it is Anti-Islam. However, through the din of moralization, the women in question are using the family planning policy for their own advantage and benefit and at their own convenience. They have found a safer alternative to the drudgery of recurring pregnancies and the fear bordering on phobia of missed cycles. Contraception and abortion that were a private affair between women and midwives were now transformed into a legitimate public sphere.

The family planning clinic is the ideal space to analyze the locus of state power exercised through a particular medical technology. We can literally watch the process of the transformation of the normal into the pathological, and what Foucault 1976 calls ‘the hysterization of women on sex’. Thus it is true that through the techniques and policies of family planning, the state brought a whole body population under its surveillance and control, peeping into” people’s sexual lives. At the same time, we see that the family planning clinic carves out a public space where a community of women is created, who review the specificities of womanhood, desires, grievances, conjugal fights, and resolution if any. This space is by the women to voice conflicts within their life-worlds and to seek
autonomy from the patriarchal authority of men exercised over them in other spheres of their lives.

B K Pattanaik and K Singh (2003) explored family life, education, and reproductive health awareness among adolescents in Punjab. The sample comprised of boys and girls from secondary and senior secondary schools. They argued that knowledge is a pre-requisite to changing attitudes and affecting practices. The FLE for adolescents will enhance them to adapt safety practices for the prevention of STDs, HIV/AIDS and the promotion of reproductive health care among boys and girls. The conclusion derived from the findings and observations by teaching in FLE sessions are as follows.

1. The adolescent girls have shown greater interest than that of boys. The percentage of girl children aware about FLE is more than that of the boys.

2. The awareness about STDs, HIV/AIDS and drug abuse should be persistently taught to the adolescents, because less percentage of the students are aware about this vital aspects as compared to the other areas of the FLE.

3. A comprehensive orientation training of teachers on FLE needs to be conducted by the Teachers Training Institutes. School libraries need to be supplied with literature on FLE. Moreover, the health functionaries should conduct health scanning of adolescent boys and girls and provide them treatment and referral services.

4. The youth club members need to be oriented on FLE so that they can impart and guide to the adolescents in the village. Moreover, Mahila mandal members, Angan wadi workers, traditional birth attendants, and village health guides need to be oriented on FLE so that they can educate adolescent girls in their respective villages.
5. Specific attention and privacy has to be maintained while imparting FLE to adolescents boys. The adolescent boys’ awareness can be reinforced at the village level through focus group discussions. At the village level, youth clubs may be utilized as “Friends Corners” for adolescents’ education.

6. Imparting FLE to adolescents needs to be primary responsibility of the teachers, parents and that of the community members. Moral, ethical, and cultural education may be given in capsular form during the FLE sessions. Moreover, in villages the grassroot government health functionaries and NGO activists can train “Peer Education” who can further inculcate FLE to others.

R Kumar (2002) presented an article on gender in reproductive and child health policy. The article deconstructs the notion of gender sensitivity by unpacking the ideological assumptions that underlie the text of the policy. It examines, through a qualitative analysis of documents and interviews with policy-makers, how the state positions women within its discourses of development, health, and gender. Further, it also explores the implications of such positioning for women’s emancipation.

The analysis demonstrated that the gender ideologies found in RCH constitute a particular rhetoric about gender, women, and their needs. The production of a homogenous conception on gender destabilizes women from the center of the reproductive process. As far as the state promotes, there is no women outside of certain prescribed social roles – as mother, as wife and as community member – therefore, little need to provide a discursive space for women’s interest.

R Jeffery and P Jeffery (2000) analyzed the study conducted by Moulasha and Rama Rao, who studied religion specific differentials in fertility and family planning. They argued that the recent contribution on the relationship between
religion, fertility, and family planning used National Family Health survey data in misleading ways. By failing to consider regional patterns in the distribution of Hindus and Muslims they exaggerate the role of religious group membership in understanding fertility differences. They give spurious credence to argument that suggest that Islam in some way encourages higher fertility. They fail to consider issues of risk and uncertainty faced by religious faced by religious minorities, and they come to unwarranted policy conclusions. In order to understand inter-religious fertility differences, analyses must be based on the understanding of specific social, economic, and political contexts.

In recent paper using National Family Health Survey (NFHS) data to look at inter-religious differences in fertility. Moulasha and Rama Rao produce a table that shows that the total fertility rate for Muslim Indians of 3.30 in 1987-88 (1999:3049). Controlling for schooling level of the woman, the table shows that the differentials range from 1.1 among the illiterate to 0.6 among those who have completed middle school. Discussion of inter-religious differences in fertility has been highly sensitive in political debate in India at least since the early 1900s (Appadurai 1993; Cohn 1987; Datta 1993; Jafferlot 1995). They have recurred since 1970, with increasing vigour since 1985, in the propaganda put out by the sangh parivar.

Comparing Muslim and Hindu fertility (or mortality) is, we would suggest, a form of essentialism, presuming that Muslims (as a whole) share common features which set them apart from Hindus (as a whole) and make them appropriate units from comparison. Simple observation suggests the fallacy of such an approach. Cast differences among Hindus are only the most obvious, with major differences in social indicators for Brahmans at one extreme and scheduled tribes at one another.
Creating the unitary ‘other’ is a way in which the Sangh Parivar strengthens its claims to represent all those who regard themselves as Hindus. Demographic data that are interpreted to argue that Muslim Indians have higher fertility rates than Hindus cannot be left unchallenged.

**N Ravichandran and S Rajashree (2005)** studied women’s status in terms of the social construction of contraception and gender relations. These are predominantly influenced by patriarch and the distorted traditions in delineating women’s activities. This may be referred to as the ‘purdah’. This paper aims at providing empirical evidence to find out whether fertility intentions and contraceptive use vary with respect to women’s autonomy. The study used the multi-stage random technique for sample selection and was conducted in Tamil Nadu between August 2000 and February 2001. It learnt that the use of contraception is not a sudden decision, though in many cases it is caused by Socio-Economic pressures. However, Religion continues to play an important role in shaping not only the internal practices and legitimacy of the claims made by the voluntary organizations but also their relationship society and the individual. Inter-spouse consultation seems to set bottom line on household autonomy and freedom and subsequent adoption of contraceptive measures.

### 3.7 Studies pertaining to Maternal Health Care Services

**A Pandey et al. (2004)** studied the pattern of utilisation of antenatal care services and assistance received during delivery in three states, namely, Chattisgarh, Jharkhand, and Uttarnchal. The objectives of the paper are to examine the pattern and correlates of utilisation of ANC services and to examine the assistance received during delivery in these states. The study presents that the utilisation of ANC services in a given population depends upon availability and accessibility of services, socio-economic status of the household and distance of the health fertility. Women living in urban areas are more likely to go for ANC
services compare with their rural counterparts. Women with lower birth order are more likely to use ANC services than women with higher birth order. The findings suggested that there is a need to apprise rural women and those with higher birth order about the importance of ANC services in all the three states. This can be achieved by strengthening existing outreach services and IEC activities. The role of mass media emerges as an important correlate of ANC.

3.8 Studies Pertaining to Socio-Economic Determinants

S Rani (2006) identified the socio-economic characteristics of selected rural women leaders. For the present study, the ‘Survey’ type of research design was used. To fulfill above objective the study was confined to the rural population of Saharanpur district. Multistage random sampling technique was used. District was divided into eleven blocks. One block namely, Nanauta was selected randomly in the first stage. A sample of female leaders was selected for the study. Information regarding their socio-economic status, i.e. family income, land education, number of children, total family members, number of houses, family size and type, holding household and agriculture outputs and social participation was obtained.

Thus, it can be concluded from the present study that now a days the concept of women leadership can be seen. In our Indian rural society, it needs more attention of promoting and developing with the other people of that area. Although the existence of high caste is decreasing but high income is still a major factor of rural leadership. We must try to remove this difference in our society. Casteism demotion is a most strong weapon for the development of any rural society. The present study shows it, as our one of the leader is pradhan although she was a schedule caste woman. The main theme of this study was that women come to know their rights.