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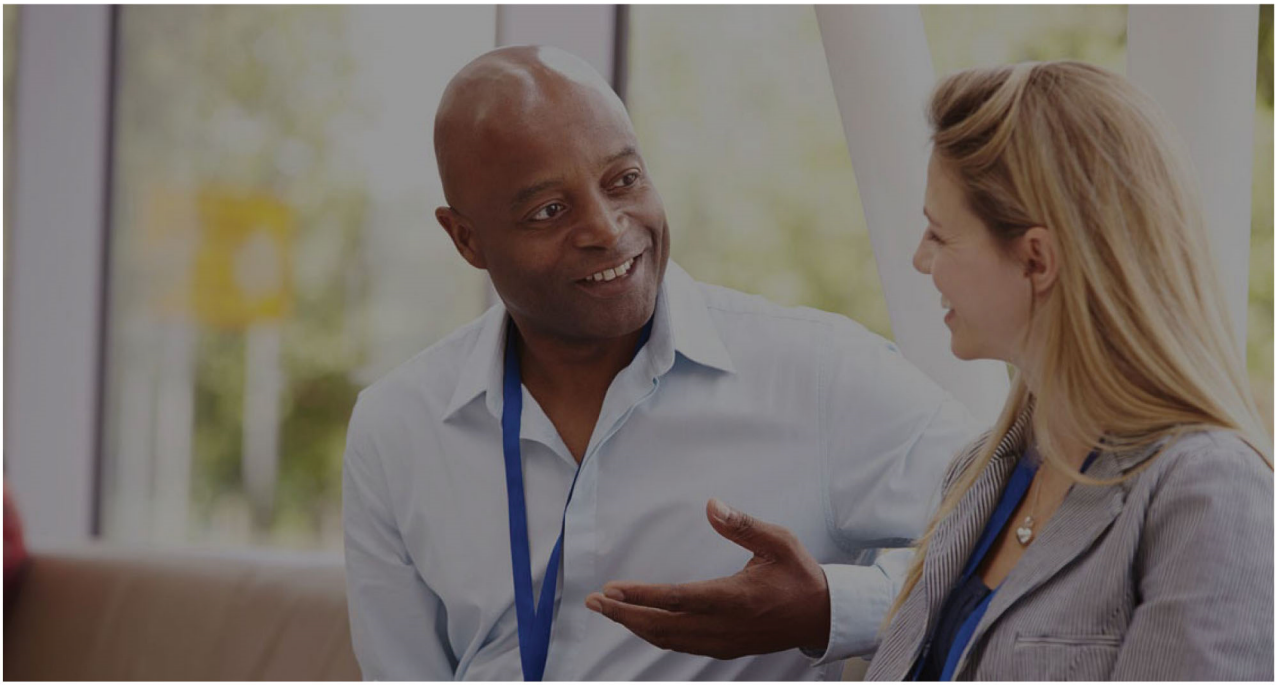

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Investigating the role of gender as a moderator in influencing the intention to use and actual use of mobile telephony

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Abstract

This paper has extended the original Unified Theory of Acceptance and Use of Technology (UTAUT) model through usage space dimensions to investigate the role of Gender in influencing the Intention to use and Actual Usage of Mobile Telephony. A framework based on Usage Space dimensions was developed by reviewing literature and then validating it in the context of Intention to Use and Actual Usage of Mobile telephony. The framework empirically examined the influence of gender as a moderator on the four determinants of the UTAUT model on the Intention to Use and examined for gendered differences in the causality between Intention to Use and Actual Usage among 417 responses. The framework was validated by using Structural Equation Modelling.

Among the four determinants considered in the UTAUT model, the influence of gender as a moderator was found in the case of Performance Expectancy (PE), Effort Expectancy (EE) and Facilitating Conditions (FC). Gender as a moderator did not influence the Intention to Use for Social Influence (SI). Gender as a moderator had a very small positive influence, more for men than for women in the case of Actual Usage (AU). The Intention to Use was found to have two distinct use patterns: Inter- Intention to Use (use for world outside) and Intra- Intention to Use (use for self). While the analysis here reinforces earlier studies that point to similarity across genders on the intensity and frequency, there were significant differences in the patterns, motivations and attitudes towards Mobile use that follow conventional gender roles. This Study provides a new research approach towards understanding how users based on gender make use of the multiple features, services and applications in their Mobile phone devices across everyday life dimensions through the Usage space dimensions. A significant new finding of this study revealed that the influence of Intention to Use on Actual Usage is a complex phenomenon and had two distinct use patterns; Inter and Intra Intention to Use.

Keywords

Mobile Usage Space dimensions, Everyday Life, Intention to Use Mobile Telephony, Actual Usage, Gender.

1. Introduction

The Mobile telephony as a technology device has been instrumental in transforming the manner in which individuals and institutions remain socially connected in everyday life. Mobile Phones in its uses and practices have become an accepted part of everyday life. It has penetrated every aspect of daily lives, owned by almost every socio- economic profile in the urban context and become a basic element of work and social life (Campbell, S.W., Ling, R., & Bayer, 2014; Jacobson, R. P.,Mortensen, C. R., & Cialdini, 2011; Taipale & Fortunati, 2014). Mobile Telephony has facilitated the restructuring of daily routines, blurring the lines between public- private, shaping social patterns and habits. The Mobile phone is a good example of a device that dislocates the traditional concept of space and time, enabling its user to bring – not only their network but the world with them. How

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the Mobile Phone and the related technologies is experienced is not totally predetermined by technological functionality or public representations but is structured by social life (Haddon, 2001).

The embeddedness and integration of Mobile Phones in everyday life has been studied in depth by Ling from the individual perspective and from the perspectives of social processes and structures (Ling R, 2004, 2010, 2012). According to Ling, Mobile communication has changed the structure and arrangement of communication at both micro and macro levels. Ling observed that the level of embeddedness of the Mobile is so deep and unconscious that its actual value and need is felt only in the absence of the Mobile device. Mobile Phone in the modern society seems to integrate time, space and communication concepts making it "flexibly instinctive" (Ling R., 2012).

At the individual level, Mobile Phone as a medium of communication has become embedded within the very arrangement of everyday life (Farman, 2012; Ito, M., Okabe, D., & Anderson, 2010). It has become as important as the wallet, keys and ID's that individuals carry everywhere with them. Mobile telephony use is a complex and contradictory phenomenon; at one end it enables better organization and coordination of everyday life and at the same time it increases the level of complexity of everyday life.

The introduction of any new technology in society and its subsequent access and control is determined by the hierarchies of patriarchy, class and other social variables including gender. The Gendered nature of the Mobile phone is located within and derived from the interactions between various meaning and actual use of the medium. Science and Technology studies (STS) and feminist scholarship approaches focus on the mutual shaping of gender and technology, in which technology is conceptualized as both a source and consequence of gender relations.

Urban professionals as a specific user group are a unique set who by the very nature of work compulsions are required to use their Mobiles extensively. These professionals have to negotiate the contradictory demands of private and professional spheres. To view their intentions towards using Mobiles and their actual usage while negotiating within the public and private spheres using a gendered lens would provide useful insights that engender their reality in their professional and personal lives.

The objective of this study is twofold. To investigate the role of gender in moderating the determinants influencing the Intention to Use Mobile Phone and to investigate the role of gender in influencing causality between Intention to Use and Actual Usage of Mobile Phone in everyday Life.

The study has been arranged into four sections. The first section provides an overview of the literature followed by the section that outlines the proposed research framework. The next section pertains to the research method used in the study. The last section presents an analysis of the results, discussion, conclusions, implications, limitations and future research scope of the study.

2. Literature Review

The literature review section has five parts. The first part reviews the literature around Mobile use practices specifically from a gendered perspective. The next part has reviewed studies based on the Unified Theory of Acceptance and Use of Technology (UTAUT), the framework used for this study. This is followed by reviewing everyday life as a concept in Mobile uses and usage space dimensions for expressing Mobile usage and the last part identifies the research gap.

2.1 Mobile uses from a gendered perspective

Several studies investigated the gender-technology relationship for differences in the perception and meaning of technology and its actual uses and also explore to reasons for these

differences. (Aronsson, G., Dallner, M., & Aborg, 1994; Busch, 1995) concluded that differences existed in terms of actual usage experience with the technology, the level of training, the ability to exercise autonomy in use and trust. (Faulkner, 2001; Henwood, 1993) highlighted that technology in everyday use and conceptualization was masculine in its orientation. According to (Jin, R., & Punpanich, 2011), technological devices continue to be representatively and symbolically more associated with men than women. (Borges & Joia, 2015) in their study of executives in Brazil found that the gendered differences in perception was rooted to structural issues that differentiate women and men based on social roles, work, family, emotional issues etc. Within Gender and Mobile use, (Ganito, 2012) concluded that the mobile phone reinforced the traditional gendering of time and the gendered division of labour. Feminization of Mobile was studied by (Lim, 2014; Shade, 2007) who concluded that the scripts used in the advertising, selling, styling and functionality of the Mobile Phones reinforced traditional gender differences in roles and relations. The gendered scripts emphasize women's primary need and uses of Mobile for social networking, leisure pursuits and maintaining familial communication.

Previous researches have also examined the practical and actual Mobile use patterns, possible reasons for the gender differences (Cardoso, G, Gomes, M. d. C, Espanha, R, & Araújo, 2007; Geser, 2006; Wang, Xiang, & Fesenmaier, 2014), cross cultural gendered usage and attitudinal patterns (Baron & Campbell, 2012), highlighting structural issues (van Deursen, Bolle, Hegner, 2015), the gender differences in meaning making, role taking and relationships in relation to Mobile Phones (Lim, 2014), gendered identities (Lemish & Cohen, 2005), Mobile use as a site for power, control and domination (Doron, 2012), gendered difference in perception of Mobile (Forgays, Hyman, & Schreiber, 2014; Gupta & Jain, 2015), Mobile as a source of liberation or oppression (Hjorth & Lim, 2012) , transnational mothering (Qiu, 2008; Vancea & Olivera, 2013).

The literature review indicates that structures, social processes, economic cultural, political realities need to be considered in understanding the manifestation of gender differences in Mobile use. Keeping urban professionals as a specific user group of this study, it can be assumed that across both genders, Mobile engagement would be intensive and on the higher side. However, there is need to examine whether intention and actual use of Mobiles are influenced by factors like societal role, work requirements, age, lifestyle, family obligations, and personal needs.

2.2 The UTAUT model

The Unified Theory of Acceptance and Use of Technology (UTAUT), is a well-established technology acceptance and use model that was formulated by (Venkatesh et al. 2003). The UTAUT model was developed to explain user intentions to use an information system and subsequent usage behaviour. As compared to the eight previous independent models from which the UTAUT model of Venkatesh et al emerged, UTAUT has been able to explain up to 70% of the of the variation in usage intention (acceptance) of technology. The UTAUT suggests that the four core constructs that directly determine technology acceptance (behavioural intention) and use (behaviour) are: Performance Expectancy (PE), Effort Expectancy (EE), Social Influence (SI), and Facilitating Conditions (FC) as shown in (Fig 1). In the UTAUT model, PE, EE and SI have direct effects on Behavioural Intention, which along with FC have direct effects on Use Behaviour. In addition to these variables the theory also considers "Moderating Factors which moderate the relations between various constructs and Intention to Use. The Moderators are Gender, Age, Experience, and Voluntariness of use" (Ahmad, 2014). The UTAUT model is presented as (Fig. 1).

This model has been extensively cited, empirically tested, validated, replicated, used

and modified since its original version across technologies, industries, cultures, countries. In Institutional and organizational context , UTAUT has been tested in Educational institutions e.g. (Birch, A., & Irvine, 2009), Government organizations e.g. (Zhan, Y., Wang, P., & Xia, 2011), in Health care e.g. (Ifinedo, 2012; Venkatesh, V., Sykes, T. A., & Zhang, 2011), within Business organizations e.g. (Anderson, J. E., & Schwager, 2004), in Digital libraries e.g. (Singh, Sharma, & Singh, 2015). (Williams et al, 2015),in their exhaustive review of 174 literature on UTAUT based researches from 2004 onwards, found that Mobile technology was the most widely examined technology within communication systems.

It is important to note here, that the original UTAUT study was based on examining the user acceptance of "new" technologies that were introduced and was used to investigate the user's initial perception, and, perception after gaining familiarity with the technology after a period of time. The UTAUT model established the influence of the four constructs of Performance Expectancy, Effort Expectancy, Social Influence, and Facilitating Condition in determining the Intention to Use (IE) and Actual Usage (AU) and also established that Intention to Use (IE) predicts the Actual Usage (AU). No study so far has examined or established the relationship of Facilitating Conditions on the Behaviour Intention. This study premises that organizational, environmental, and technical infrastructure that comprises Facilitating Conditions is likely to influence the Intention to use and proposes to examine this dimension also.

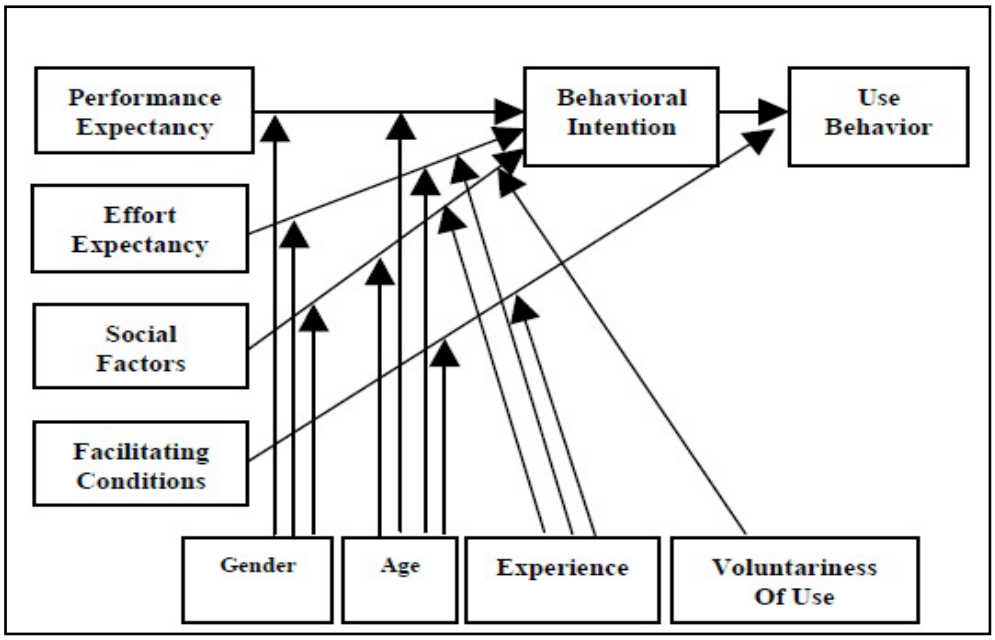

Fig 1 UTAUT Model
Source: Venkatesh et al. 2003

With respect to moderating variables, while studies by (Carmen C. Lewis, Cherie E. Fretwell, 2013; Jaradat & Faqih, 2014; Yi Shun Wang, Ming Cheng Wu, 2009) have considered gender as a moderating variable in the adoption of technologies, studies by (Guo, 2015; Yi Shun Wang, Ming Cheng Wu, 2009) specifically examined gender as the moderating variable in Mobile use. Apart from these, there is very limited research that has been done to investigate how gender moderates the

determinants influencing the Intention to Use of Mobiles among users.

Lastly , the original UTAUT study (Venkatesh et al. 2003) used only three items to measure the Intention to Use ("I intend to use the technology in the next <n> months , I predict that I would use the technology in the next <n> month and I plan to use the technology in the next <n> months). The Actual use was measured either with only one item or with system logs. This indicates that until now, the UTAUT model has looked at Intention to Use as a simple variable. Mobile use is an integral part of everyday life now and not a newly adopted technology and has become a one stop technology device to meet most everyday technology needs of individuals such as relationships, work, leisure, information sourcing, financial transactions etc. Therefore, the Intention to Use Mobile is complex and needs a deeper investigation especially for the types and variety of usage. The UTAUT model if used as is, to investigate the Mobile Phone adoption and uses would not be very helpful in understanding which features, applications and services are being used by users as they are contextual and constantly evolving.

2.3 Everyday Life

Everyday life " is a modern phenomenon and its impact on human existence and perception (repetitive and uniform aspects of everyday) is associated with industrialization, urbanization and the capitalistic economy"(Lefebvre, 1984). Gender has been an important factor in the conception of everyday life. Woman and their everyday life have commonalities to the nature of everyday (mundane, invisible, insignificant, undervalued and yet indispensable) (Featherstone, 1992). Time, Space and Modality determine everyday life (Felski, 1999). Every day is one of the most omnipresent and non-negotiable taken for granted lived reality in the human living process. Everyday life encompasses the public and private sphere, including domestic activities besides routine form of work, leisure, travel, and socializing. Every day is actually a way of experiencing the world within the act of performing a set of routine activities within the world. Tasks that appear awkward, strange, difficult initially become second nature gradually like driving or in the current context navigating technology in everyday life. The pragmatic need for repetition, familiarity and taken for grantedness in everyday life is a necessary pre- condition to human survival. (Dén-Nagy, 2014) has observed that the stringent demarcation between the time for work, family, leisure as part of everyday routines are getting diffused with technology intervention.

The Mobile Phone as a device has had a very big role and made a deep impact on the way people have become accustomed to remain socially connected in everyday life. Mobile Phones in its uses, practices have become a natural part of everyday life. It has penetrated every aspect of daily life, owned by almost every socio-economic profiles in the urban context and become a fundamental constituent of social life (Campbell, S.W., Ling, R., & Bayer, 2014; Jacobson, R. P.,Mortensen, C. R., & Cialdini, 2011; Taipale & Fortunati, 2014). (Bayer, Campbell, & Ling, 2016) developed a model to depict how societal norms and psychological perspectives influence the manner in which connection habits get triggered in everyday Mobile use. (Harmon & Mazmanian, 2013) identified that Mobile use at once triggers two contradictory discourses; of completely integrating technologically, becoming proficient in multi-tasking or becoming completely disintegrated from Mobile use in everyday life as it distracts and leads to addiction. However, the reality seems somewhere in between.

(Campbell & Park, 2008) concluded that the personal nature of technology as symbolized by Mobiles is contributing to a completely new type of social arrangement which needs to be understood along with examining the social consequences arising with the large-scale adoption and use of Mobile technologies. (Wajcman, Bittman, Johnstone, Brown, & Jones, 2008) found that Mobile use has spread across income and occupation levels; varied based on

age; convenience and micro-coordination was mentioned as the most important reason for use; connecting with family through texting was the most frequent use; managers, traders & production workers were found to be using the Mobiles most; majority of respondents followed mobile etiquettes like turning their mobile on silent in public settings; safety and indispensability was the typical association with the Mobile . (Barkhuus & Polichar, 2011) found users to have very individual ways of using their devices that involved complex interplay of adoption, rejection, adjustment, prioritization, creative options for adapting the features and functions in order to make it suitable to the specific needs of users in everyday life.

From Mobile infrastructure point of view, (Lord et al., 2015) explored the role of mobile devices in relation to network connectivity and online services in everyday lives. Everyday life thus, is an important and valuable context for studying Mobile intention to use and usage. There are no comprehensive studies that have examined everyday life use of Mobile Phones as multi-functional and convergent multimedia devices from an urban professional's perspective.

2.4 Usage Spaces

The purpose for using Mobiles Phones were identified by (Ling, R., & Yttri, 1999) as " Safety & Security , Micro coordination and Hyper coordination" . The Intention to Use Mobile has been summarized as " Mobility , Immediacy and Instrumentality along with sociability and affection " by (Han Sze Tjong, S., Weber, I., & Sternberg, 2003). Motivational needs of " Personal , Navigation and Social" have been classified by (Tamminen, S., Oulasvirta, A., Toiskallio, K., & Kankainen, 2004). According to (Katz, J. E., & Sugiyama, 2005), "power, status and identity" also influence Mobile Phone use. Safety and security as a need for using Mobile Phones has been mentioned by (Campbell, S. & Russo, 2003; Katz, J. E., & Sugiyama, 2005; Ling, R., & Yttri, 1999). All these motivational needs point to Mobile uses being around particular usage spaces such as functionality, safety, relationships navigation, status etc.

Mobile Usage around particular usage spaces has previously been conceptualized by (Marcus, A., & Chen, 2002a, 2002b, Marcus, 2005a, 2005b) who used the six dimensions of "Identity , Self Enhancement, Relationships, Information, Commerce and Entertainment. These usage space was subsequently tested in the Mobile Phone Technology Usage Model (MOPTUM) by (van Biljon, 2006) who concluded that usage spaces can represent usage variety in a way that is usable and useful to understand actual Mobile use. Usage variety was defined as "the different applications for which, or the different situations in which, a product is used" (van Biljon, 2006).

The review of literature on Mobile usage along usage dimensions suggests that it is easier to express Mobile usage in non- technical terms. Moreover, comparing specific features, services and applications that are technical, continuously evolving and termed differently by different manufacturers is cumbersome. Previous studies validate that usage space dimension is a better, more useful and usable construct to measure Mobile Intention to Use and Actual Usage as compared to the one-dimensional construct used in the original UTAUT. It must however be noted that usage spaces mentioned by previous studies have undergone significant expansion over the last decade and need to be reviewed for additional new usage spaces that will be able to reflect the current contexts.

2.5 Research Gap

The Unified Theory of Acceptance and Use of Technology (UTAUT) has mostly examined user acceptance of new technologies. Besides establishing the influence of independent Variables (PE, EE, SI, FC) and validating a strong positive relationship between Intention to Use and Actual Usage, there are no previous studies that have examined the role of gender as a moderator in influencing Intention of Use on Actual Usage using usage spaces as a measure and using everyday life as a concept. (Michael D

Williams Nripendra P Rana Yogesh K Dwivedi, 2015) concluded that publications and conferences on UTAUT research have mainly emerged from the US. Thus, there exists opportunities for original research that are region, cultural and context specific. Looking at studies that have specifically considered the moderating effects of gender on Mobile uses, a significant gap in research exists in examining how gender impacts the adoption of mobile usage in the urban Indian context.

3. Research Framework and Hypotheses

According to (Williams et al, 2011; Dwivedi et al, 2011), gender as a moderating variable in UTAUT cited articles has not been considered along with all constructs of UTAUT model.

The literature review reveals that the original UTAUT and subsequent studies thereafter have only examined the relationship between Facilitating Conditions and Actual Usage and have overlooked the influence of Facilitating Condition on Intention to use. This study will also examine this relationship.

The research framework (Fig. 2) aims to fill these gaps and explore the moderating role of gender in the domain of Mobile usages among one of the most intensive users of Mobiles, urban professionals.

Objectives

The study will examine two objectives. The corresponding hypotheses are mentioned alongside the objectives.

1. To investigate the role of gender in moderating the determinants influencing the Intention to Use Mobile Phone.

The following Hypotheses are proposed:

H1: The influence of Facilitating Condition (FC) on the Intention to Use (IE) Mobile Phone will not be moderated by gender.

H2: The influence of Performance Expectancy (PE) on Intention to Use (IE) Mobile Phone will not be moderated by gender.

H3: The influence of Effort Expectancy (EE) on Intention to Use (IE) Mobile Phone will not be moderated by gender.

H4: Social Influence (SI) on Intention to Use (IE) Mobile Phone will not be moderated by gender.

H5: The influence of Facilitating Condition (FC) on the Actual Usage will not be moderated by gender.

2. To investigate the role of gender in influencing causality between Intention to Use and Actual Usage of Mobile Phone in everyday life?

The following hypothesis is proposed:

H6: The Intention to Use (IE) Mobile Phone will not be moderated by gender in influencing its Actual Usage.

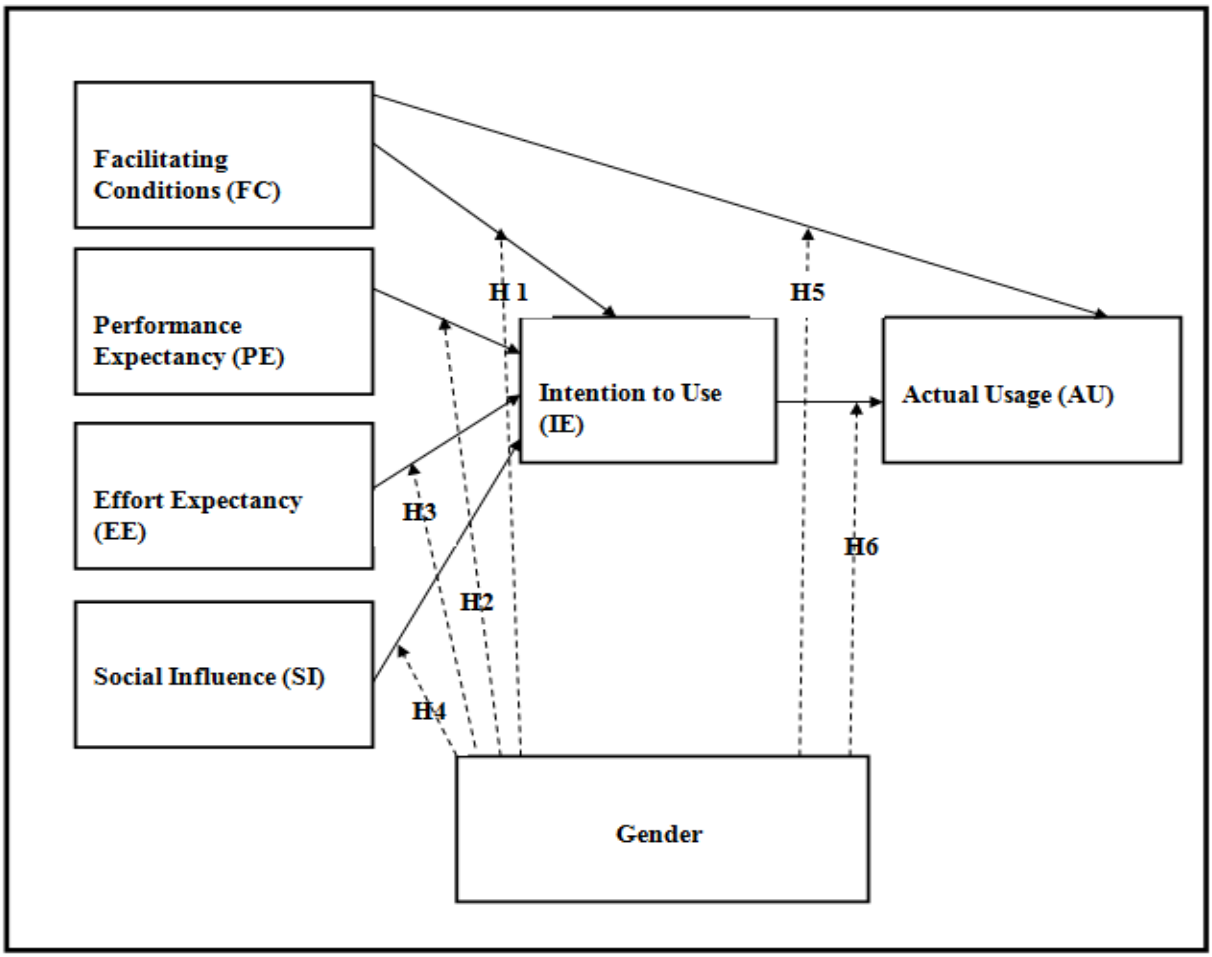

Fig. 2: Research Framework

The working definitions of the Independent Variables, Intention to Use (IE), and Actual Usage (AU) used in this study are provided as (Table 1). This study has examined the Intention to Use (IE) and Actual Usage (AU) from the point of usage space based on the original Usage Space Model conceptualized by (Marcus, A., & Chen, 2002a, 2002b, Marcus, 2005a, 2005b). Using Marcus and Chen's Usage space model and the MOPTUM model (van Biljon, 2006) as a starting point and based on exploratory interviews, this study identified 12 Usage Spaces that urban professionals usually used in everyday life. Subsequently using Focused Group Discussions, the usage spaces were reduced to 10 as depicted in (Fig. 3).

The Usage Space dimensions along with their definitions have been summarized as (Table 2).

S. No.	Variable	Original Definition	Relevant References	Working Definition
1	Facilitating Conditions (FC)	The degree to which an individual believes that an organizational and technical infrastructure exists to support use of the system.	(Viswanath Venkatesh, Michael G. Morris, Gordon B. Davis, 2003) pp453	The degree to which an urban professional believes that organizational, environmental and technical infrastructure exists to support the use of Mobile Phones in everyday life.
2	Performance Expectancy (PE)	The degree to which the individuals believe that the use of the technologies will results in performance gains. This may also be viewed as the perceived usefulness of the technologies.	(Viswanath Venkatesh, Michael G. Morris, Gordon B. Davis, 2003) pp 447	The degree to which an urban professional believes that using a Mobile Phone would improve his or her everyday performance.
3	Effort Expectancy (EE)	The degree of ease of use of the technologies.	(Viswanath Venkatesh, Michael G. Morris, Gordon B. Davis, 2003) pp 450	The degree of simplicity associated with the use of Mobile Phones in everyday life.
4	Social Influence (SI)	The extent to which the individuals believe that important others believe that they should use the technologies.	(Viswanath Venkatesh, Michael G. Morris, Gordon B. Davis, 2003) pp 451	The degree to which an urban professional perceives that important others believe he or she should use Mobile Phones in everyday life.
5	Intention to Use (IE)	Behaviour intention to enact the behaviour of a technology.	(Davis, 1989; Marcus, A., & Chen, 2002; Viswanath Venkatesh, Michael G. Morris, Gordon B. Davis, 2003) pp 456	The degree to which the urban professional perceives his or her motivation in the purpose and variety of using Mobile Phones in the various dimensions of everyday life.
6	Actual Usage (AU)	The actual use of the mobile phone measured in terms of frequency of use, type of uses (i.e. how many different applications), dimensions of uses in everyday life.	(van Biljon, 2006)	The degree to which the urban professional uses Mobile Phones in the various dimensions of everyday life.

Table 1 Working Definitions

S. No.	Usage Space Dimensions	Definition
1	Relationships (REL)	Building and maintaining relationships e.g. phoning, messaging friends, family.
2	Work Management and Organization (WMO)	Making arrangements, coordinating, scheduling, communicating for official activities.
3	Family and Household Coordination (FHC)	Meal planning, arranging for goods, services, coordinating, scheduling, supervise children while on the move etc.
4	Expansion (EXP)	Using Mobiles as a tool for exploring and finding one's way in new environments, location navigation etc.
5	Personal Information (PI)	Finding personal information such as Phone books, reminders, alarm, creating personal history of photos, messages, recording and storing things, personal health and medical tracker, spiritual discourses, blogging etc.
6	Non-Personal Information on Services and Products (NPI)	Finding information such as current news, prices, sport results, weather, dictionary, reading, stock market etc.
7	Self-Image (SELF)	Enhancing image by brand, model, ringtone, accessories, profile picture, other ways of personalizing of the phone.
8	Entertainment and Leisure (ENT)	Listening to music, jokes, playing games, watching videos or subscribing to chat rooms, reading etc.
9	E Commerce (ECOM)	Financial transactions, e.g. electronic banking, transactions, notifications from the bank, online shopping, travel booking, booking movie shows etc.
10	Safety and Security (SAFE)	Ensuring and enhancing safety e.g. allowing people to call for assistance, summon aid or assistance in emergencies.

Table 2 Usage Space Dimensions Definitions

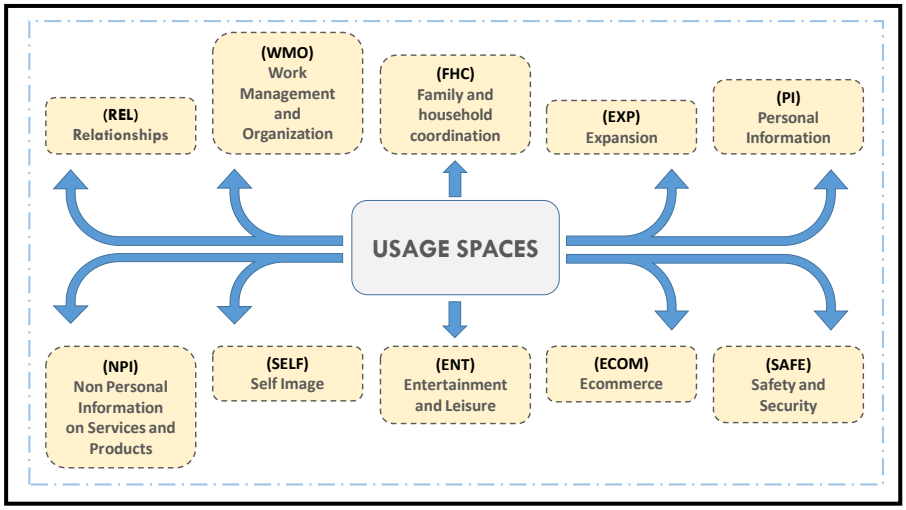

Fig. 3 The Usage Space Dimension

4. Research Method

This section will provide an outline of the research method used in this study.

4.1 Participants

The data for this study has been collected from urban professionals located in the National Capital Region (NCR), Delhi. NCR provides a good representation of the Organized sector consisting of Government and Private which includes Indian and Multinational Companies across diverse sectors. The tertiary sector consisting of trade, hotels and restaurants, transport, communications, financial and insurance services, real estate, public administration and other social and personnel services is the key driver of NCR's economy (Economic Survey of Delhi, 2013). It can therefore be concluded that for selecting the Sampling Universe for this research study, NCR has all the criteria required for providing a good representation of the sample of urban professionals.

4.2 Construct measurement

The study used standardized statements from the original UTAUT model study with minor modifications for measurement of the Independent Variables (Venkatesh et al. 2003). The Intention to Use and Actual Use were adapted and modified from the MOPTUM model (van Biljon, 2006) and from inputs obtained from exploratory interviews. The pretest for content validity was established with the help of Expert Opinions and Focus Group Discussions for item refinement, addition and deletion. A pilot test was performed on 100 respondents in order to calculate the reliability measure, to assess the consistency of the statements, which showed satisfactory internal reliability and convergent validity. A total of 10 statements for the Independent Variables, 12 statements for Intention to Use and 15 statements for Actual Usage were used to measure the Variables. A five-point Likert scale was used for measuring, 1 being (Strongly Agree) and 5 being (Strongly Disagree).

4.3 Research Instrument

A structured questionnaire was used to measure the Intention to Use and Actual Usage behaviour through self-reported usage on a five-point Likert scale, which was different than the original UTAUT model that used log data. The instrument was designed as per the constructs defined previously. The questionnaire contained closed-ended questions about the various items in each construct. The questionnaire was pre-tested for its structure on a sample of 100 respondents selected through convenience sampling for the purpose of testing the reliability of the questionnaire. Analysis of the pilot study indicated that few of the items within some constructs were not explaining the relation among the constructs. Therefore, necessary modifications were done to establish a more valid relationship among the constructs. A total of 29 statements out of the initial 37 statements altogether were validated and finally used in the model.

4.4 Data Collection and Sampling

Data Collection process was undertaken between June and September 2016. The study was proposed on a stratified random sampling which means that groups and categories which are particularly relevant for exploring the research objectives (Gender, Age, Industry Diversity, Managerial Levels in Organizations) were selected to guide the sampling process. Since the study is through a gendered lens, it was essential to bring out comparative data to look at the gendered differences in the Intention to use and Actual Usage of Mobile phones in everyday life of urban professionals. The Structured questionnaire form was administered to a total of 422 professionals in the age group of 21- 60 years. A total of 417 responses were considered valid and have been included in the study out of which 126 (30.21%) were from women and 291(69.78%) were from men.

The sample were selected from professionals who belonged to the top 10 occupational group as per the quintile income classes in terms of share of employment in terms of highest Quintile

income class in Delhi (Institute of Human Development, 2013)*, were part of the Managerial cadre in the Corporate sector and belonged to the upper most segment of the consuming class-A1, A2 and B1 of the socio-economic classification, and segments of urban India. These profiles were familiar with electronic gadgets, owned Mobile Phones and were using them in their daily life.*

The survey was conducted in three ways; Paper and Pen version, Online version on Google Form and a WhatsApp link also linked to the Google Form. All versions were in English considering the educated profile of the participants. The Paper and Pen version was administered to professionals either in their offices as groups or individually.

5. Data Analysis and Results

The data was imported to SPSS 21 and was coded in specific variables. The data were quantitatively analysed and interpreted using SPSS 21 tools. The Confirmatory Factor Analysis (CFA) and Structural Equation Modelling (SEM) were conducted using AMOS 21 software. Establishing the reliability of the different constructs was followed by Exploratory Factor analysis (EFA) after which Confirmatory Factor Analysis (CFA) was performed using structural equation modelling (SEM) to confirm the findings. The following sub-sections describe the result of the analysis.

5.1 Reliability Analysis

Cronbach's α was used to evaluate reliability. Values of 0.7 and above are normally considered acceptable (Hair, J. F., Anderson, R. E., Tatham, R. L., & Black, 1998). Though the Cronbach's coefficient alpha value of .657 for PE and .611 for FC were below the 0.7 threshold, they were not dropped from the model because of their importance in the original model (Table 3). Besides as mentioned by (Field, 2013), values below 0.7 can be expected when working with psychological constructs owing to the diversity of the constructs being measured.

5.2 Validity Analysis

Most researchers agree that EFA is usually preferred for developing scales and CFA is more appropriate for validating scales (Hurley et al. 1997). The Independent Variables: PE, EE, SI and FC, are all constructs that have been previously tested in the UTAUT model and therefore construct validity was not required to be verified. Therefore, CFA for establishing the validity of the model was directly performed to check the loadings of the factors, considering that there was an a priori, theoretically-driven specification of factors, i.e., the exact number of factors and how these factors are related to their items (Brown, 2006; Hair et al. 2010).

For Intention to Use (IE) and Actual Usage (AU), factor loadings and KMO and Bartlett's test of sphericity were considered to check validity.

EFA was conducted to check the construct validity. Principal Component Analysis Extraction Method was used and Varimax Rotation Method with Kaiser Normalization converged in 3 iterations for both IE and AU as shown in (Table 4 and 5). It was interesting to observe that in the case of IE, all factors that were concerned with coordinating and using Mobile with the world outside that included Relationship, Work Management & Organization and Family &Household Coordination loading under Component 2 These have been termed in this study as Inter Factors. All factors that involved coordinating and using Mobile for personal self-included Expansion, Personal Information, Non-Personal Information, Self-Image, Entertainment and Ecommerce loaded on Component1 and have been termed Intra Factors. The value of Kaiser-Meyer-Olkin results (Table 6) were all above 0.8 which is good as anything above 0.7 is acceptable. Barlett's test of sphericity is also significant (.000) as the resultant value is less than .005 (Table 6). Thus, the measures of the scale used in the study show good content validity. Reliability and convergent validity of the factors were estimated by composite reliability and average variance extracted (Table 7). CR of each construct was above or close to 0.7 and AVE of each construct above or close to 0.5, and AVE was less than CR (Bagozzi, RP & Yi, 1988; Hair et al. 2010), showed good internal consistency .

Factors	Abbreviation	N of Items	Cronbach's Alpha
Facilitating Conditions	FC	3	.611
Performance Expectancy	PE	2	.657
Effort Expectancy	EE	2	.750
Social Inclusion	SI	3	.730
Intention to Use	IE	12	.865
Actual Usage	AU	15	.885

Table 3 Reliability Statistics

	IE	
	Component	
	1	2
Relationships (REL) IE		.797
Work Management and Organization (WMO) IE		.832
Family and Household Coordination (FHC) IE		.560
Expansion (EXP) IE	.579	
Personal Information 1 (PI 1)IE	.673	
Personal Information 2 (PI 2) IE	.810	
Personal Information 3 (PI 3) IE	.748	
Non-Personal Information (NPI) IE	.775	
Self-image (SELF) IE	.584	
Entertainment (ENT) IE	.820	
E-commerce (ECOM) IE	.724	

Table 4 Rotated Component Matrix (IE)
Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization (Rotation converged in 3 iterations)

	AU	
	Component	
	1	2
Relationships 1 (REL 1) AU		0.769
Relationships (REL 2) AU		0.904
Expansion 2 (EXP2) AU	0.69	
Personal Information 2 (PI2) AU	0.67	
Non-Personal Information (NPI) AU	0.736	
E-commerce 1 (ECOM 1) AU	0.841	
E-commerce 2 (ECOM 2) AU	0.871	
Safety 2 (SAFE2) AU		0.719

Table 5 Rotated Component Matrix (AU)
Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization (Rotation converged in 3 iterations)

.

		IE	AU
Kaiser-Meyer-Olkin Measure		0.87	0.822
Bartlett's Test of Sphericity	Approx. Chi-Square	478.059	398.126
	df	55	36
	Sig.	0	0

Table 6 KMO and Bartlett's Test

Construct	Items	Factor Loading		CR	AVE
FC	3	fc1	0.761	0.7457	0.495474
		fc2	0.643		
		fc3	0.702		
PE	2	pe1	0.699	0.61162	0.441253
		pe2	0.627		
EE	2	ee1	0.78	0.800072	0.667197
		ee2	0.852		
SI	3	si1	0.761	0.74654	0.496266
		si2	0.668		
		si3	0.681		
IE	11	REL	0.797		
		WMO	0.832		
		FHC	0.560		
		EXP	0.579		
		PI1	0.673	0.779054	0.149185
		PI2	0.810		
		PI3	0.748		
		NPI	0.775		
		SELF	0.584		
		ENT	0.820		
		ECOM	0.724		
AU	8	REL1	0.769		
		REL2	0.904		
		SAFE 2	0.719		
		EXP 2	0.690		
		PI2	0.670	0.841901	0.240692
		NPI	0.736		
		ECOM1	0.841		
		ECOM2	0.871		

Table 7 Internal Consistency

5.3 Confirmatory Factor Analysis (CFA)

A confirmatory factor analysis using AMOS 21 was performed to test the measurement model. Seven common model-fit measures were used to assess the model's overall goodness of fit: the ratio of Chi Square (CMIN) to degrees of freedom (*df*), Goodness-of-fit index (GFI), Adjusted Goodness-of-Fit Index (AGFI), Normalised Fit Index (NFI), Comparative Fit Index (CFI), Root Mean Square Residual (RMR) and Root Mean Square Error of Approximation (RMSEA). A model is considered a good fit if the value of the chi-square test is insignificant, and at least one incremental fit index (like CFI, GFI, TLI, AGFI, etc.) and one badness of fit index (like RMR, RMSEA, SRMR, etc.) meet the predetermined criteria. Most measures were in the acceptable range which satisfy the criteria for goodness-of-fit as provided in (Table 8).

The comparison of all fit indices with their corresponding acceptable values provides evidence of a good model fit. df, degrees of freedom, goodness-of-fit index; AGFI, adjusted goodness-of-fit index; NFI, normalised fit index; CFI, comparative fit index; RMSR, root mean square residual; RMSEA, The Root Mean Square Error of Approximation.

5.4 Hypotheses Testing

Structural Equation Modeling (SEM) was used in order to test the hypotheses pertaining to Intention to Use and Actual Usage. The SEM tested all the six proposed hypotheses in the proposed model at $p < 0.05$ significance level. The empirical analysis reveals that alternate Hypotheses H1a, H2a, H3a are accepted. This means that the Influence of Facilitating Conditions (FC), Performance Expectancy (PE) and Effort Expectancy (EE) on Intention to Use (IE) Mobile Phone will be moderated by gender among urban professionals. Null hypothesis H4o and H5o are accepted which means that the influence of Social Influence (SI) on Intention to Use (IE) Mobile Phone and the influence of Facilitating Condition on the Actual Usage (AU) will not be moderated by gender among urban professionals. H6a is accepted which means that that the Intention to Use Mobile Phone among Urban Professionals will be moderated by Gender in influencing its Actual Usage. (Table 9) provides the overall results. (Fig. 4) depicts the Standardized path coefficients for men and women, at significance level, $p < 0.05$.

6. Discussion and Conclusion

The Study found that gender as a moderator had an influence in case of FC, PE, EE. This is one of the only studies in the recent past that has examined the relationship between FC- IE. The study revealed that gender as a moderator was stronger for women than for men in case of FC-IE. Although, this study has not specifically examined the possible causes for the same, the overall picture suggests that women largely depend on the significant others (usually spouses, children, colleagues) on their Mobile decisions and extending this further, also on the infrastructural support to enable Mobile use. Future studies should investigate this dimension for providing an explanation to this causality.

The influence of gender as a moderator in the case of PE was such that it was strong and positive for men and negative for women. This confirms previous researches by (Abdulwahab Lawan, 2012; Carmen C. Lewis, Cherie E. Fretwell, 2013; Chian-Son Yu, 2012; Viswanath Venkatesh, Michael G. Morris, Gordon B. Davis, 2003) that established that PE is stronger for men than for women. In the context of urban professional men, one can hypothesize that they are more task oriented and this reflects in the PE being stronger. The earlier literature reviewed also mentions that gender differences in PE can also be attributed to gender roles and the socialization process which gets reflected even in Mobile use. Gender roles are deeply embedded and more enduring, so any change to occur would be a gradual process.

Fit Indicators	Observed Value Independent Variables	Observed Value Intention to Use (IE)	Observed Value Actual Usage (AU)	Observed Value SEM Model Fit	Recommended Value	Source
CMIN/DF	3.079	3.259	3.585	2.839	1≤CMIN/DF≤3: Very Good Between 2-5: Acceptable	(Kline, 2004)
GFI	.955	0.942	.959	.937	≥0.9	(Joreskog & Sorbom, 2002)
AGFI	.914	0.911	.922	.898	≥0.8	(Hu, L.-T., & Bentler, 1999)
NFI	.922	0.911	.765	.682	≥0.8	(Bentler, P. M., & Bonett, 1980)
CFI	.945	0.936	.812	.755	≥0.8	(Bollen, 1986)
RMR	.027	0.047	.065	.057	≤0.07	(Browne, M.W. & Cudeck, 1993)
RMSEA	.071	0.074	.079	.066	<0.05: good fit; <0.08: reasonable fit	(Steiger J H, 2007)

Table 8: Model Fit Summary

Relationship	Estimate			P value			Results			Hypotheses
	Overall	W	M	Overall	W	M	Overall	W	M	
H1 FC-IE	0.53	0.57	0.48	***	0.127	***	Sig	NS	Sig	Accept H1a
H2 PE-IE	0.17	-0.13	0.5	0.201	0.54	0.006	NS	NS	Sig	Accept H2a
H3 EE–IE	0.44	0.5	0.45	***	0.053	***	Sig	Sig	Sig	Accept H3a
H4 SI–IE	-0.16	-0.294	-0.26	0.427	0.425	0.206	NS	NS	NS	Accept H4o
H5 FC-AU	0.09	0	0.1	0.231	0.217	0.984	NS	NS	NS	Accept H6o
H6 IE-AU	0.87	0.73	0.86	***	***	***	Sig	Sig	Sig	Accept H7a

* sig, p < *0.05*

Table 9: Results of Hypotheses Testing

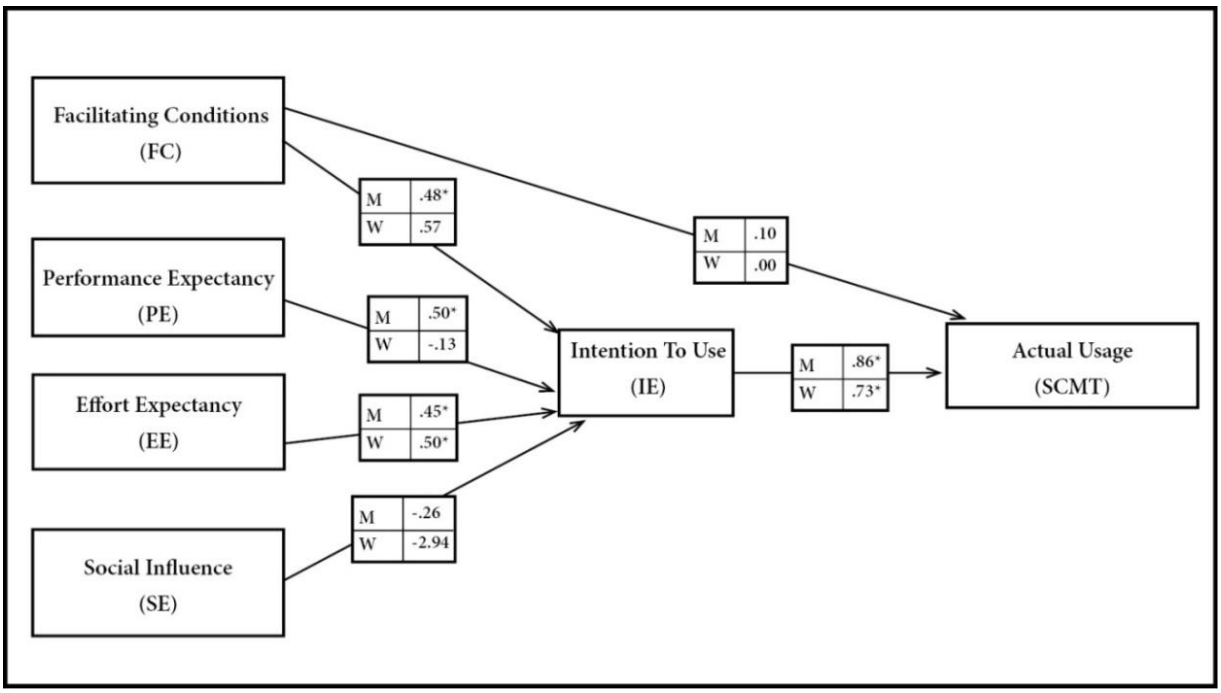

Fig. 4 Standardized path coefficients for Men and Women, * sig, p < *0.05*

In case EE, gender as a moderator was stronger for women than for men which confirms previous researches by (Carmen C. Lewis, Cherie E. Fretwell, 2013; Viswanath Venkatesh, Michael G. Morris, Gordon B. Davis, 2003). However, it is to be noted that with sustained and repetitive usage, the expertise increases which is likely to reduce the influence of EE on IE.

The effect of Social Influence (SI) was insignificant and gender as a moderator did not influence the Intention to use. This finding is contrary to the literature review that indicates that the socialization process and the gendered nature of social roles would influence the SI on IE such that it would be stronger for women than for men (Abdulwahab Lawan, 2012; Carmen C. Lewis, Cherie E. Fretwell, 2013; Viswanath Venkatesh, Michael G. Morris, Gordon B. Davis, 2003; Yi Shun Wang, Ming Cheng Wu, 2009). Or even otherwise where it was found to be stronger for men than for women (Yi Shun Wang, Ming Cheng Wu, 2009). This can be explained such that Mobile technology particularly in the context of urban professionals is not a new technology and "with experience the role Social influence is likely to reduce" (Venkatesh et al. 2003, pp 453). The embeddedness and integration of Mobile in everyday life across genders is so deep that life would not function smoothly without the Mobile. Therefore, it can be inferred that Mobile use for urban professionals in mandatory work context or in personal and social context has moved out of the ambit of the influence of important significant others in everyday life.

The path coefficient for FC- AU was also not found to be significant for either men or women. This implies that FC has little role to play in Actual Usage. This can be explained such that urban professionals have found multiple ways to navigate and solicit support for their use in the form of carrying dongles, modems to remove any actual barriers and hindrance such as poor network connectivity to sustained Mobile use.

With respect to gender and the relation between IE- AU, there was high positive, significant causality between Intention to Use (IE) and Actual Usage (AU), being stronger for men than

for women. This means that the intention to adopt and subsequent use of Mobile Phones also follows the traditional gendered pattern as found in most other technologies where it is initially acquired and adopted by men followed by women. The reason for this gendered pattern has been mentioned in several studies on gender- technology relationship that were discussed previously in the literature review section (Aronsson, G., Dallner, M., & Aborg, 1994; Borges & Joia, 2015; Busch, 1995; Faulkner, 2001; Henwood, 1993; Jin, R., & Punpanich, 2011) .

The study has revealed that the Intention to Use shows two distinct patterns in use when studied from the Usage Space dimensions: Self Usage termed as "Intra Intention to Use" and usage in relation to the world outside termed as "Inter Intention to Use" are important findings of this study that warrant more detailed study across different usage groups. The empirical model used in this study shows that in the case of Intention to Use (IE), the Usage spaces follow a clear distinction between using Mobile for Self- Intra IE (Expansion, Personal Information, Non-Personal Information, Self-Image, Entertainment and Ecommerce) and using Mobile with the World outside- Inter IE (Relationship, Work Management & Organization and Family &Household Coordination). This also implies that the influence of Intention to Use on Actual Usage is a complex phenomenon and future studies using UTAUT to study Mobile usage should look at Intention to Use as a multi-dimensional variable.

Implications, limitations and future research scope

The Practical Implications of this research demonstrates the value of studying reported Intention and Actual usage using a new approach of usage dimensions to analyse adoption on a practical level in the Indian context. It is clear that not everybody uses all the features, applications or services available on the Mobile and therefore the presented approach of studying usages across separate usage dimensions gives a better analysis. For organizations, it provides insights on how differently and similarly Mobiles are being deployed by professionals based on gender. This study has provided an overview on Mobile usage, their negotiation within the public and private spheres which reveal areas for organizations to work on policies to enable professionals to manage their conflicting priorities such as balancing work and family life. From a broader standpoint, the study provides useful insights to further socio- cultural studies of mobile communications through a gendered lens. For Mobile Companies, it provides data that can be utilized for moving the focus from mere functionality of Mobile Features and Services to incorporating the socio- cultural dimensions in designing Mobile Phones and Services.

Although the sample from NCR, Delhi was adequate for the purposes of the present study, future studies could include different and more diverse samples from across India to further enhance variability in responses. Like in all questionnaire-based studies, this study also captured only self-reported usage of the respondents. This can be resolved in future research by undertaking actual observational studies and capturing real time data, using a multi method approach that could make the observations and data more accurate and richer. Another limitation of such a study is the contextual nature of Mobile Uses which are moving targets, are continuously evolving and rapidly changing which makes it difficult to generalize.

With respect to future research directions, future studies using UTAUT to study Mobile usage should look at Intention to Use as a multi-dimensional variable. This study pointed out the high causality between FC–IE which suggests that future studies must consider FC as an important determinant that influences the Intention to use Mobiles. However, the scope of this study did not include investigating the results between the strong causality of FC–IE and weak FC–AU. It is suggested that future studies

should examine this dimension for explaining the causality. There is a potential to explore extending the UTAUT model beyond Behaviour Intention and Actual Use Behaviour to also measure consequences and impact in different life spaces of everyday life. The UTAUT model can be quantitatively used to substantiate trends and directions of long-term longitudinal Mobile use consequences and impact.

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Medico-Legal Evidence in Rape Cases: Analysis with Special Reference to Sri Lanka

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Abstract
Rape incidents against women have increased due to various reasons over the past few years in Sri Lanka. In the recent past, the brutal nature of the rape incidents has escalated along with the subsequent assassination of the rape victims. It is a known fact that the dark figure rate of rape is considerably higher than the reported rape incidents in Sri Lanka. Many reported rape cases are not concluded with conviction and this allows the perpetrators to unjustly enjoy impunity. This thrusts victims into vulnerable situations shrouded in social stigma. Medico-legal evidence plays a vital role in rape cases; perhaps, it may be the best evidence that the prosecution has to prove the case. Furthermore, the medico-legal evidence can be used for the purpose of corroborating the story of the victim. This evidence has immense probative value as the witness is an independent third party who is a professionally qualified expert in the field of forensic medicine and the Law of Evidence in Sri Lanka considers the opinion of expert as direct evidence. The quality and the reliability of medico-legal evidence depends on the medico-legal examination performed on the victim. An efficient medico-legal service is of utmost importance in this regard. In many instances, medico-legal evidence has not been consistent with the story of the victim which have raised concerns regarding the quality of medico-legal evidence and medico-legal services available. The objective of this paper is to review legislation relating to medico–legal evidence and services in Sri Lanka to improve its quality such that justice is provided to the rape victim through a successful prosecution.

Keywords
Medico-legal evidence, medico-legal service, offence of rape, Sri Lanka

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1. Introduction

Committing the offence of rape has been recognized as a social and public health issue. In Sri Lanka it is considered as a gender specific violence, committed by a man against a woman. In addition to the physical injuries, a rape victim has to under go mental trauma (Guidelines for medico-legal care for victims of sexual violence, pp 12-16; *Rattan Sing vs. State of Punjab* 1979 4 SCC 719; Jack Straw, 1999 cited in Sanders, 2002, p. 197) associated with social stigma. In a culturally conservative country like Sri Lanka, such an incident would be seriously devastating to mental health, physical wellbeing, self-esteem and adversely damages the social recognition and future aspirations of a woman. In some cases, the woman is ostracized by her own family. Unlike other offences that are categorized under physical offences against the human body, the offence of rape entails both immediate and long-term sexual and reproductive health issues as well.

Bringing the perpetrators before the justice system and punishing them is necessary to provide justice to the rape victim. Often, the

victim is the only witness to the crime. From investigation to determination of the verdict, the woman has to recall and repeatedly converse with the officials of the criminal justice system about the painful ordeal she underwent. Due to this, rape victims are often hesitant when cooperating with authorities. Therefore, contradictions occur between the first complaint made to the police and the testimony (evidence) given at the trial in the court by the rape victim. These contradictions results in the victim losing her case.

According to the existing criminal law, in a rape case, prosecution should prove that the accused had the purported sexual activity with the victim without her ('voluntary') consent (Section 363 of the Penal Code). Independent (expert) third-party (forensic) science-based evidence known as medico-legal evidence is extremely important in proving her account at the court of law. It depends on the quality of such evidence. Assessing and maintaining the accuracy of collection and preservation of the evidence and reporting it with scientific analysis to the relevant authorities are of utmost importance in this regard.

The purpose of this study is to analyze the laws pertaining to medico-legal evidence in rape cases. To reach the aforementioned objective the definition, use, purpose and significance of this evidence and medico-legal services available in Sri Lanka will be discussed. A desk review (which includes published journal articles, text books, websites, decided cases and relevant statutes) has been completed to define the key words in this study. Crime statistics pertaining to the offence of rape during the past ten years were analyzed to emphasize the magnitude of the crime. The information gathered from the officials of criminal justice system and field of medicine have also been used to support the objective of the study.

2. Prevalence of the offence of rape and magnitude of the issue

The statistics shown in the Table 1 reveal a disturbing trend. Except in 2007 and 2008, the number of reported rape cases reveals that the rate of rape has increased during the last ten years by 30 %. This illustrates the vulnerability of women in Sri Lanka for this crime. Nevertheless, some scholars (Edirisinghe A., Wijewardena S., et al , 2014, p. viii ;) are of the view that the dark figure of (rape) rate is higher than the number of reported rape cases to the police. In other words, they are of the view that the actual number of the rape incidents should be higher than the reported cases due to rape survivors not reporting the incidents to the law enforcement authorities (police). Kanagasabapathipillai D., (2013, p. 7) states that sexual assaults including rape have increased in the Northern and Eastern provinces since the end of the civil war due to the lack safety and security for women in these areas.

Out of the rape incidents reported to the police, a great number remains unsolved. The figures in table 1 show that a large number of reported rape cases was pending at the (police) investigation stage in each year from 2006 to 2016. In 2006, 77% of reported cases to the police remained at the investigation stage and it stood at 88% in 2016. This shows a 11% increase in rape cases which were pending at police investigation. In the year 2006, only 369 plaints were filled out of 1540 that were reported to the police. This was only 23%. 268 paints were filled out of (2036) total number of the reported cases in 2016 which was 13% of the total number of the reported cases in that year. It was 10% decrease. The officials of the law enforcement state that proceedings cannot be instigated due to unnecessary delay in receiving the medico-legal reports and other relevant medical certificates.

The statistics of table 1 indicates an increase in the total number of pending (unsolved) cases at different stages such as investigation, preliminary inquiry and trial, from the year 2006 to 2016. For the year 2006, the total number of reported cases was 1540 and the unsolved number of cases stood at 1476. The percentage of unsolved cases in the year 2006 was approximately 95%. Out of 2036 cases which have been reported in the year 2016, 2007 cases were pending/unsolved. Statistics confirm that the percentage of unsolved rape cases remained at or above 95% during the period from 2006 to 2016. Information gathered from the Attorney General's Department endorsed a similar view of the police with regards to the delay in sending case files to the relevant High Courts. Statistics reflecting the negligible number of cases solved .and insignificant number of convictions clearly illustrate the poor quality of response by the criminal justice system.

Statistics in table 2 reveal that during the period from 2006 to 2016, the highest number of rape incidents was recorded in Ratnapura and Anuradhapura. It is also seen that women in rural areas are more vulnerable to rape. Majority of the women in these districts are less educated and unemployed. In many cases, the victim is the sole witness and do not disclose the incident to anybody due to various reasons attributed to the socio-cultural setup in these areas. Often, the first complaint is not lodged immediately after the incident. The incident is not fully disclosed by the victim due to various reasons including social stigma, fear, trauma, anxiety and frustration. This situation is weakening her case against the perpetrator. Furthermore, women who get pregnant as a result of rape are compelled to commit illegal abortion in order to prevent the unwanted pregnancy.

Year	**Number of cases recorded**	**Plaints filed**	**Investigation pending**	**Case Pending In MC/ With AG / In HC**	**Total pending**	**Ending in conviction**	**Ending in Discharged or Acquitted**
2006	1540	369	830	646	1476	03	09
2007	1463	295	795	503	1398	01	06
2008	1397	264	874	482	1356	03	02
2009	1624	280	1091	477	1568	zero	03
2010	1854	167	1397	397	1794	03	01
2011	1870	235	1344	475	1819	02	02
2012 First quarter	260	44	393	55	248	Zero	Zero
2013	2181	234	1410	706	2119	07	04
2014	2008	249	1159	813	1972	01	Zero
2015	2097	239	1126	641	2033	01	01
2016	2036	268	1277	730	2007	Zero	Zero

Table 1 Statistics pertaining to the Offence of Rape in Sri Lanka from 2006-2016
CRIME STATISTICS - GRAVE CRIME ABSTRACT FOR THE YEAR – Crime Statistics published by the Department of Police of Sri Lanka

Year	The highest number of Rape cases reported	The District
2006	129	Anuradhapura
2007	129	Anuradhapura
2008	102	Ratnapura
2009	131	Anuradhapura
2010	137	Anuradhapura
2011	157	Anuradhapura
2012 First quarter	37	Ratnapura
2013	155	Ratnapura
2014	138	Ratnapura
2015	107	Ratnapura
2016	192	Ratnapura

Table 2: Rape incidents according to the Districts from 2006-2016. Source: Sri Lanka Police Department

Medical Evidence

Definition of Medico-Legal Evidence:

In general terms, medico-legal evidence refers to science based evidence that can be used in a court of law. A similar definition is given in the Law Dictionary (http://dictionary.law.com). More accurately, it refers to documented extra and ano-genital injuries, damages to the emotional state of the victim as well as to the samples and specimens which are taken from the victim's body or clothing for medical tests to submit to the court of law. Such medical records can be used only for legal purposes. This evidence includes saliva, seminal fluid, head hair, pubic hair, blood, urine, DNA, fibre, debris, and soil etc.. (Combrinck H 2003 p.10; Fedkovych H, 2006, p. 9). According to Janice Du Mont and Deborah White (2007 p.9) medico-legal evidence refers to documented proof collected from the victims. This evidence is the best tool in certain circumstances that can be used in court of law to support the case scientifically. Due to the specialized nature of the medico-legal field as a special branch of medical jurisprudence, only medical officers who have been equipped with special knowledge and training can give such evidence in the court of law (Singhal M.L., 1995 p. 86). It is mainly documentary (report /certificate) evidence. In some instances, the relevant medical officers are summoned by the court to testify. Therefore, medico-legal evidence given before the court of law is of two forms, i.e. documentary and oral (http://shodhganga.inflibnet.ac.in/bitstream).

Since this evidence is given by an independent third party who is an expert in the relevant field, medico-legal evidence has great corroborative value. In a rape case, medical opinion could be tendered to establish the *mens rea* (states of the

guilty mind of the accused/criminal intention) that the accused has had at the time of committing the offence.

In Sri Lanka, laws relating to tender the evidence, and the relevancy and admissibility of the evidence in a court case are governed by the Evidence Ordinance No 14 of 1895. No specific definition is given to the medico-legal evidence in the Law of Evidence in Sri Lanka. Furthermore, medico-legal evidence is not recognized or understood as a distinct form of evidence under the Evidence Ordinance in Sri Lanka. According to section 3 of the Evidence Ordinance called the Interpretation Clause, evidence is defined under the categories of oral evidence and documentary evidence. Therefore, the medico-legal evidence given before a court of law can only be either in oral or documentary form. However, it is important to note that medico-legal evidence can be regarded as an expert opinion under section 45 of the Evidence Ordinance and the relevant medical officers can be summoned before the court to testify when the court is of the view that there is a question regarding any point of science pertaining to the particular (rape) case/ fact in issue.

Significance of Medico-Legal Evidence

As stated earlier, medico-legal evidence is collected from a victim's body (Ferris LE, Sandercock J.1998 p 349 ; Kelly L, Regan L.2003 p. 10). Therefore, primarily, this evidence can be used to support the investigation and to prosecute the perpetrator (Green W, Panacek EA. 2003 pp 97–99). Consent given by the rape victim is the key fact in establishing the *mens reas (the mental element of the crime)* in a rape case . Therefore, at the trial, this evidence can be used to prove the inability to consent voluntarily due to uncontrollable influential factors (intoxication insane etc..) resistance made by the woman and the force used by the perpetrator, the facts which are directly relevant to the fact in issue. It can also be used to prove or to exclude the physical connection between the rape victim and the perpetrator, to indicate the connection between the rape victim and the crime scene, to determine the recent occurrence of sexual contact/sexual activity, to identify the perpetrator, to prove penetration/sexual intercourse took place between the woman and the perpetrator, which is important in establishing the *actus reus* - the physical element of a rape case. In a rape case, it is the strongest evidence that can be used by the prosecution to corroborate the story of the rape victim at the trial in the court of law. However, it is important to note that the same evidence can also be used by the accused to prove his innocence.

Removing the requirement that the physical act (sexual intercourse/access) should be against the woman's will, interpreting the term 'consent' as voluntary consent given by the woman (Sections 363 and 364 of the Penal Code Amendment Act No. 22 of 1995) and removing the need of evidence for actual physical injuries to prove the resistance made by the woman /rape victim (Section 363 Exception 2 of the Penal Code Amendment Act No. 22 of 1995) are some significant changes made to the rape law in Sri Lanka. Prior to 1995, there was a rule of practice which deemed mandatory that independent corroboration to be made to the testimony of a prosecutrix (woman) in a rape case (*The King* vs *Ana Sheriff* (1941) NRL 169; *The King* vs *Marthelis* (1942) 43 NLR 560; *The King* vs *Themis Singho* (1944) 45 NLR 378; *The King* vs *Basnayake* (1948) 49 NLR 414 CAA; *King* vs *Athukorala* (1948) 50 NLR 256 CCA). The said requirement, that the physical act should be against her will is no longer presented in the current criminal law of Sri Lanka. Currently, evidence for resistance such as physical injuries to body (especially the victim of rape) is not essential to prove that the particular act (sexual intercourse/penetration) took place without her

consent. Therefore, it is now established in rape law in Sri Lanka, that it is not essential to corroborate the evidence given by the woman /rape victim (*Inoka Galage* vs *Kamal Addararachchi* (2002) 1 SLR 307). However, until to date, in practice, (many) Judges (on several occasions) looked for corroborative evidence to prove the resistance made by the rape victim /woman. Theoretically, one might argue that the effect of medico-legal evidence as a corroborative evidence is not of a considerable level as of today.

In this study, it was found that many defense lawyers (Un-Official Bar) and judicial officers are of the view that it is unsafe to convict the accused on uncorroborated evidence of the prosecutrix. This view can be supported and justified by the judgments pronounced in Nimal *Kumara Jayalath* vs *Republic of Sri Lanka* decided in 2009 (CA 128/06) .and *Heen Banda vs AG* (C.A.129/2013) decided in 2013. According to them, the degree of corroboration may vary with the circumstances of the case. Both judicial officers and lawyers representing the Official Bar (Attorneys from the Attorney General's Department) are of the view that with the help of the medico-legal evidence, it would be possible to understand and determine whether sexual intercourse took place between the man and the victim. According to prosecutors, medical evidence is vital in the absence of direct oral evidence of eye witnesses (further see section 60 (1, 2, 3) of the Evidence Ordinance) and it is the best evidence (section 60 (4) of the Evidence Ordinance) in the event the victim is the sole witness testifying at the trial. However, they agreed upon the fact that this depends on the quality and the reliability of the evidence.

Collecting Medico-Legal Evidence

The law relating to police investigation of a crime is governed by the law of criminal procedure that set out in the Code of Criminal Procedure Act No 15 of 1979 (Cr.P.C). The relevant provisions for police investigations are set out in Part V, Chapter XI – section 108-125 of the Cr.P.C. In a rape case, the police investigation is initiated after receiving the first information about the incident (Section 109 (1)). The first information can be lodged by the rape survivor (rape victim) or any person on behalf of the victim. During the investigation period, the victim has to interact with the police and other relevant public officials such as the Government Medical Officers as interpreted in section 3 of Cr.P.C. For the purpose of the Act Government medical officer includes any of the Department of Forensic Medicine of any Faculty of medicine of the University of Ceylon (Sri Lanka).

According to section 122 Cr.P.C. it is mandatory for the rape victim to be referred only to a government hospital for medical examination (section 122 Cr.C.P) . Consent of the rape victim is required prior to the referral (section 122 (1)). However, in a situation where the woman does not offer consent for a medical examination, the police may apply to the Magistrate who possesses the jurisdiction within the area the investigation is being conducted, for an order authorizing a Government Medical Officer (GMO) to examine the woman and report there on (Section 122(2)). In such circumstances the Magistrate is empowered to issue an order authorizing a GMO in order to examine the rape victim who did not consent to being examined (Section 122(2). Therefore, it may say, in a rape case, the victim's consent for medical examination is immaterial or of minor importance. The medical reports showing the results of the examination (and if there is any other medical certificate) should be submitted to the police by the GMO after conducting the medical examination (Section 122 (1). This medical report supports the investigation and prosecution against the accused. It is also important for medico-legal evidence to prove

the charge levelled against the accused or to prove his innocence during the trial. Furthermore, the medical examination helps to detect any ailments of the patient, to decide if any further medical attention and treatments are required. However, it is observed that our criminal law is silent with regards to the execution of procedures adopted in conducting medical examinations and /collecting medico-legal evidence.

Medico-Legal services

According to (Janice Du Mont and Deborah White , 2007 p. 9) , as a result of the ongoing weaknesses of criminal justice systems and the lack of quality medico-legal evidence to prove the account of the crime victim, in some countries a service has been established to improve medico-legal responses to criminal cases especially sexual assault cases including rape. This is known as medico-legal services. Under such services medical examinations or medical tests /assessments are carried out by a medico-legal expert for the purpose of preparing a report (medico-legal report) which can be potentially used only for the legal purposes. In general term, medico-legal expert means an independent person who would , if called as witness at a trial of criminal proceedings, be qualified to give opinion as an expert medico-legal witness in relation to a medico-legal issue arising in the proceeding. Generally the medico-legal experts are the medical doctors who have special knowledge and training in Forensic Pathology. And a medico-legal report is a document prepared and submitted by a medico-legal expert with his/her opinion on the issues regarding the proceedings. The institutions that should provide such services, professionals who deliver this services and the procedures that should be followed when providing the services are defer among the countries due to the difference in the health care system from one country to another.

In Sri Lanka neither the Evidence Ordinance nor the Criminal Procedure Code has a specific definition for medico-legal services. According to the Criminal Procedural Law, a rape victim is referred by the police or sometimes by the court to the GMO. Thus, only the government healthcare system which is governed under the Ministry of Health can provide these services. In Sri Lanka, medico-legal services are available from Peripheral Units to all the hospitals such as District Hospitals,. Teaching Hospitals and Tertiary Care Hospitals. The procedural laws in Sri Lanka have not set out provisions pertaining to the procedure of carrying out the medical examinations, preserving the specimens and preparing reports etc.,

A set of guidelines for the examination, reporting and management of sexually abused survivors for medico-legal purposes was introduced in 2014 by the College of Forensic Pathologists of Sri Lanka to improve the quality of the medico-legal services provided and to ensure the uniformity of the service conditions island-wide. (The guidelines are known as 'National for the examination, reporting and management of sexually abused survivors for medico-legal purposes').

For the purpose of the national Guidelines there are three categories of doctors who can carry out medico-legal examination . They are Category One - Board Certified Specialist in Forensic Medicine; Category two- Grade Medical Officers - doctor who has a postgraduate diploma or has been working in the Government Medical Care after internship. And category three - Government Medical Officer- a doctor who has a basic medical degree (MBBS/ or equivalent) registered in the Sri Lanka Medical Council (SLMC) and works for the Government.

In practice, the Judicial Medical Officer (JMO) who is a medical doctor , full –time specialist

consultant in forensic medicine, a branch of medicine/medical field that links medicine with law and the legal process comes under the category of Board Certified Forensic Medicine Specialist for the purpose of National Guidelines. JMO is a state employed servant, accountable to the Ministry of Justice. JMO is specially qualified in forensic pathology with extensive post graduate qualifications with domestic and international training. (Lewis Davis, 2010). For the purpose of the National Guidelines, JMOs belong to the category one. Grade Medical Officer , in practice known as Medical Officer – Medico-Legal (MO Medico-Legal) fall under category two. Government registered ordinary doctors belong to category three.

According to the National Guidelines, in a situation where the said doctors come under category one and two are not available in a government health care institution, the doctors belonging to the third category can perform such an investigation and prepare the report. It seems that there is a deference between section 3 of Cr.P.C and National Guidelines on the definition given for Government Medical Officer. One may argue that the National Guidelines do not serve the purpose outlined by the Criminal Procedural Laws. Also it could be argued that the legal validity of a medico-legal report submitted by such medical officer with analysis and onion can be challenge at the trial.

Edirisinghe A (Medico-Legal Journal of Sri Lanka 2011,p. 12) states that there were many areas that requires improvement especially on operational procedures where medical expert input can change many things. This study observed that there is considerable gap between the carder position of JMO and MO Medico-Legal available and the number in-service. In many government health care institutions (especially in rural areas- including Anuradhapura, Ratnapura and North and Eastern) GMOs with basic medical degree have to perform such medical examination. Further, observed that the less interest of the medical doctors to specialize in forensic medicine and in Sri Lanka only a few female medical doctors serve as JMOs and MO-Medico Legal. This situation will continue without any changes.

According to the National Guidelines, it is required to be obtained the consent in writing from examinee (a patient who is referred by the police or the court a medico-legal examination). However, such consent is not necessary if the referral is made by the Magistrate. (section 122 (2) of Cr.P.C)

Although the national guidelines define some terminologies such as victim perpetrator, survivors of sexual abuse, health workers, examinee, child , specialist in forensic medicine , grade medical officer and government medical officer, some important terminologies such as medico-legal service, medico-legal evidence and medico-legal report were not described the national guidelines provide the necessary (detailed) guidance on conducting the medico-legal examination, reporting and management of individuals who have been sexually assaulted. It further, guided the doctors who conducted such examination, to ensure some important rights of the individuals such as right to health care, right to human dignity, right to non-discrimination, right to information and right to for self-determination.

Although, the National Guidelines introduced comprehensive guidance with regards to the procedure adopted in performing the medico-legal examination and preparing the medico-legal report, in many rural parts of the country the guidelines are not implemented effectively. According to law enforcement officers, rape victims are not given priority, if there is no mortal threat to the victims. They have to wait long hours in the hospitals with the police until

the victim is taken in for medical examination. This might aggravate her traumatic condition. In Sri Lanka, there is no mandatory time window within which evidence must be collected. However, the guidelines recommend samples collection and perform of examination within 72 hours after the incident of rape took place.

If the victim is a person who is not mentally sound she is referred to a psychiatrist to examine the her memory power, thinking ability, understanding capacity, communication capability to ascertain the nature of the disability and to opine whether that disability affects, giving consent for sexual activity with the perpetrator. The study found that in many instances, the victim patients have to be transferred from lower level medical care institutions to higher level hospitals due to the unavailability of medical resources.

The gap

The study conducted a field research to understand the gap between the law relating to medico-legal evidence and practice (-the medico-legal services available). One on one interviews were conducted with law enforcement officials, judicial officers and counsels of official and unofficial bar. Furthermore, the information was gathered from the medical officers who serve in rural areas where the rape rate was high from 2010 2016 in relation to the medico-legal services provided by the low level government medial care institutions. Information was also gathered from the medical officers who serve in North and East government health care institution including both low level and high level medical care institutions. In addition to the above said lacuna in law the study found the fowling weakness in medico-legal service available. They are: lack of advanced technical knowledge of medical officers to interact with rape victims who are under post traumatic stress disorder, lack of special skills to handle the sensitive situation like this nature, lack of the knowledge of basic human rights, lack of support and assistance from other medical experts (non forensic medical officers due to non availability) inadequate supporting staff including nurses who have been specially trained in the field as well as those having special skills to interact with rape victims, lack of infrastructure facilities, reluctance to appear in courts for cross-examination, delay transferring the victims to nearest hospital for JMO consultancy, delay in dispatching the samples and specimens obtained from the examinee, (often rape victims), delay in completing the medical examination as well as sending the report to the relevant authorities. These weaknesses in the service have negative effects on the quality, reliability and evidential value of medico-legal evidence.

Conclusion

According to the Criminal Code Procedure of Sri Lanka, a police officer investigating a crime of alleged sexual abuse is expected to produce the victim as well as the alleged perpetrator to a government medical officer and obtain a report for evidential purposes. The purpose of this legal requirement is to assist in the administration of justice. Medico-legal evidence of substantial quality is vital in proving the case of the victim and the innocence of the accused. The quality of the evidence depends on the medico-legal examination performed on the examinee. Sound theoretical knowledge, skills in medical examination and interpretation backed by scientific reasoning are required for a quality medico-legal report. Medico-legal services available within the medial care system is imperative in this regard. Though there are laws in existence relating to medico-legal evidence along with a set of guidelines applicable for medico-legal services provided, there is gap seen between the law and practice. This gap has a negative effect on the quality of evidence and in

effect, the outcome of the case. There is a great necessity to minimize the found lacking and weaknesses to strengthen the services available in order to submit medico-legal evidence with strong evidential value to provide justice to the rape victim.

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Utilization of maternal and child health care interventions by rural poor mothers of Jammu & Kashmir State of India

Neeru Sharma*, Meenakshi Anand, Ambika Sharma and Gulshan Kumari

Abstract

The Present study was conducted to understand the governmental health care interventions utilized by the rural mothers belonging to Below Poverty Line Families (BPL) of Jammu District of the State of Jammu and Kashmir. The objectives of the study were to assess the maternal and child health care practices followed by mothers during (a) Pre-natal period (b) Post-natal period (c) Infancy and early childhood; to know the awareness of mothers regarding various schemes implemented by the Government for welfare of women and children belonging to below poverty line families, and to know the utilization of maternal and child health care services by the mothers during their pregnancy and child care. The sample consisted of sixty mothers in the age group of 20 -25 years belonging to BPL families of Bishnah block of Jammu District, having a child in the age group of 0-3 years. The results revealed that most of the mothers followed many traditional practices during pregnancy and child rearing. They had immunized themselves and their children and had utilized the health services for post-natal consultation, though the immunization advice was not available to all of them. Most of the mothers preferred delivery in the hospitals. The children were mostly breast fed and weaning was done after six months of the birth. The mothers were not aware of many governmental schemes for maternal and child health even though they were availing benefits of these, due to interventions from health care workers. The grass root level health worker under the National Health Mission, ASHA (Accredited Social Health Activist), was delivering her services in these areas, as per the information provided by the respondents. She had prepared their health cards and was helping them in utilization of health care facilities during pregnancy and child birth. The other health providers consulted and health benefits received were also mentioned by the respondents. In spite of this most of the respondents appeared anaemic. Based on the findings, strategies have been suggested for the better coverage and utilization of health facility by the Below Poverty Line women.

Keywords

Women, Children, Health, Welfare Schemes, Below Poverty Line, Rural Area, Jammu, Jammu and Kashmir, India

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INTRODUCTION

Poverty in India:

India is world's largest democracy and in recent years it has become second fastest growing economy. It is also estimated to have a third of the world's poor. According to the World Bank 1 in 5 Indians is poor and 80% of India's poor live in rural areas (World Bank, 2016). *Below Poverty Line* is an economic benchmark and poverty threshold given by the Government of India to indicate economic disadvantages, and to identify individuals and household in need of government assistance and aid. In tenth plan (2002-2007) survey, BPL for rural areas was based on the degree of deprivation in respect of 13 parameters such as landholding, type of

houses, clothing, food security, sanitation, literacy status, means of livelihood, status of children reasons for migration etc. According to 2011census of India 69% of population resides in rural areas and among them women constitute about 48% (Census of India, 2011). Almost 10.35% of the population falls under the below poverty line (BPL) category in Jammu and Kashmir, with the rural areas holding poorer than the urban areas (The Tribune, Jan 14, 2017).

According to the MDG Report (2015) the factors that contribute to women's heightened vulnerability to poverty include unequal access to paid work, lower earnings, lack of social protection and limited access to assets, including land and property. Even where women are equally as likely to live in poor households as men, they are more likely to be deprived in other important areas of well-being, such as education (MDG Report, 2015). The report further says that despite the progress in MMR, the MDG 5, and every day hundreds of women die during pregnancy or from childbirth-related complications. In 2013, most of these deaths were in the developing regions, where the maternal mortality ratio is about 14 times higher than in the developed regions. Globally, there were an estimated 289,000 maternal deaths in 2013, equivalent to about 800 women dying each day. Maternal deaths are concentrated in sub-Saharan Africa and Southern Asia, which together accounted for 86 per cent of such deaths globally in 2013 as per the MDG Report, 2015.

Maternal Health Status in India

The maternal mortality ratio (MMR) is defined as the number of maternal deaths during a given period per 100,000 live births during the same period. According to UNICEF, annually, it is estimated that 44,000 women die due to preventable pregnancy-related causes in India, but India's maternal mortality rate reduced from 212 deaths per 100,000 live births in 2007 to 167 deaths in 2013 (http://unicef.in/Whatwedo/1/Maternal-Health). Maternal mortality is a key indicator for maternal health and reveals inequality between and also within states that cannot be attributed to biological differences alone. As per the SRS 2001-2003 the medical causes of Maternal Mortality can be direct or indirect. The most common direct medical causes of maternal deaths as per SRS (2001-2003) are haemorrhage, mainly postpartum (37%), sepsis because of infection during pregnancy, labour, and postpartum period (11%), unsafe abortions (8%), hypertensive disorders (5%) and obstructed labour (5%). These conditions are largely preventable and once detected, they are treatable. A significant proportion of maternal deaths are also attributed to 'indirect causes', the most common of which are anaemia and malaria. (Census of India, SRS 2001-2003). In a more recent review of selected maternal death cases, Subha Sri and Khanna (2014) found that about 26 % of maternal deaths occurred at home, 25 % occurred in transit, and 48 % occurred at the health facility. The international community was committed to decrease the Maternal Mortality Ratio (MMR) by 75.0 percent by 2015 and improve overall maternal health care to achieve MDG-5. With one maternal death reported every ten minutes, India missed this Millennium Development Goal related to maternal health.

Vora et al (2009) conclude from their case study that India's goal is to lower maternal mortality to less than 100 per 100,000 live births, but that is still far away and they attribute it to the geographical vastness and socio-cultural diversity, which they say, means that maternal mortality varies across the states, and uniform implementation of health-sector reforms is not possible (Vora et al 2009). Most of the deliveries in India occur at home and without any assistance from skilled health professionals and hence majority of the maternal deaths occur because of the home delivery (IIPS,2010). Women's post-natal health appears to take

second place for all once the process of child birth is over (Thomas,1998). The mothers who do not avail antenatal care and/ or give birth unattended by the trained personnel, invariably indulge into wrong practices related to child care and hence the child health complications adding to the infant mortality rate(IMR).

However, adolescent and illiterate mothers and those living in hard to reach areas still have a much greater chance of dying in childbirth. Adolescent girls outside Indian cities are especially vulnerable as teenage marriage and pregnancies are very high in rural and remote areas of the country (http://unicef.in/Whatwedo/1/Maternal-Health). According to Joe et al (2015) high maternal mortality in India, particularly across empowered action group (EAG) states, is a critical policy concern. and several important initiatives have been rolled out under the Reproductive and Child Health (RCH) programme and National Rural Health Mission (NRHM). Despite such unprecedented attention, however, the reduction in MMR has been decelerating in recent times; and most maternal deaths in India continue to be associated with determinants such as nutrition, poverty, and socioeconomic marginalisation, over which policies have had little or no impact (Joe et al, 2015). NFHS 4 (2015-16) data indicates that in India the number of mothers who had full ante natal care were 31.3% in Urban areas, 16.7% in rural areas, 21% in total as compared to 11.6% in NFHS 3 conducted in 2005-06 (rchiips.org/NFHS/pdf/NFHS4/India.pdf). The NFHS 4 data further shows that 40.8% urban, 25.9% rural and 30% in total women consumed Iron/Folic Acid for 100 or more days almost double from 15.2% in NFHS 3. Post-natal care, from the doctor/nurse/LHV/ANM/midwife or other health personnel, was received by 71.7% urban women,.58.2% rural women, 62.4% in total as per NFHS 4 as against 34.6% in NFHS3 and financial assistance under Janani Suraksha Yojna, for institutional deliveries, was received by 21.4% urban, 43.8% rural and 36.4% in total as per NFHS 4.The current challenge is to identify and outline the role of governments, health and other sectors, communities, and households in population-wide strategies to improve access, delivery, and utilization of health care services (World Bank 2012; Jeffery and Jeffery 2010, as cited by Joe et al 2015).

Family being the smallest unit of society, the women are its backbones and the fulcrum. Poor pregnancy outcomes affect not only the mothers but also the child, family and community in all manners i.e. physically, mentally and economically. In Indian society where women's rights are repressed the health of women and children suffers significantly (Ganjiwale,2012). In the patriarchal system, prevalent in most parts of India, women's position is subordinate to that of men in various household decision-making matters, and this is ascertained by the customs and the traditions. This is also concretized through gender roles, relations, and unequal power in various household decision-making aspects. Maternal health, in this pretext, is also ingrained in this cultural context, where health seeking during this phase is not her own singular decision. It is the household's decision, and in case of nuclear families, the husband's decision, that's why in spite of so many health inputs the maternal health is not showing any improvement. Hence the present study was designed to understand the context of maternal and child health in a rural location among the families living in poverty.

Child Health Status in India

Assessing the MDG 4, reducing the child mortality rate, the MDG (2015) report says that every day in 2015, 16,000 children under five continued to die, mostly from preventable causes, hence child survival must remain the focus of the post-2015 development agenda. Assessing India's status on SDG, WHO (2017) found that both the Child Mortality Ratio and

Neonatal Mortality Ratio have declined since the year 2000. They have almost halved till 2017-CMR from 91 in 48 and NMR from 45 to 28 per 1000 live births (http://www.searo.who.int/entity/health_situation_trends/countryprofile_ind.pdf?ua=1). 38.4% children under 5 in India were found stunted, 21% wasted and only1.9% overweight as per WHO (2017). As per the NFHS 4 statistics, children who received health check-up, from doctor/nurse/LHV/ ANM/midwife/ other health professionals, 2 days of birth were 27.2% in urban areas, 23% in rural areas, and 24.3% in total. The children who were underweight were 29.1% in urban areas, 38.3 % in rural areas and 35.7 % in total as compared to 42.5% in NFHS3. As per the NFHS 4 immunization status has improved a lot during the intervening period from NFHS 3.

MDG Report (2015) concludes that majority of neonatal deaths worldwide are caused by preterm birth complications (35 per cent), complications during labour and delivery (24 per cent) and sepsis (15 per cent). In sub-Saharan Africa and Southern Asia many deaths are also due to preventable infectious diseases. Many neonatal deaths could be avoided with simple, cost-effective and high-impact interventions that address the needs of women and new-borns across the continuum of care, with an emphasis on care around the time of birth. However, analysis shows that too many new-borns and mothers miss out on these key interventions (MDG Report, 2015). Mortality is more likely to strike children in rural areas as these children are about 1.7 times more likely to die before their fifth birthday as those in urban areas.

Seeking Maternal Health Care by Women in India:

Health seeking behaviour (HSB) is an important aspect of utilization of health services or benefits. Sanneving et al (2013) concluded that in India, economic status, gender, and social status are all closely interrelated when influencing use of and access to maternal and reproductive health care. Appropriate attention should be given to how these social determinants interplay in generating and sustaining inequity when designing policies and programs to reach equitable progress toward improved maternal and reproductive health (Sanneving et al., 2013). To enhance the understanding of how inequities in health are rooted in societal structures, the Commission on Social Determinants of Health (CSDH) developed a conceptual framework of the social determinants of health inequities (Solar et al., 2010). This is an action-oriented framework, applicable to identify entry points for interventions and policy that could reduce inequities in health in a specific setting. It is based on the notion that health inequities emerge from a systematically unequal distribution of power, prestige, and resources among groups in society. The framework is organized into three elements: socioeconomic and political context, structural determinants, and intermediary determinants. The structural determinants, or the social determinants of health inequity, operate through a series of intermediary social factors. These intermediary factors include material circumstances such as housing quality and physical environment, psychosocial circumstances such as stressful living conditions and relationships, (lack of) social support and coping styles, and behavioural and biological factors such as lifestyle and genetic factors. The health system is also described as a social determinant of health, particularly since it mediates the differential consequences of ill health (Solar et al., 2010). India spends a huge amount on health sectors with a large number of preventive and curative schemes for women but women's health indicators still show a poor trend, especially the reproductive health. The United Nations defines reproductive health as a "state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or

infirmity, in all matters relating to the reproductive system and to its functions and processes".

Seventy-four percent of women sought antenatal care (ANC) from a qualified provider and 52 percent of births were attended by qualified providers (El-Saharty et al, 2014). Wide gaps in contraceptive prevalence rate (CPR) and access to skilled-birth attendance remain by geography and wealth quintile. India will focus on preventing unwanted pregnancies especially among adolescents; improving demand-side strategies; strengthening access and quality in public and private sectors; improving antenatal, intranatal, and postnatal care; strengthening monitoring and evaluation (M and E) systems and reducing inequities; and improving nutrition (El-Saharty et al., 2014).

Devansenapathy et al. (2015) found that Compared to the poorest, the least poor women were more likely to be registered for ANC and more likely to have made ≥ 4 ANC visits. They were more likely to have given birth in a facility, to have visited a hospital within one month of childbirth. In general, government funded health insurance and conditional cash transfers schemes were underutilized in this community. Study on the health-seeking behaviour (HSB) and utilization of health services by pregnant mothers in Vadodara slums reported that majority of women preferred private hospital for delivery in spite of being from lower socioeconomic group and most of the mothers ignored PNC (Kotechal et al., 2012).A study by Manna et al.(2011) in Jalpaiguri and Darjeeling Districts, West Bengal reported that non-utilization or under-utilization of maternal health care services, especially among urban slum population are high due to lack of awareness or access to health care and this calls for understanding the HSB and utilization of services by those in need of them. Dandappanavar and Khan (2014) conducted a study in an urban slum of Dharwad town in Karnataka and reported that antenatal period is determined by religious beliefs and practices, which were learnt through the process of socialization. Apart from this literacy, education and exposure to mass media are less significant when it comes to the HSB because the people opine that pregnancy and childbirth are intertwined with the functions of religion, family, kinship and marriage.

An encouraging result, though, is seen in a study conducted by Arun et al (2017) on health seeking behaviour among married women of reproductive age group in a rural area was studied by community based cross sectional method. The health seeking behaviour of women in rural area was found to be satisfactory, as more than two-third of the study group has sought some treatment. They further conclude that more focus on educating the women, increasing their awareness towards health and highlighting the facilities and schemes in government health sectors will fill the gaps in health seeking behaviour. Large inequities remain in maternal health, along with gaps in access to and use of sexual and reproductive health services that must be consistently addressed and monitored. Hence the present study focused on the awareness among mothers, living below poverty line, about the schemes related to maternal and child health.

OBJECTIVES

1. To understand the context of maternal and child care among the families living below poverty line in the rural areas of Jammu during prenatal and post-natal periods and in infancy and early childhood years.
2. To know the awareness, access and utilization of health services by the rural mothers, belonging to Below Poverty Line (BPL) families, of Jammu District of the state of Jammu and Kashmir, India.
3. To know the rural mothers' awareness about the governmental schemes in operation for BPL Families especially for maternal and child health.

Research Methodology

The study was conducted to understand the utilization of health acre interventions by the mothers, belonging to BPL families of Jammu, regarding the schemes for welfare of women and children.

1.**SAMPLE**: The sample for the present study comprised of 60 rural women having at least one child in the age group of birth to 3 years.

Criteria for sample selection:

i) Age of the reference child: Only those women were selected who were having at least one child in the age group of birth to three years.

ii) Area: The sample was selected only from the rural area of Bishnah block (administrative unit) of Jammu District of the state of Jammu and Kashmir in India.

iii) Financial Criteria: The sample consisted of only those women belonging to the **BPL** families as identified by Department of Rural Development, Government of Jammu and Kashmir.

Sampling Techniques

Multi-Stage Sampling Technique was used for the data collection. From Jammu District (Administrative Division) of Jammu and Kashmir state, Bishnah block was purposively selected. Out of 130 villages of this block, only six villages namely Adlehar, Allah, Chak Fateh Khan, Pandori, Karyal and Shibu Chak were selected randomly. Then the list of BPL families, residing in these areas, was obtained from the Department of Rural Development, Government of Jammu and Kashmir, and from each village, women fulfilling the criteria for sample selection were listed. Out of the list ten women were randomly selected from each village.

2.TOOL USED:

***a. Interview with the Block Medical Officer*:**

The Block Medical Officer, Bishnah was interviewed about schemes regarding care of mother and child health operational in his block.

b. Interview Schedule for mothers*:*

As per the governmental initiatives, MDG Report, and other studies conducted in the area, some of the key indicators for maternal health are antenatal check-up, institutional delivery and delivery by trained and skilled personnel, post-natal care etc., hence a self-structured interview schedule was prepared covering these areas. The main components were:

i). ***Background information***: This part of interview schedule helped to know about age, education, qualification and occupation of the respondents and their family.

ii). ***Information regarding family***: This part includes the type of family and number of child etc.

iii). ***Practices related to pre-natal period and role of Governmental schemes*.**

iv). ***Practices related to post-natal period and role of Governmental schemes*.**

v). ***Practices related to Early Childhood*.**

vi). ***Mothers awareness about the governmental schemes in operation for mother and child health.***

vii) ***Mothers report of role of various health providers during pregnancy and child care****.*

3.DATA COLLECTION*:*

The tools were given to experts for their opinion and the suggestions were incorporated. Pre-testing of the tool was done on a similar sample. The necessary modifications were made before the actual data collection. Data was collected through home visits. To establish rapport the help of the local health worker was sought. The researcher visited the women along with the local health workers. After initial ice-breaking another visit was made to collect the information. It took about one hour to carry out a single interview. Some of the respondents were not able to give responses to some questions in the interview. They were made comfortable and were told that they should not be embarrassed if they are unable to answer any question. After the initial ice breaking the

interviewing process went on smoothly. The interviews were conducted in the local language "*Dogri*" to make the process more comfortable for the respondents, as most of them were having low level of education.

4. DATA ANALYSIS*:*

The raw data thus obtained was consolidated through coding and tabulation. After that the data was subjected to descriptive analysis using frequencies and the analysis has been presented in the form of tables and diagrams.

RESULTS AND DISCUSSION

BACKGROUND INFORMATION ABOUT THE RESPONDENTS:

Background variables	**Frequencies**	**Percentage (%)**
Age (in years)		
20-25	29	48.36
25-30	26	43.34
30-35	4	6.67
35-40	1	1.6
Educational Qualifications of Respondents		
Illiterate	7	11.67
Upto 5^{th}	3	5
8^{th}	26	43.34
10^{th}	23	38.34
12^{th}	1	1.67
Type of family		
Joint	37	61.67
Nuclear	23	38.34
Number of children		
1	26	43.34
2	26	43.34
3	7	11.67
4	-	-
5	1	1.67
Age of children* (in years)		
0-3	60	100
3-6	26	43.33
6-9	7	11.67
Above 9	7	11.67

Table 1 Background information about the respondents. *Multiple responses

Table 1 shows that 48.36% of the respondents were in the age group of 20-25 years, and 43.34% were in the age group of 25-30 years. Forty three percent of the respondents were educated up to eighth standard, 38.34% of them were educated up to 10th standard, 11.67%

were illiterate, 5% were educated up to 5th standard and only 1.67% of mothers were educated up to 2th standard. Sixty two percent of the respondents were living in joint and 38.34% in the nuclear families. Forty three percent of the respondents had one child, 43.34% had two children and 11.67% mothers were having five children. All the respondents had the children in the age group of 0-3 years, 43% families had children in the age group of 3-6 years, 11.67% each had children in the age group was 6-9 years and above 9 years of age, respectively.

Practices followed during the Prenatal Period	**Frequency (N=60)**	**Percentage (%)**
Changes in food consumption pattern		
Yes	50	83.33
Foods Added		
Milk/green leafy vegetable	39	65
Dry fruit	11	18.34
No change	10	16.67
Hygiene related practices		
a) *Bathing during pregnancy*		
Everyday	45	75
Every other day	15	25
b) Brushed teeth in the morning before eating anything		
Yes	60	100
c)Washed hands before eating		
Yes	60	100
d)Cut nails		
Yes	60	100
Health related practices		
a) Took proper rest		
Yes	57	95
No	3	5
b) Avoided picking up heavy things		
Yes	54	90
No	6	10
c) Advised to walk		
Yes	41	68.34
No	19	31.56
d) Monitored weight (during pregnancy)		
Yes	60	100
Weight during pregnancy		
30-40	6	10
40-50	36	60
50-60	8	13.34
Don't know	10	16.67

Table 2 Practices followed by the respondents during pre-natal period

PRE-NATAL PERIOD:

Table No :2 shows that 83.33% of respondents had brought changes in their food consumption patterns during pregnancy. 65% of the respondents added green leafy vegetables and milk, 18.34% of respondents added dry fruit, whereas 16.67% of respondents made no changes in their food intake. Seventy five percent of respondents bathed every day during pregnancy whereas 25% of respondents had bath every alternate day.

All respondents brushed their teeth before eating anything in the morning and kept their nails cut. Majority (95%) of respondents took proper rest, 90% of them avoided picking up heavy things, as advised by the doctor, and 68.34% of respondents went for walk during pregnancy. Sixty percent of the respondents' weight during pregnancy was 40-50 kilograms (kgs), for 13.34% it was 50-60 kgs and for 10% it was 30-40 kgs. 16.67% mothers do not remember their weight during pregnancy.

Role of doctor	**Frequency (N=60)**	**Percentage (%)**
How was the pregnancy confirmed?		
By visit to a doctor	42	70
Through symptoms (Nausea & vomiting)	18	30
Consulted doctor from		
Urban Area	54	90
Own Village	6	10
Took doctors' advice		
Yes	60	100
Followed doctor's prescription		
Yes	60	100
Weight measured by doctor		
Yes	49	81.67
Others	11	18.34
Doctor advised consuming green leafy vegetable		
Yes	58	96.67
No	2	3.34
Consulted doctor for any problem during pregnancy		
Yes	60	100
Frequency of consulting doctor		
Twice in a month	35	58.34
When required	25	41.67
Received maternal tetanus vaccination		
Yes	60	100

Table 3 Role of health providers during pre-natal period

Table 3 shows that 70% of respondents had received the confirmation of their pregnancy by a doctor and 30% of respondents detected pregnancy from the symptoms such as nausea and vomiting. Majority (90%) of the respondents consulted doctors from urban areas near their villages, whereas 10% consulted doctor from their own village only. All the respondents consulted and followed the doctor's advice and prescription during pregnancy. Eighty two percent of the respondents said that the doctor used to measure their weight during pregnancy, for the rest ASHA, Anaganwadi Worker or someone else measured it. Majority (96.67%) of the respondents were advised by the doctor to consume green leafy vegetables. All the respondents had consulted doctor in case of any problem during pregnancy, though the frequency varied, 58.34% of the respondents consulted doctor twice in a month and 41.67% of respondents consulted doctor only when required. All the respondents said that they had received maternal tetanus vaccination. Table 4 shows that 66.67% of the respondents suffered from mild illness during pregnancy like nausea, 18.34% suffered from fainting and 10% from vomiting. Forty three percent of respondents reported that they were anaemic (*kat khoon ha*) during pregnancy.

Responses	**Frequency (N=60)**	**Percentage (%)**
Any illness during pregnancy?		
Nausea	46	66.67
Vomiting	6	10
Fainting	11	18.34
Were you anaemic?		
Yes	26	43.34
No	34	56.67

Table 4 Mother's health during pregnancy period.

Table 5 shows that 88.34% of respondents preferred Government Hospitals for treatment and 11.67% of respondents preferred Private Hospitals. All the respondents preferred normal delivery, but 36.67% of them actually had their delivery either through caesarean section or *minor surgery* (as they call it), 63.34% of the respondents had a normal delivery. Sixty two percent of respondents said that they preferred hospital delivery because of the availability of all facilities, 38.34% of respondents said that they preferred home delivery because of the fear of *operation* (caesarean section*)*, few cited the lack of emotional support in the institutional settings as the reason for favoring home delivery and few cited financial problems for preferring home delivery. Delivery of 80% of respondents took place in hospital and 20% of respondents had their delivery at home. During home delivery 8.34% of respondents said that the *doctor* was present and 11.67% of respondents said that *Dai* (mid-wife) was present at the time of delivery.

Table No 6 shows the role of ASHA or Accredited Social Health Activist who works under the National Health Mission for promotion of Maternal and Child Health in India. Majority (93.34%) of respondents said that ASHA visited them during their pre-natal period and registered their names, advised them to consult doctor and told them to take prescribed medicines regularly. Eighty seven percent of respondents said that ASHA advised them to take iron and calcium tablets (supplements). Majority (83.34%) of respondents said that ASHA suggested them to opt for institutional delivery but 53.34% of them said that ASHA did not advise them to have proper check up by the

doctor after delivery.

Responses	Frequency (N=60)	Percentage (%)
Preference for type of health care facility		
Government	53	88.34
Private	7	11.67
Type of delivery preferred		
Normal	60	100
Type of delivery that actually took place		
Caesarean	22	36.67
Normal	38	63.34
Place of delivery preferred		
At home	23	38.34
Hospital	37	61.67
Actual place of delivery		
Hospital	48	80
At home	12	20
If home delivery, healthcare personnel present at the time		
Doctor	5	8.34
Mid wife	7	11.67

Table 5 Place and type of delivery.

ASHA's role	Frequency (N=60)	Percentage (%)
ASHA visited during pregnancy		
Yes	56	93.34
No	4	6.67
Registered name at the time of pregnancy		
Yes	56	93.34
No	4	6.67
ASHA advised		
a)To consult doctor during pregnancy		
Yes	56	93.34
No	4	6.67
b)Take proper supplementation of iron and calcium		
Yes	52	86.67
No	8	13.34
c)To have delivery in hospital		
Yes	50	83.34
No	10	16.67
d) To have proper health check –up after delivery		
Yes	28	46.64
No	32	53.34

Table 6 Mother's report on role of ASHA (Accredited Social Health Activist) during pre-natal period.

Role of ANM	Frequency (N=60)	Percentage (%)
ANM advised you for regular checkup?		
Yes	60	100
Did you go for regular check up?		
Yes	60	100
ANM suggested you to have delivery in hospital?		
Yes	30	50
No	30	50
Advised about immunization after delivery		
Yes	20	33.34
No	40	66.67

Table7 Mothers report on the role of Auxiliary Nurse Mid Wife (ANM) during pre-natal period.

Table 7 shows that when the respondents were taken to the hospitals by the ASHA, the ANM present there provided them advice related to pregnancy and birth process and regular check-ups. All of them followed ANM's advice. In 50 % of the cases the respondents were advised by ANM's to have delivery in hospitals. Only in 33.34 % cases the ANM's advised the respondents for immunization of the child after delivery, but some respondents said that they did not consult the ANM's, they directly consulted doctors regarding the immunization.

Ceremony performed	Frequency (N=60)	Percentage (%)
Yes (*Reetein*)	22	36.67
No	38	63.34

Table 8 Ceremonies performed during pregnancy.

Table 8 shows that the ceremony before birth of the child, known as *reetein*, similar to baby shower in West, was performed in only 36.67% cases during pregnancy. The ceremony '*reetein*' (*godh bharayee*) is performed during the 8th month of pregnancy, to mark the wellness of the mother and child, and the safe arrival of the time of delivery. In this ceremony people shower blessing on the unborn child and the mother and give the mother gifts in the form of money, dry fruits, fruits, clothes etc. The family of the expectant mother arranges a party (*dhaam* in local language) and serves the traditional food to their guests. Sixty three percent respondents said that no ceremony was performed during pregnancy as they did not have resources for that.

POST-NATAL PERIOD:

Table 9 shows that the height and weight of all the new-borns was measured after birth and the respondents were informed that it was normal, even though the birth took place at home in some cases. In all cases the Child Care Card was prepared by the ASHA, but the respondents were not able to give correct information regarding the height or weight because they were unable to locate the Child Care Card. Sixty five percent of the respondents had been provided information about immunization by ASHA, 15% of respondents were given this information by the doctors, 10% each of the respondents by ANM and family members, respectively, though at the time of health check-ups the ANM's did advise them about immunization. Forty three percent of respondent had received information about Polio Vaccination from television, 35% from ASHA, 8.34% from Anganwadi Workers and 6.67% each from doctors and family members, respectively. All the respondents had immunized their new-borns against polio. All respondents consulted doctors during their child illness.

Post-natal health care of infant	**Frequency (N=60)**	**Percentage (%)**
Height and weight of the newborn measured after delivery?		
Yes	60	100
Informed that height and weight was normal?		
Yes	60	100
Information about immunization provided by:		
ASHA	39	65
Doctor	9	15
Family member	6	10
ANM	6	10
Information about polio drops given by:		
Television	26	43.35
ASHA	21	35
Anganwadi worker	5	8.34
Doctor	4	6.67
Family member	4	6.67
Polio drops administered to infant child		
Yes	60	100
Consult doctor during childcare /illness		
Yes	60	100

Table 9 Post-natal care and advice provided to the mothers by health staff

Variables	**Frequency (N=60)**	**Percentage (%)**
Prelacteal Food Given to the infant		
Honey	**34**	**56.67**
Jaggery	**24**	**40**
Sugar	**2**	**3.34**
Infant bathed for the first time after delivery		
After 5 days	**51**	**85**
After 10 days	**9**	**15**
Massaging of the infant		
Yes	**60**	**100**
Colostrums given		
Yes	**60**	**100**
Feeding preferred for the child		
Breast Feeding	**60**	**100**
Weaning done after the age of		
6 months	**60**	**100**

Table 10 Practices related to post delivery, feeding, weaning.

PRACTICES FOLLOWED DURING INFANCY

Table 10 shows that 56.67% of the respondents' infants were given prelacteal food in the form of honey and 40% in the form of jaggery. There is a belief that the child should be given prelacteal foods to clear his digestive and respiratory system and also to imbibe sweetness in his/her behaviour. Eighty five percent of the infants were bathed five days after the delivery. Mothers preferred breast feeding and all of them gave the colostrums for healthy development of the child. Weaning was done after 6 months of the age of the child, mostly with water from cooked rice (*pich*) or Pulses (*dal ka paani*).

Variables	Frequency (N=60)	Percentage (%)
At what age was the child was fully toilet trained?		
2years	**20**	**33.34**
3years	**40**	**66.67**
At what age they started going independently to the toilet?		
2 ½ years	**18**	**30**
3 years	**42**	**70**
Does the child have fixed routine for going to the toilet?		
Yes	**60**	**100**
Are you aware of the preventive vaccines to be given to the child?		
Yes	**47**	**78.34**
No	**13**	**21.67**

Table 11 Early childhood care beliefs and practices followed by the respondents

EARLY CHILDHOOD CARE BELIEFS AND PRACTICES

Table 11 shows that 66.67% of respondents had fully toilet trained their child at the age of three years and 33.34% of the respondent's toilet trained their child at the age of two and a half years. Seventy percent mothers had started to let their child go to toilet independently by the age of three years and 30% of the respondents started it at the age of two and a half years. All the respondents said that their children had a fixed routine for going to the toilet. Seventy eight percent of the respondents were aware of the preventive vaccines given to the child at this age but 21.67% of the respondents were unaware of such preventive vaccines.

MOTHERS AWARENESS ABOUT THE WELFARE SCHEMES

Table 12 shows that all the respondents were BPL cardholders and they know the criteria for BPL card. Eighty eight percent respondents were not aware of any type of schemes or benefits that the government is providing for them or their children's and 11.6% of respondents do know about these, though none of them could name the schemes. Fifty three percent of respondents said that ASHA educate them about various governmental schemes. Fifty eight percent of the respondents did not know that there were cash incentives for delivery and the rest said that they had taken Rs. 1400 after delivery. Sixty eight percent of respondents did not get any special funds for their children under such schemes meant for them, and only 18.3% got some special funds for their children under such schemes. Fifty percent of the respondents said that they were aware about how much they

are required to pay for 1kg ration and 50% were unaware about this. Sixty five percent of respondents said that they have to pay only half of the fee of their treatment in government hospitals and 35% were unaware about it. 86.67% of respondents said that they were not aware about the loans provided by the government for small business whereas 13.34% of respondents were aware about such government loans.

Variables	**Frequency (N=60)**	**Percentage (%)**
Are you BPL card holder?		
Yes	60	100
Do you know what the criteria for BPL card is?		
Yes	60	100
Do you know the benefits government is providing to you and your children?		
Yes	7	11.6
No	53	88.3
What type of demand are you putting in the front of the government?		
Job opportunity	23	38.3
Small business for women	3	5
No demand	34	56.6
Does ASHA worker educate you about various schemes launched by the government for pregnant women?		
Yes	32	53.3
No	28	46.6
Do you know how much cash incentive is there for an institutional delivery?		
Yes	25	41.6
No	35	58.3
How much cash did you take after delivery?		
1400	25	41.6
Are you getting any special fund for your children from these schemes?		
Yes	11	18.3
No	41	68.3
Are you aware how much you have to pay for 1 kg ration?		
Yes	30	50
No	30	50
Should you pay for treatment in Governmental Health Care Units?		
Yes	39	65
No	21	35
Do you know government provides you loan for starting small businesses?		
Yes	8	13.34
No	52	86.67
Do you know SGSY provides you with additional job opportunity?		
Yes	-	-
No	60	100

Table 12: Respondents awareness about the welfare schemes for BPL Families

DISCUSSION

Poverty often leads to lack of access to the basic necessities such as food, shelter and medical care. Maternal Health is an important aspect for the development of any country in terms of increasing equity and reducing poverty. The survival and wellbeing of mothers are not only important in their own right but also central to solving broader, economic, social and developmental challenges (Annual Report 2013-14).

The National Health Mission (NHM) with its two Sub-Missions, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM) was approved by the Cabinet in May, 2013. The NHM envisages universal access to equitable, affordable and quality healthcare services that are accountable and responsive to people's needs. The main programmatic components include Health System Strengthening in rural and urban areas, Reproductive- Maternal- Newborn- Child and Adolescent Health (RMNCH+A) and control of Communicable and Non-Communicable Diseases. Jammu and Kashmir have been identified as a Low Performing State by the NHM under the Janani Suraksha Yojna (JSY) because of less than 25% institutional delivery rate. JSY is a safe motherhood intervention under the National Rural Health Mission (NHM) launched in the year 2005. It is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among poor pregnant women. Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011. The incentives include free-delivery, C-Section, drugs and consumables, diagnostics, diet during stay in the health institutions, provision of blood, exemption from user charges, transport from home to health institutions, transport between facilities in case of referral, drop back from Institutions to home after 48hrs stay. The treatment of the new-born in case of sickness till 30 days of birth is treatment, drugs and consumables, diagnostics provision of blood, exemption from user charges, transport from home to health institutions, transport between facilities in case of referral, drop back from institutions to home.

The present research was focused on knowing the utilization of the schemes for maternal and child health among rural mothers of BPL families of Jammu. Interview schedules were used for data collection. The researchers visited the office of the Block Medical Officer, BMO, at the initial stage of the research. He informed the researchers that the Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram were implemented in their block for the care of mother and child. For data collection from the respondent mothers home visits were made after the identification of the sample.

Most of the respondents were young and in the reproductive age, with most of them having low level of education, living in joint families and having 2 offspring. All the respondents were home makers. Their husbands were mostly daily wagers earning a meagre amount, not enough for even for meeting day to day expenses. Most of their offsprings were males. The mothers had access to the health services and were following the advice given by the doctors, whom they consulted at the behest of ASHA. Birth registrations were done for all by ASHA. The health status of the mothers during pregnancy, as reported by them showed that they suffered from mild illness but many were anaemic in spite of consulting the doctors. Most of them were underweight during their pregnancy and on observation too they looked underweight at the time of data collection. They did not observe pre-birth traditional ceremonies, markers of safe pregnancy, due to lack of resources. They had modified their food consumption pattern and had been vaccinated against tetanus. They were following hygienic practices too but most of them were underweight. Measuring weight is a taboo among the expectant mothers as it is

believed that an evil eye will cast its bad influence on the mother and child.

In a country where population is in billions, people still fear the evil, as it may cause harm to their unborn child, a child who should preferably be a male, as females have to be sent to other households after marriage. It's the protection of the unborn son that is done by following such beliefs and practices. Females are believed to be strong at the time of birth, so even after the birth of the child weight or height measurement, and disclosure of that is considered to invite the spell of evil eye. The mothers and grandmothers prefer saying "*kamjor ae*"(the infant is weak).

The respondents consult doctors at the advice of the ASHA, but sometimes the people refer to Registered Medical Practitioner (RMP) or the person owning a Medicine Shop as a Doctor too, and many times it is observed that they seek advice from them when they have medical problems, as they don't have finances to visit block hospitals or Primary Health Centres (PHC).The mothers are not aware that even the government is providing finances for early registration, delivery and follow ups at medical facilities. Respondents preferred delivery in government hospitals as they consider them safe. Poverty seems to be one of the reasons for choosing home deliveries because of the cost incurred on the institutional deliveries, even if they happen in the government facilities. A household survey from Chandigarh Union Territory comparing coverage of maternal health care showed that among the women studied, only 32% of the women living in urban-slum areas had an institutional delivery, compared to 93% of the non-slum urban women, and 79% of the women living in rural areas (Gupta et al 2008). Most of the respondents had a normal delivery; home delivery was preferred by a few women but in the presence of a doctor or a mid-wife. A study using the National Sample Survey from 2004 showed that a vast majority of the poorest households in the country paid more than 40% of their capacity to pay for maternal health services (Bonu et al., 2009). Gupta et al. (2008) reported that about 68% of the deliveries were at home and not assisted by a skilled birth attendant (nurse, midwife, or doctor) in the slums, compared to 21% and 7% in rural and urban areas ($p < 0.001$), respectively. In the present study many respondents also had home deliveries, though in the presence of a doctor or *dai* (mid wife). Fear of *operation* (Cesarean section) and lack of emotional support were cited as reasons for preferring home deliveries, by the respondents of the present study. In a study by Griffiths and Stephenson (2001), too, respondents identified the poor quality of services offered at government institutions to be a motivating factor for delivering at home.

The most commonly cited reasons for home birth were custom and lack of time to reach a healthcare facility during labour. Seventy percent of home deliveries were assisted by a traditional birth attendant (dai), and 6% by skilled health personnel (Das et al 2010). Home births are frequent among the urban poor and fear of hospitals (36%), comfort of home (20.7%) and lack of social support for child care (12.2%) emerged as the primary reasons for home births (Devasenapathy, 2014). Though initiatives like JSY and JSSK and the recent Maternity Benefit Programme- Conditional Maternity Benefit, implemented in India in 2017, have encouraged the women to seek health care at institutions, yet a lot needs to be done still because the studies carried till recently, along with the present study, show that still there are some reservations -personal, cultural, economic and social- which inhibit women from institutional deliveries.

Mother's education remains the most powerful determinant of inequality in survival. Children of mothers with secondary or higher education are almost three times as likely to survive as children of mothers with no education (MDG Report,2015) and poverty results in low level of education, as can be seen among the mothers in the present study too.

The respondents of the present study have access to the health services and they have utilized these, though a further in-depth study is required to understand the frequency and amount of utilization and the benefits accrued by the pregnant and lactating mothers. All of them have visited the doctor during their pregnancy, though the frequency varied, yet it cannot be concluded that they are aware of the health care facilities available to them because many still had their deliveries at home and were not eligible for CMB (Conditional Maternity Benefit), where early registration, institutional deliveries and referral are essential. CMB has been launched to encourage institutional delivery and some conditions are attached to it so that the recipients take full coverage of the health facilities available to them. The scheme envisages providing cash incentive amounting to Rs 6000/-, transferred to the bank accounts of the beneficiary directly, during their pregnancy, childbirth and lactation period, provided they register early, go in for at least one ante natal check-up, register the birth of their child and immunize the child. Their underweight status and their responses show that post-natal care was not accessed by them, though according to them they had sought care during pre-natal period. The Child Care Card had been prepared after all deliveries, by the ASHA, yet the mothers had not kept it safe and it may be concluded that they have not immunized their children fully, against the prescribed diseases. They gave very vague responses to the questions regarding immunization status of their reference child. Living below the poverty line they can hardly afford the transport expenses to the medical facilities, frequently.

Regarding the role of health care workers, it can be concluded that ASHA workers played a positive role during pre-natal period but had not advised the mothers regarding post-natal check-ups. All respondents gave colostrums to the child as the ASHA workers had advised them about this. The ANM played positive role during pre-natal period, but immunization advice was not given to most of the mothers after the birth of the child. Mothers were provided necessary information, regarding their new born, by the health staff during post-natal period, but since they had lost the Child Care Card the mothers were not able to tell the birth and post-natal history of their reference child. Mathew (2012) concluded that there are significant inequities in childhood vaccination based on various factors related to individual (gender, birth order), family (area of residence, wealth, parental education), demography (religion, caste), and the society (access to health-care, community literacy level) characteristics. Urban infants have higher coverage than rural infants and those living in urban slums. There is an almost direct relationship between household wealth and vaccination rates. The vaccination rates are lower among infants with mothers having no or low literacy, and families with insufficient empowerment of women (Mathew 2012). In the capital of this country, Elizabeth et al. (2015), in their study on slum dwellers of Delhi, found that majority of these slum women are ignorant about the importance of post-natal care which was necessary for post-delivery care of the women and her infant.

The correct knowledge on the importance of ANC and PNC and various check-ups need to be carried out during pregnancy and postnatal period needs to be imparted to these women. Thus, health education and health promotion campaigns are needed for bring changes in the existing health-seeking

behaviours among urban slum women (Elizabeth et al.,2015). It was observed that ASHA, doctors and ANM's played an important role during pre-natal period, but during post-natal period, infancy and early childhood they did not play significant role.

Modi et al. (2014) conducted a study on the Health seeking behaviour of the Anganwadi Workers, the grassroot workers in the Integrated Child Development services scheme, having adolescent and maternal health as a key delivery area. The findings from their study assert that knowledge and awareness are not enough to motivate women to seek health care from the Government sector. The policymakers need to re-orient their priority towards these women health care providers who work at the grass root level and in fact are a "harbingers" of better health practices among women and children. They are the role models for their community, and their dismal performance in relation to their own health and government service utilization, may create a negative impact and reduce credibility (Modi et al., 2014).

Mothers were not aware about schemes launched by Government of India, for their welfare, but had availed some benefits due to them. All of them were BPL card holders and wished for more job opportunities from the Government. Most of them did not know about the CMB, though some of them had received Rs 1400 under the JSSK. They were not aware that their treatment at the Governmental facility was free, as most of them said that they have to pay fees for that. They were also not aware of the SGSY, Swarnajayanti Gram Swarojgar Yojanaa, a development initiative launched by the Government of India to provide sustainable income to poorest of the poor people living in rural and urban areas of the country, or any other schemes in operation for the poverty alleviation. The findings of a contextual analysis on women's autonomy and pregnancy care in rural India indicate that women's autonomy was associated with greater use of pregnancy care services, particularly prenatal and postnatal care (Mistry et al 2009). The respondents in the present study were mostly home makers, having low level of education and were living in poor conditions. They were dependent on their husbands and other family members for seeking health care, though the grassroot level health workers were playing a positive role.

CONCLUSION

There is still a need to improve the outreach of the developmental programs by using a multipronged approach:

a) **Generating awareness** among the women regarding the developmental and health initiatives is essential because in the present study most of the women were not aware of the schemes or the benefits or facilities they could avail from these. Till this happens the programs will not reach the grassroots. The Grassroot level heath workers should make the target groups aware of the complete package of schemes of maternal and child health.

b**)** Awareness regarding **Post-natal care** needs to be increased and all the grassroot level health workers have to converge their efforts regarding this. Though Anagnwari worker has a big role to play here, yet she is entrusted with so many responsibilities that she may not be able to do justice to the maternal and child health during infancy and early childhood on her own. She needs support for the other functionaries too.

c) **Education** is related to many indicators of maternal and child health. The Right to Education is granted by the Constitution of India, free and compulsory education is provided till 14 years of age, but still education is not a priority in families living below poverty line, where it is difficult to make the two ends meet. The awareness regarding the importance of education still needs to be generated in the rural and tribal areas, and the urban slums, among the

populations which have been marginalized, especially the females. Adult or continuing functional education programs should be extensively developed.

c) Government is taking a lot of initiatives but still somehow the maternal and child health seems to be improving at a very slow pace because of lack of ownership among the common people. **People's participation** has to be increased. This is possible only when each core worker and each individual feel it their responsibility to seek health.

d) Awareness regarding the **poverty alleviation programs** also needs to be generated. The families living below poverty line can take help of such initiatives to improve their financial conditions which will ultimately influence the maternal and child health status.

e) All the schemes of the government are now linked to ADHAAR, the unique identification number. The mothers need to be registered for the **Direct Transfer of Benefits** and for tracking them too, so that they could avail the benefits and be monitored.

f) The **local self-governance institutions,** under Panchayati Raj, need to be strengthened and made responsible for the maternal and child health care.

g) Though Health Providers in India are overburdened with the care, yet they need to be **sensitized about the need for dignity** among all the citizens, as many women refuse institutional deliveries due to lack of emotional support from the health care staff.

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In Search of Empowerment: Shirley Clarke's *Portrait of Jason* and Cheryl Dunye's *The Watermelon Woman*[1]

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Abstract

American filmmaker Shirley Clarke, in search of empowerment in the male-dominated world of cinema, challenged the racist and homophobic America of the 1960s with her pseudo-documentary (*Portrait of Jason*, 1967). This centered on a homosexual black man, Jason Holliday, who dreams of a nightclub act as a way of attaining success as a performer. The 16 mm indie film was forgotten for forty-six years until its 2015 success at the Berlin Film Festival. Over thirty years (1999) after *Portrait of Jason* was shot, American filmmaker Cheryl Dunye, a black lesbian who both represents and acts herself on screen, searched for archival material that might empower women actresses of the past by recovering their names and personalities. She thus shines some light on the "stories that have never been told", of those queer black actresses usually limited to stereotyped roles as mammies and perhaps not even credited in the movie. Both Clarke and Dunye present us with the small world that emerges from these hidden lives. Thanks to their art, both filmmakers were empowered; for the former, however, this happened too late.

Keywords

women; film; filmmakers; black culture; homosexuality; archives; empowerment.

It is the Sixties: "There is a feeling in the air that cinema is only just beginning" (*Film Culture* Editors 11). Such a "beginning" was identified with *cinema vérité*, known in France as a style of documentary filmmaking whose pioneer was French director Jean Rouch. As an anthropologist, Rouch was interested in the ethnographic quality of the conceptual framework of the films he directed, among which is the seminal *Moi, un noir* (1958), released for English-speaking countries as *I, a Negro*.

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The film focuses on a Nigerian immigrant in Abidjan, the Ivory Coast: it casts non-professional actors (some of them using a pseudonym), is shot with a 16 mm camera, uses nonsynchronous sound (due to the failure of the camera to provide sound and images simultaneously), and experiments with "jump-cuts" in the editing process.[2] The film ushered in the French New Wave movement, which was re-interpreted in the United States as New American Cinema, "a movement of feature-length, low-budget narrative films that ran against the grain of commercial filmmaking" (Suarez 40). John Cassavetes launched the movement – "an inheritor of the ideology of the Beat poets and writers and of the underworld of bebops and hipsters" (41) – in the States with *Shadows* (1959), an independent improvisational film exploring racial discrimination and interracial relations.

Not subject to the Hollywood industry and its time restrictions, or to the control of studio distribution, independent films mostly tackled political and social questions, such as discrimination and social representation, or topics that were held to be scabrous such as alternative sexualities and drug-addiction. The discussion of racial matters, which provoked acrimony and negative reactions among the conservative classes, was embraced by the left wing, the young, and the intellectually enlightened; indeed, the issue became a key element in film studies, and attracted several black students to university film programs (Snead 115). Black filmmakers' interest in "*recoding* black skin on screen and in the public realm by revising the contexts and concepts with which it had long been associated" (115) answered the desire of their black students', and of black members of the audience, to see their identity represented and honored. As time passed, the idea of assimilation and integration gave way to black self-awareness and sensibility, which informed the following decade (Brigham in Curry 93-94).

Women's cinema broke with patriarchal conventions in the filming of women and the stories that concerned them. As Judith Mayne puts it, "The development of feminist film theory and criticism in the United States has been shaped by three major forces, all of which are, like feminist film theory itself, phenomena of the late 1960s and early 1970s: the women's movement, independent filmmaking, and academic film studies" (83). A mordant critique addressed stereotyped images of women in the cinema, particularly Hollywood cinema; documentary feminist films inspired by independent filmmaking tackled feminist issues in such a way that political consciousness was raised, while developments in film studies stimulated women to question the very image of woman (84). On the other hand, the question of "female authorship," deriving from the debate on the meaning and function of *auteur* in France, was ambiguously received at the time.[3] Issues such as "the *auteur* theory" and "the film director is" [or isn't] "the single force responsible for the final film," could [or might not] be interpreted according to the "famous equation of the camera with a writer's pen" as a "denial of the possibility of any female agency" (94), became the order of the day, and threatened the public and critical success of a film.

As far as racial matters were concerned, African-American issues re-surfaced in movies where cultural stereotypes about black people abounded, but now there were also characters who were "hip, powerful, rebellious, and sexually active directly [defying] Hollywood's stereotypes of black men as asexual servants and yes-men," and offering glimpses of a new reality (Covey 3). One reality that had been covered up, or ignored, until then was that of people with both a "black and queer" identity. In the Sixties and through the Seventies such cinema images tended to be those of the "sad, lonely, "deviant" homosexual on the fringe" (Pincheon 154).

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Shirley Clarke (1919-1997), a white privileged woman of an affluent Polish-Jewish background, stands out as an independent female filmmaker who produced a number of films about the events in black people's lives in urban Sixties America. A biographical sketch written for *The New York Times* at the time of the restoration of the first of these films, an adaptation from Jack Gelber's play that Clarke produced after seeing Judith Malina's staging of it at The Living Theater on 14th Street earlier in the year, reads as follows:

"Dancer bride, runaway life, radical filmmaker and pioneer – Shirley Clarke is one of the great undertold stories of American independent cinema. A woman working in a predominantly male world, a white director who turned her camera on black subjects, she was a Park Avenue rich girl who willed herself to become a dancer and a filmmaker, ran away to bohemia, hung out with the Beats and held to her own vision in triumph and defeat." (Dargis 2012 online)

In another article, the journalist mentions some equipment Clarke lent to Cassavetes, "bankrolled by family, friends and strangers," to work on the improvisational film on interracial relations that would launch his career (Dargis 2004, 2012, and Baumgarten, all online). An instance, that is, of her personal involvement with the group of filmmakers that was working on independent productions. She was a supporter of African American filmmaker Madeline Anderson, who said of herself, "I filmed history in the making, and it was an honor," and of Clarke, "Shirley was one tough lady whose values and humanity was what… I know a lot of people disapproved of her" (Martin 89).

Just as Clarke turned her shoulders to her own social environment, she also made friends with people she "did not at all resemble, at least sociologically — the beat poet, the jazz musician, the black junkie queen" (Gustafson, 1977, 2). After her marriage with Bert Clarke, to escape her father and devote her talent to dance, that ended in divorce, she had a long romantic relationship with African American black actor, Carl Lee – Cowboy in *The Connection* – that lasted until his death. On her private-and-professional choices, she commented in 1976: "For years I'd felt like an outsider, so I identified with the problems of minority groups. I thought it was more important to be some kind of goddamned junkie who felt alienated rather than to say I am an alienated woman who doesn't feel part of the world and who wants in."[4]

In 2008 Milestones Films started an archival research with the purpose of restoring her

films. "Project Shirley," which comprises four volumes – *The Connection* (1961), *Robert Frost: a Lover's Quarrel with the World* (1963), *Portrait of Jason* (1967), and *Ornette, Made in America* (1984) – was completed in 2016. All, except the one on Frost, focus on black culture, as does *The Cool World* (1963), a piece on black street stories shot in Harlem. The last of the Sixties' productions has been the most provocative and the most provoking. To Rabinovitz, it is "an insightful exploration of one person's character while it simultaneously addresses the range and limitations of cinema-verité style." An interview made in 1985 at the Chelsea–Hotel in New York City, where Clarke had been producing her video work since the Seventies, reveals her attitude at things feminine or feminist:

"I like to see feminist films, but I've never been able to make one";
"I prefer to be in the anthologies of filmmakers: between René Claire and René Clemont is Shirley Clarke. What I'm saying by that is that I want to be identified with the body of filmmakers, not just women. What will really help women is if they show up everywhere";
"Classifying the kinds of women's films that are being made and analysis [are] needed. We need to take ourselves seriously. Even things as basic as: what is women's consciousness? It has to be politicized. It has to be historical. There are certain biological facts. Women do give birth, but I think when a man puts out his sperm he's also giving birth. The main differences are cultural. In an intrinsic human way, there are very few differences between men and women. It has nothing to do with whether you can lift a brick. None of this matters anymore";
"My images are not feminine images or masculine images, they are general political concepts. But I have a theory about the coming world, the future millennium. If creatures exist, the choice will not be the man. Man does not have the endurance. He won't be necessary. He's the expendable one. Stash a whole bunch of sperm somewhere and go on for the next fifteen hundred years."
(Hallek 1985, online)

From the interview one realizes that, in order to be empowered in a profession that rewarded only men, Clarke's social consciousness suggested that she did not need to choose between playing a female or a male role, but that her work would need to make a political and cultural difference. In *Portrait of Jason* she acts out her differences while her character acts out his own: she plays the man-director, he the woman-actress. That is enough to expose the limits of *cinéma verité.*

Jason Holliday is, in real life, a friend of Lee's father, the actor Canada Lee. Unasked, he would appear at Clarke's place to help with domestic work and earn some money for "his nightclub act." Sometime later, as Clarke tells her interviewer, she bumped into him and revealed her idea: "I'd like to film you doing what you do, telling those stories you tell and talking about your life". Her partner Lee would question him, while her role would be that of "white lady director" (Rabinovitz 1983, 10-11) and off-screen interlocutor. The film starts and Jason, the one-time "houseboy" turned hustler, performs – through "every story" and "every variation" (11), through being his own self and impersonating female stars, through recollection and quotation – the narrative of his life. Overall, twelve hours filming at the Chelsea hotel came down to roughly an hour and forty-five minutes after editing. Clarke reflected on her experience as director:

"An interesting and important fact is that I started that evening with hatred, and there was a part of me that was out to do him in, get back at him, kill him. But as the evening progressed, I went through a change of not wanting to kill him but wanting him to be wonderful. Show him off. I went through getting to love him as I spent months sitting at my editing table trying to decide which half of what I filmed I was going to drop. I developed more and more of a total ability to understand where he was coming from – leaping cultural gaps, his homosexuality, his opportunism, his hype. I changed a lot of judgmental ideas by really getting to know Jason."

There is verbal aggression towards Jason on the part of the film crew. He "has been laying himself bare," the interviewer adds, "except you don't know if it's real or if he's performing" (11); then, Clarke:

"He cries, and then in the middle of his sobbing, he turns it off. I tried to make a good ending, but each time I thought it was over, he

would pull back and do another trip on us: "I'm not lying." "Yes I am." You're right, and we are left with nothing else except that particular reality which happens to be Jason." (11)

The Sixties was a time when homosexuality was a crime: "To be black and gay meant a life on the margin of the margins" (Westphal online). Second-wave feminism, however, though divided along the lines of race and sexuality, offered new ways of thinking about the struggle for black freedom. Film theory, on the other hand, followed the revival of women's studies, and instilled in cinemagoers a tendency to reflect on gender and power within the patriarchal structure of society. With homosexuality being something that even the person involved did not have clear ideas about, *Portrait of Jason* was among the first to promote the notion of LGBTQ culture. Jason was bold enough to expose his sexual identity, and fight to enforce the reality of it; Shirley had the intelligence to record his dramatic outpouring and believe in her character's survival. In the end, as a human being, he triumphed; his director, unfortunately, did not. Though the film was eulogized as an important product of the New York avant-garde (by Bergman, Ginsberg, and others), and Jason attracted Gilles Deleuze's attention for his style of *fabulation* that provides it with "political" validation (Ning'o, online), Clarke was eventually "written out of histories and dismissed as a dilettante" (Dargis 2012, online).

* * *

Thirty years later, and another independent filmmaker, black director Cheryl Dunye, risked ruffling people's feathers – to borrow *New York Times* reviewer Stephen Holden's figure of speech – with the politics of gender in her film *The Watermelon Woman* (1996). "A hybrid of autobiography, documentary, comedy, and meta-narrative, it was a landmark of New Queer Cinema and the first feature film directed by an African American lesbian" (Kelsey, 2016, online), reads a report of its 2K HD restoration on its 20th anniversary. Alexandra Juhasz, Dunye's partner at the time, was the producer; photographer Zoe Leonard created the fictional archive of the documentary photos, an artwork that provides visibility for what was invisible and has functioned independently from the movie; the author's own relationships were involved in this undoubtedly artful production. The title comes from Melvin Van Peebles' *The Watermelon Man*, a story by Herman Raucher about a white insurance salesman who wakes up one morning to find that he has become black. From white identity to a black identity. Dunye uses her own version of the entitlement as "another way to talk about race" (Kelsey, 2016, online). She does so from a feminist viewpoint that coincides with Mark Reid's claim that black films focus on the black community, and are written, directed, produced, and distributed, of necessity, by black filmmakers. He also appeals to Teresa de Lauretis to support his argument for a "gender-class-race analysis that also examines black films in relation to its political and cultural context in African-American history" (Reid 3); hence the word "feminist" used as one of the qualifiers of his cinematic critique (3). With humor and grace Dunye focuses on real and fictional identity; the representation of identity; the expectation or disbelief of a gender identity; the acknowledgement or refusal of a gender identity; the entitlement or repression/denial of a racial identity; and finally, reciprocal interracial desire.

The irony that runs through the film draws attention to the various aspects of identity that are left unresolved. The director's search is an inquiry into these aspects, while the fictional director (the real director is cast as a film director in the movie), who works in a video store, sets out to make a film about a Thirties black actress who played the stereotypical black woman's role; the mammy. This woman with "something interesting, something serious" in her face is not credited by name but is simply referred to as "the Watermelon woman"; she shares, in fact, the destiny of several other black actresses, whose "stories have never been told" (as we can hear at the beginning of the film, *The Watermelon Woman*).

The fictional Cheryl Dunye digs into the archives in search of all possible biographical details of the fictitious queer black actress who tends to her missy in *Plantation Memories*, a long-forgotten film on slavery. Through the protagonist's historical library and repository research, a complex intersecting of social, gender, racial, and class identities is revealed, which addresses issues of social inequality, discrimination, and oppression. A name, finally, emerges: the actress and singer is called Fae

Richards, who, Cheryl discovers, worked, and had an affair with white director Martha Page.

The dynamics of intersectional issues develops diachronically in *The Watermelon Woman*, also thanks to "the search for the (fore) mother"— as Frann Michel (2007, online) puts it— that "drives the protagonist" to iconize black womanhood (and thus the stereotypical elderly black fat mammy) as the "grandmother" figure. In order to support her claim, Dunye interviews distinguished cultural critic Camille Paglia, who, far from stigmatizing the watermelon as the "signifier of racist representation alluded to in the film's title," professes her "love for the mammy figure […] who reminds her of her Italian grandmother." She thus exposes her "critique of oppressive essentialist stereotypes operating in the academic discourse" (Mazur, 2013, 78). Synchronic intersections, on the other hand, are at work in the cinematic gaze that reworks the conventional patriarchal gaze into a multitude of possibilities, the foremost being the black lesbian perspective within a wider spectrum of gender, race, class, age, and even body shape or size (Mason 2017, 51). All in all, the final product can work as "a powerful medium to catalyse social change" (Kaur, 2017, 22), in keeping with the idea of cinema as a weapon to demolish stereotypes and taboos as expressed in this year's first issue of the *Amity Journal of Media & Communication Studies*. However, a critique in a germinal text by race theorist Kimberlé Williams Crenshaw *et al.* published twenty-eight years ago and reiterated in a 2013 article, makes it clear that "a particularized intersectional analysis or formation is always a work-in-progress, functioning as a condition of possibility for agents to move intersectionality to other social contexts and group formations"[5] (303). If the next move in intersectionality theory is to reconceptualize identities in coalitional terms, then let us bear in mind that "[f]ocusing on the self, on its wholeness, provides a major impetus for individual and collective empowerment." (Collins, 2016, 135).

As an African-American lesbian, Dunye has revisited the 'local' – developing into 'universal' – memory and has peopled it with the female artist's female ancestors, as well as the female members of the audience, reuniting them to form a collective multifamily community within which all marginalized characters and identities can be at home and not feel rejected. In this type of extended family there is no room for privileged members, not even – since we are focusing on cinema – for a privileged gaze that assumes a male director or spectator and makes women the objects of the male director's or even the spectator's gaze. If we think of English critic Laura Mulvey's critique of the male gaze in her much-quoted essay, *Visual Pleasure and Narrative Cinema* (1975), we can easily interpret Dunye's work as an intention to *unscrew the locks from the doors* of all marginalized people's homes in order to free them from the dominant mainstream wielding of power.

Much of what is problematized in the film remains open to further discussion. The pairing, for example, of the black director Cheryl with the white and rich beautiful idler Diana, recalls the discovered relationship between the actress Fae and her director Martha Page. According to Mark Winokur, while the text represents "a desire for wholeness," it highlights the project of integrating "the filmmaker and her on screen persona," and also "the filmmaker and the possibility of making films" (2001, 243, 235). It also integrates the biological with the social, the actual and the metaphorical, the documentary with the fantastic, history and fiction. Brutality and violence are excluded from this richly multifaceted film. It is an all-female world where women's empowerment is not only possible, but just as natural as men's empowerment in the different world that we inhabit. "Engaging with the past and present histories of African-American women's experiences," writes Michel, "reveals both the permeability of borders and the power of creative transgressions" (2007, online). Could such border-crossing work at all levels, and resistance to boundaries become assistance, compliance and cooperation?

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Portrait of Jason and *The Watermelon Woman* endow two representatives of humanity in different ways, providing unforeseen visibility. For different reasons, the two films would not be the same without the "lack of control" that derives from the editing of the work. An alternative editing technique might have removed certain psychological aspects: for instance, important Freudian slips, "those accidental errors, which

result from momentary loss of control over language, where we would normally edit or entirely edit out the undesirable (suppressed) content" (Mazur, 2013, 77). Whether we hear what we wouldn't like to hear (like Clarke's and Lee's racist comments in *Portrait of Jason*), or we are caught within a non-functional digression (like the interviewees staring back to Dunye's camera in *The Watermelon Woman*), we are being shown different stories or fragments of different stories that would otherwise be lost. What is underneath may be just as interesting as what is on the surface.

Both Shirley Clarke and Cheryl Dunye present us with a small world that works within these differences.

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[2] This technique consists of two sequential shots of the same subject taken from slightly different camera positions, and gives the effect of jumping forward in time and space (Bordwell and Thompson 254).

[3] For a discussion of the question of cinema authorship following the heated debate in France on the *auteur* of the film and the development of the notion up to today, see the chapter "Female authorship reconsidered" (Mayne 89-123).

[4] The quotation is from projectshirley.com.

[5] Crenshaw published, with other authors, "INTERSECTIONALITY. Mapping the Movements of a Theory." The essay followed "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics" (1989), and "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color," where intersectionality is advocated to elide the vulnerability of women of color from immigrant and socially disadvantaged communities (1991).

Democratization, Globalization and Women's Empowerment: A Critical Review and Conceptual Framework

Barbara Wejnert*

ABSTRACT

This manuscript attempts to provide an answer to several theoretical questions concerning the interaction between the processes of democratization and globalization, and women's empowerment. By integrating conceptual models of political processes and global market economic development, this study overviews several mechanisms of democratization and globalization that could lead to women's empowerment but may fall short of actual positive outcomes for women. The critical review and derived conceptual framework groups political and economic variables to explain why the benefits of democracy and globalized development are not equally distributed across genders. Consequently, this critical review can be used to address the implications for future research on, and policy making for, women's empowerment.

INTRODUCTION

Two trends have dominated the world since the 1970s—the rapid diffusion of democracy and the proliferation of globalized development--defined as countries' level of development through the spread of the global market economy (Przeworski et al., 2000). There is a pervasive belief that these two trends interact, that liberal democracy, human rights, and equality go hand-in-hand with being modern and with adopting a global market economy.

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Accordingly, since the turn of the millennium, many studies have focused on the relations between people's quality of life, democracy, and development (Kapstein & Converse 2008; Przeworski et al 2000; Przeworski 2010), as well as on the positive impact of democratization on development and societal well-being (Garrett 2004; Shafer 1994). These studies indicate generally that both trends have brought substantial improvements in people's lives, where democracy and modern development are paths to increased levels of literacy, education, industrialization, urbanization, and overall well-being of citizens. Accordingly, democratic growth is considered a symbol of progress, wealth, a high standard of living, freedom, liberty, and happiness, as well as a sign of modernity and the forces that advance the technological and cultural progress of world societies (Lipset 1960, 1994; Joffe, 2009). Furthermore, economic problems are believed to be ameliorated with the adoption of democracy (Lederer, 1992), leading financial institutions often to require that countries democratize in order to receive financial aid or to be eligible for foreign investment (Robinson, 2004; Wolf, 2001).

One might assume that the global growth of democracy and economic globalization (i.e., a global spread of market economy) across the recent decades would improve the well-being of women, and in turn lead to women's empowerment, as reflected by increases in their representation in the workforce, equal pay for equal jobs, equal educational opportunities, improvement in women's health care, longer life expectancy, higher decision making power in familied and comunities, greater political

participation, and overall womne's higher social position. Indeed, in the long term, women do achieve improvement in countries that achieve a high level of development and democracy (Molina and Purser, 2010) and gain political rights in democracies (Fallon 2003, 2010; Fallon et al. 2012). In turn, once empowered, women significantly contribute to improvements resulting from democracy and development in terms of (i) increased education and decreased dropout rates of their daughters (Coleman, 2004; Kabeer, 2005; Luz and Agadjanian 2015; Shahidul, 2013); (ii) increased ratios of girl-to-boy enrolment in primary and secondary education, which directly increases a country's GNP (Hill and King, 1995; United Nations Millennium Project, 2005: 47); (iii) increased autonomy in health decisions regarding maternal and family health and fertility (Beer 2009; Murthy, 1996), which leads more generally to increases in societal health (Bloom, Wypij and Gupta, 2001) and a decline in child mortality (Gakidou, 2010); (iv) increased participation in the labor force (Beer 2009); (v) increased engagement in civil society, including feminist movements that demand gender equality and advancement of women's rights (Chattopadhyay and Duflo, 2004; Fallon, 2010); (vi) increased political and legal awareness and engagement in national politics, thereby establishing policies that protect minorities (Murthy, 1996; Rueschmeyer 1998; Tripp, Casimiro, Kwesiga and Mungwa, 2014); and (vii) increased input into policymaking, which typically invests in areas relevant to families (Bertrand, Duflo & Mullainathan, 2002).

However, there are recent findings that are discordant with conclusions about the benefits of democratization for women. For instance, during the transition to a global market economy and democracy in former Soviet countries, relative to men, women's employment declined substantially (Wejnert, 2002), as did their rate of inclusion in politics. For example, by the late 1990s, women's unemployment skyrocketed to 60-70 percent in Russia and the Ukraine, while the rate for men was also high but reached on average 40-50 percent (Zherebkina 2000). Such high women's unemployment rate constrasted sharply with the communist period when the female employment level was one of the highest in the world (Bodrova & Anker 1985). The disadvantaged position of women in the labor market was further amplified by gender wage inequality (on average, women earned 60 percent of men's wages). In some of the former Soviet countries, a decline in the provision of women's health care, especially medical assistance at birth, led to an alarming increase in maternal mortality (Wejnert and Djumabaeva 2004; Wejnert, Steimetz and Prakash, 2013).

Similar processes are being observed in currently democratizing West Africa, where the interplay between gender relations, democratization, and economic empowerment of women (e.g., via microfinance) is challenged by persistent economic crisis and a dominant patriarchal ideology in gender relations (Belanger, 2012). Particularly, the demise of domestic manufacturing (an economic domain in which women are particularly involved), the decline in the practicality of small farms and rural areas, and the privatization of some of the governmental institutions that are vital to women's employment and services has had a particularly negative impact on women in West Africa (Belanger, 2012).

Consequently, it is quite possible that the beneficial effects of democratization and global market economic development (popularly known as globalization or globalized development) are not uniformly equal, nor occur temporally at the same rate, in all groups within a society. Indeed, across countries, women who have more complex societal roles than men and whose employment is more tenuous, are more vulnerable to the rapid restructuring in macro-political and economic systems and bear more of the costs of politico-economic changes (Walsh 2012, Waylen 2007). Thus, several scholar demonstrate that across countries, the effects of globalization and democratization on men are positive concerning education and economic

opportunities, however, women experience several challenges (e.g., Beneria 2003, Fallon, Swiss, and Viterna 2012; Seguino, 2000). These include a decline of women's labor force as a function of democratic growth and the ratio of girls to boys in elementary and secondary schools (Wejnert 2015: 14-15). And as research show, low schooling for girls means slower growth for all (Klasen, 2002:346). Plausibly, the indicated decrease in women's labor force participation leads to a decline in women's decision-making power within families causing a lower enrolment of female children in schools—an assumption in accord with Coleman (2004) and other studies (Luz and Agadjanian 2015; Shahidul, 2013). Morever, some studies indicates that the economic and social equality of gender is often absent in emerging democracies. For example, over time, female life expectancy declines with an increase in democracy in lower developed countries, a seeming contradiction to the popular assumption about postivie effects of democracy (Wejnert 2015: 14-15), and the emerging democratic regimes co-opt the voice of women and absorb gender issues into their agendas suppressing demands for women's empowerment, like in Latin America and South Africa (Walsh 2012).

In sum, the effects of democratization and globalization on men and women across countries vary and while democratization and globalization leads to an increase in men's education and labor force participation, women's educational attainment, labor force participation and life expectancy are often challenged. Why, then, is democratization and economic globalization not as beneficial to women as to men despite feminist scholars' postulates that democracy, and modern, global development entail the enhancement of women's social status and position?

Regardless of substantial importance, critical review of studies on differential effects of worldwide democratization and a globalized, neoliberal economy as a function of gender are rarely available. Such paucity stems in part from limited research on effects of political and economic processes on women (few exceptions are studies by Fallon, Swiss and Viterna 2012, Viterna and Fallon 2008, Paxton et al. 2006, Walsh 2012 and Wejnert 2015). Nevertheless, the theoretical explanations seem necessary given the complexity of the interaction of democratization and global development in and of themselves, and the potential differential outcomes of these processes as a function of gender.

This study builds on the work of world polity (e.g., Fallon et al. 2012; Paxton et al. 2006; Przeworski et al. 2000; Welsh 2012), and global market economic development (e.g., Beneria & Bisnath, 2004; Beneria, Berik and Floro, 2016; Harvey 2005; Kabeer 2005; Kingfisher 2002). It integrates models of political and economic processes to uncover several mechanisms that could lead to positive outcomes for women from democracy and globalization but fall short of actual women's empowerment. This critical review and resultant conceptual framework are subsequently used to develop a conceptual model of women's empowerment and to explain why benefits of democracy and globalized development are not equally distributed across gender, i.e., why democracy is gendered.

MAJOR PROCESSES EFFECTING WOMEN'S EMPOWERMENT GLOBALLY

Two major components that refer to outcomes of a) democracy and b) globalization group political and economic variables to create the integrative conceptual framework of women's empowerment. Each component offers a different lens for understanding how variables o democracy and globalization influence women's empowerment and gender equality. The *first* of these components is associated with *variables of democracy,* which encompasses two sets of variables—*women's movements* and *legislative representation,* and each of these sets of variables is associated with sub-variables described in the text that incorporate women's opportunities to impact laws, policies, and

practices aimed at women's empowerment. The *second* component involves characteristics of the global market economic system, i.e., *variables of globalization* and incorporates three sets of variables that influence women's probability of empowerment and incorporate processes that modulate outcomes of globalization via structural characteristics of the modern market economy. Taken together in an interactive, heuristics manner, variables of democratization and globalization determine the probability of whether indicators of democracy and the assistance of globalized development empower women. Subsequently, the political and economic infleunces are altered by the characteritics of the women *per se* as important contributors to the empowerment process. The conceptual framework of women's empowerment combines sets of variables of democratization and the assistance of global market economy to determine a country's overall estimate of the probability of an adoption of policies that empower women.

1. Effects of Democratization: Women's Political Engagement
   - *Women's movements*
   a) Movements' strategies (outsider tactics, partial engagement and insider tactics)
   b) Movements' solidarity (international, national)
   c) Foreign aid
   d) Global milestone events
   - *Legislative representation*
   a) Election
   b) Gender quota

2. Effects of Globalization: a Global Market Economy
   - *Neoliberal principles*
   - *Economic disfranchisement*
   - *Welfare benefits*

3. Effects of Women's Characteristics

Effects of Democratization

The effects of democratization are mainly expressed by women's political engagements that have led to enormous changes in women's status, rights and women's empowerment across the modern world. These changes were brought through two main pathways 1) the emergence of *women's movement* frequently assisted by a formation of gender-oriented organizations, and 2) the *women legislative representation* either via election or by gender quota.

Women's movements

Starting with the women's suffrage in Western democracies in the early twentieth century until the most recent women's movements that have spread across the developing world, women have been able to secure the right to vote and ask for a broad range of social and political benefits using strategies associated with movements (Beckwitz, 2007). At the same time, countries have responded to women's demands by granting women's rights, implementing support for women's policies and legislation (Coleman, 2004, Coleman and Wittes 2008), and advocating gender equality that has led to the feminization of states (Viterna and Fallon, 2008). In Africa, burgeoning women's power and political engagement secured the largest number of women's parliamentary seats in the world (Tripp**,** Casimiro, Kwesiga and Mungwa, 2014), while in Canada, Mexico, and the United States women's political engagement led to the establishment of gender oriented policies (Bayes and Hawkesworth, 2014). However, as studies demonstrate, the success of a women's movement depends on several factors, including a) the movement's strategies, b) the movement's solidarity and coalition building, c) the impact of foreign aid, and d) milestone global events that propagate feminist goals.

Movements' Strategies. The most successful strategies employed by women's movements are (i) "outsider tactics", which are defined as the grassroots mobilization of women and men who press political institutions to establish and comply with gender policies; (ii) partial engagement of movement activists with the state by lobbying with legislators and policy makers to establish gender equality; (iii) "insider strategies", which engender good governance by increasing the number of women in elective and appointive governmental offices; and (iv) any

combination of the above (Bayes and Hawkesworth, 2014). Women's movements select strategies based on their longevity, historical legacy, and quality of democracy. In well-established democracies, such as the United States, Canada, and Mexico, movements use "insider strategies" or partial engagement with the state and compromise with other contesting social forces to achieve goals (Bayes, Begne, Gonzalez, Harder, Hawkesworth and Macdonald, 2006; Rueschmeyer, 2008). In low level democracies or non-democracies, women's movements use either "insider strategies," whenever a movement is organized by the social elite, or "outsider tactics" whenever a movement is formed on a strong platform of grassroots activism. For example, in Jordan, where most of the official and voluntary women's organizations have been established and led by women from the social elite, such as Queen Noor Al Hussain, Princess Basma Bint Talal, and the wives of the prime ministers, ministers, and senior officials, movement leaders use "insider strategies" and demand progressive gender reforms (Salameh 2016). In contrast, the grassroots feminist activists in Africa react to spreading international norms sympathetic to women's empowerment by insisting that governments incorporate gender equality in national policies—an" outsider tactic" (Tripp et al., 2014).

Movements' Solidarity. It is important to note that both insider strategies and outsider tactics are more successful when local women's movement is in solidarity both a) *internationally with a global women's movement* and *b) nationally* across social strata and movements within each country. Subsequently, since the early twenty's century, the cross-national solidarity of suffragist movements have led to the establishment of women's voting rights in Europe (Rubio-Martin 2014). As some scholars claim, the European suffrage movement was also associated with movements outside of Europe, and it started in the periphery (in Pitcairn Island and New Zealand) before moving to Europe and Western world (Markoff, 2003).[1] The international collaboration and contacts add momentum, strength, and legitimacy to the feminist agenda, which accelerates gender reforms. Unsurprisingly, women's activists work in alliances that model their activities on examples and accomplishments of successful movements (Tripp, et al., 2014). Across most countries in the world, as Paxton et al. (2006) demonstrate, international support is essential to women's suffrage and is vital for the election of the first women parliamentarians and the acquisition of 30 percent of a country's national legislature by women. Cross-national solidarity also stimulates the establishment of political organizations open to women's membership including one of the most progressive pro-gender organizations, the Pan-African Parliament of the African Union led by Gertrude Mongella of Tanzania, in which half of the parliamentarians are women (Tripp et al., 2014: 1-24).

Similar to the international solidarity, the national unity augments the success of women's movements. Thus, the unity of Spanish NGO's that represented women's movement exposed and publicized concerns affecting Spanish women, including the burden of austerity measures that has been particularly harmful to women, persisting gender-based violence and limited gender equality in politics. United Spanish NGOs delivered these concerns to the Spanish government (Women's International League for Peace and Freedom, 2015). Similarly, Indonesian women's movement to create the sense of Indonesian womanhood has defined

[1] Such claim is disputed by other scholars, showing drawbacks of studies that largely relied on sources available in English and thus considering only a fraction of the sources and literature available for the specific national histories of women's political rights. The outcome could be misunderstanding, particularly regarding the complicated history of women's suffrage in the Austrian half of the Habsburg Empire (Adams 2014). Not all scholars, however, support this dispute (Bader-Zaar 2015).

itself as peacemaker and fighter for liberation, simultaneously promoting issues of women's rights, such as banning polygamy, forced marriage, and Bali's tourism associated with sexual exploitation of women (Martyn 2005: 167-179). Thus, to increase success, women's movements shift alliances between different social groups (Kadivar 2013) and include non-feminist activists, political parties, civic organizations and non-state institutions (Viterna and Fallon, 2008). In contrast, limited solidarity deters the success of movements and the implementation of gender policies, e.g., the case of South African women's movement (Hassim 2006).

Foreign Aid. The success of women's movement is also modified by the support of *foreign aid* that helps to spread movements' agenda, legitimizes goals, and propagates policies that advance gender equality, thereby overcoming the inherent masculinity of states (Brush, 2003; Fallon, 2010; Waylen, 1998).[2] For instance, in a vacuum created by the absence of women's organizations in Africa, it was the grassroots feminist movements that gained access to the international aid aimed at improving *good governance*. According to Tripp et al., (2014) "…with a generally positive political climate brought on by the end of war and conflict, and redrawn national constitutions that included multiparty systems and incorporated women as members of governments, the ability to deploy available resources of international aid in a way that advanced women led to much greater gender equality across many African countries" (p. 13). As a result, female-friendly policies often are established out of a desire to be seen as compliant with donor objectives (Dollar and Kraay, 2000)).

There are, however, conditions in which foreign aid does not advance women. In contrast to the early stages of democratic transition that facilitate the global diffusion of pro-women policies, international donors dictate the conditions for women's empowerment in the aftermath of democratic transition, thus stiffening local innovations in activism (Viterna and Fallon, 2008). Pressure from international institutions limits the ability of local women to assert their position when programs proposed by international agencies unintentionally reinforce patriarchal power relations and traditional gender roles as was the case in Afghanistan and Kosovo (Eifler and Seifut, 2009).

Global Milestone Events. By-and-large, foreign aid has a positive effect on the increase of women's well-being, particularly during the occurrence of *milestone global events* that shift the attention of world polity towards women's empowerment and substantiate the pro-women agenda. Among these international landmark-like events are the 1st United Nations World Conference on Women in Mexico City in 1975, the United Nations Convention on Elimination of All Forms of Discrimination against Women (CEDAW) that was signed and ratified by almost all independent countries, and the 4th World Conference on Women in Beijing in 1995 that proposed an equal proportion of men and women in national legislatures and openly called for the greater inclusion of women in politics (Paxton et al., 2006; Ramirez, Soysal and Shanahan, 1997). These milestone events particularly impact countries that are open to new policies and where mobilized women can support female candidates, create forums for political lobbying, and run supportive media campaigns for decision makers with feminist agendas who vie for positions in their country's legislature (Bayes, et al., 2006; Tripp et al., 2014). In less open societies, global events have had a limited effect on the success of women's movements as was the case in some of the

[2] In 1997 the IMF adopted a policy of "…a more proactive approach in advocating policies and the development of institutions and administrative systems that eliminate the opportunity for bribery, corruption, and fraudulent activity in the management of public resources" (IMF, 1997). A similar approach was adapted by institutions of international aid.

democratizing post-Soviet countries (Saurer, Lanzinger and Frysak, 2006).

Women's Legislative Representation

The second factor affecting women's political engagement and the impact of women on the establishment of gender policies is *women's legislative representation*, either via a) *elections* or b) *gender quota*. By definition, democracy leads to an "increase of conformity between state behavior and citizens expressed demands" (Tilly, 2007: 140) and an opening of dialog and trust between government and citizens. An increase in democratization should lead to a higher representation of women in the legislatures of their countries (Dahl, 2000: 31) and, as some scholars argue, women representation in governing bodies have a stronger impact on women's empowerment than the impact of social movements (Hawkesworth, Harder, and Bayes, 2006). Nonetheless, a rise in the number of women in political institutions depends on (i) elections that are determined by the quality of democracy, and (ii) the adoption of a gender quota.

Elections. Quality of democracy, defined by multivariate measures of social equality, social diversity in public offices, rule of law, the competitiveness of an electoral system, and competent political parties, alters the likelihood of the election of women as legislative representatives–the higher the quality of democracy, the higher the chance for women to be elected (Diamond and Morlino, 2005). In particular, the completeness of political transition, i.e., the complete replacement of old regimes by new democratic leaderships, permits women to enter legislatures since new regimes do not hold preconceived gender discriminatory biases (Viterna and Fallon, 2008). However, in regimes that are in the process of democratic transition, leading institutions in the public sphere, civil society, and the media are rarely open to women, and women's participation in the legislature doesn't advance (Paxton and Kunovich, 2003). In these regimes, the process of democratization itself is guided by a country's pre-democratization legacy and historical experience with elections (i.e., multiple elections) (Fallon, Swiss and Viterna, 2012). As explained by Walsh (2012), when regimes are in the process of transition to democracy, the effects of democratization follow a curvilinear trend starting with an initial drop in women's legislative representation during the institutionalization of democracy followed by an increase in representation when countries gain electoral experience. The downward trend results from a shift in support for women observed after the initiation of democracy. Democratizing regimes that initially supported women's issues co-opt the voice of women, thereby lessening the power of women's demands. For example, during this turning point in South Africa, tribal leaders glorified women's domestic roles, political parties of demcoratizing Chile suppressed women's demands by absorbing women's issues into their agendas (Walsh 2012), and leaders of democratizing Poland ban abortion, promote procreation and asked women to return to domestic duties (Wejnert 2002). Often, non-democratic leaders sidestep the democratizing of leadership by incorporating women as legislative representatives and giving nominal power to women to create the impression of being modern and developing a modern society. Such strategy helps the non-democratic leaders to gain political advantage in elections but diminishes the *de facto* significance of women's political representation (Tripp, et al., 2014: 13), as was illustrated by policies of the President Alberto Fujimore in Peru in 1997 (Town, 2004) and leadership of President Pinochet of Chile (Walsh 2012).

Gender Quota. The effect of the gender quota, another key element influencing the efficacy of women's political power, is also conditioned by political factors. When at least one third of governmental positions are offered to women—the "gender quota"—more policies focusing on the improvement of women's well-being are likely to pass (Jones 1998). Thus, in India, the inclusion of women into one-third of the panchayats (local councils) enabled the councils

to elect women as political leaders (Bertrand, Duflo & Mullainathan, 2002). Subsequently, women-led councils in India completed 62 percent more drinking water projects than panchayats led by males (United Nations Women 2015). Also, in Norway, the presence of women in municipal councils increased childcare coverage (United Nations Women 2015). It is not surprising that women legislators actively work on an increase in women's representation in politics (Carr 2008). In established western democracies, women legislators concentrate on women winning presidential elections and on breaking the male control of governments (Jaquette 2009), while in fledging African democracies women legislators concentrate on passing gender quotas (Tripp et al., 2014).

Importantly, however, according to Paxton et al., (2008), democracy may have a positive impact on suffrage but not on the number of women in parliaments and many non-democratic regimes have a higher women's legislative representation than democracies. Therefore, the effectiveness of gender quotas varies highly and is a function of several factors including international pressure (gender quotas were only mildly successful prior to the Beijing conference) (Paxton et al. 2008), local culture such as the masculine cultures found in Latin America (Jaquete 2009), and the position of women in the social strata, such as an overall low position of women in India (Gibson, 2012). Consequently, despite the introduction of a gender quota, Mexico lags behind Canada with a smaller number of women in local and national governments, unequal employment, discriminatory employment due to pregnancy, limited access to health care, and higher levels of gender violence (Hawkesworth, Harder, and Bayes, 2006: 183). Also, gender quotas do not secure *de facto* political power for women in scheduled tribes (the socially disadvantaged casts) in India. Despite holding one third of the seats in such governments, the only power these women hold is a redistributive power, specifically, direct access to the redistribution of public good (e.g., housing and latrines) but not to decision making in the local governing institutions (Gibson, 2012). Similarly, prevalent "gender quotas" in the municipal and central governments of the former and current communist states have not empowered women as much as the Swedish women are empowered without a gender quota. Russia, which endorses a gender quota, scored 0.0 (on a scale of 0.0 to 1.0) on the index of Gender Empowerment Measure (GEM).[3] It is the lowest score in Europe and contrasts with the score of 1.0 found in equalitarian countries such as Norway and Sweden.

Thus, although many scholars consider the electoral system and political institutions to be detrimental to women's political power (Waylen 2007), gender quotas often advance women *de jure* but not *de facto*.[4] Especially, as argued by Fallon et al. (2012), in developing countries gender quotas do little to modify the curvilinear (initially negative and later positive) outcomes of democratization on women's representation in legislatures and women's rights, and the limited impact of gender quotas does not change even when feminist groups frame gender quotas as symbols of modernity and those supporting gender quotas as being modern.

In sum, regardless of the belief that political and cultural factors, rather than socio-economic factors, are the main contributors to women's parliamentary presence (Inglehart, Norris and Welzel, 2002) and that freedom of expression of citizens' political preferences is a

[3] Gender Empowerment Measure (GEM) was created by the United Nations Development Program to capture gender disparities in "women's participation in political decision-making, their access to professional opportunities and their earning power" (UNDP 1995:72).

[4] According to the feminist definition of democratic equality, both spheres, *de jure* and *de facto* equality of women should be present to account for gender equality.

major determinant of the provision of social welfare in democracies (Brook and Manza, 2007), neither the representation of women in legislatures nor gender quotas guarantee sufficient outcomes in democracies to increase women's empowerment so that it is on par with men (Vullnetari and King, 2011). Gender inequality could be especially problematic for new democracies in developing countries that are economically volatile, politically unstable, and are in the process of social, economic and political transitions. Not surprisingly, while analyzing women's political engagement in democracies, Fallon et al. (2012) found that "democracy operates differently in the context of developing countries" (p. 383). The uncertain effect of women's legislative representation on the increase of women's empowerment poses questions as to whether the interaction of democracy and the global market economy could shed more light on this issue.

Effects of Globalization

Since the 1970s, the global market economy also referred to as economic globalization, is considered to be a route to modern development and one of the most favorable precursors for the establishment of democratic institutions (Dahl, 2000). It focuses on curing the weak economies while simultaneously increasing the well-being of citizens across all social strata (Harvey, 2005:
88). Indeed, during the globalization era, since the 1970s through 2002, across the world, infant mortality rates decreased by almost half, adult literacy increased more than a third, primary school enrollment rose, the average life span increased by 11 years in low-developed countries, and looking forward, through 2025 worldwide life expectancy is projected to rise from 62 years to 68 years in less developed countries (United Nations Development Program, 2005). At the same time, the development of the global market economy leads to greatly increased inequality within states, and the social inequality is predicted to increase over time (Bourquiquon, 2016).Simultaneously, the power of disenfranchised social groups is predicted to weaken (Inglehart, 2016). Regardless of its expected potential, market economic growth has led to a substantial increase in social inequalities within countries, with the richest segments of societies gaining the biggest portion of resources and using economic power to shape politics in their favor, e.g., states reduce welfare support and decrease expenditure on state infrastructures like schools and roads to accelerate economic growth (Harvey, 2005). On the global scale, the most economically powerful countries can have a greater influence on global trade and finances, obtaining greater assets at the expense of others.

Growing social inequality particularly affects women because they are mothers and employees, and states support women's employment but not occupational achievement (Mandel and Semyonov 2006). Also, the globally prevalent gender gap in salaries adds to gender inequality. Therefore, regarding women, three factors illustrate the impact globalization a) *neoliberal principles*, b) *economic disfranchisement* of women, and c) effects on *welfare benefits*.

Neoliberal Principles. Neoliberal economy proposes that "human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade" (Harvey, 2005: 88). In developed countries, the global economy is intended to increase overall economic growth (e.g., by lowering inflation and interest rates) and in developing countries, it is supposed to cause state welfare expansion, thus improving citizens' well-being (Brady, Beckfield, and Seeleib-Kaiser, 2005). Consequently, democratizing countries are often "pressed" by foreign donors or networks of well-established democracies to adopt global market economy as a prerequisite for foreign aid or inclusion into global economic and political pacts.

Regardless of its benefits, entrance into the neoliberal global economy leads to many unexpected negative consequences. Rapid economic growth leads to a substantial increase in social inequalities within countries, with the less privileged segments of societies gaining the smaller portion of resources. According to comparative analyses conducted by United Nations Development Program, the social inequality that results from the market economy impacts the security and status of women's employment, lower women's earning power and disfranchise women economically (UNDP 1995: 72). With the expansion of social and gender inequality "in Latin America, where the first wave of forced neo-liberalization struck in the early 1980s, the result was, for the most part, a whole 'lost decade' of economic stagnation and political turmoil" (Harvey 2005: 88).

Economic Disfranchisement of Women. Considering increasing social inequality, Sequino (2000) argues that neoliberal economies use gender wage inequality to increase profit. The author claims that "inequality born by women appears to have a positive effect because this condition stimulates exports and raises profit expectations" (Sequino 2000: 1222) and in low-developed countries, the global economy leads to a surge of newly created jobs for women but these jobs are low-paid and tenuous. Democratizing and globalizing countries that are middle-economies, on the other hand, to stimulate economic growth and reduce unemployment, encourage female employees to forgo employment and return to domestic duties, e.g., semi-economicaly developed, post-communist democracies in the 1990s (Wejnert 2002).

Not surprisingly, a study by Tzannatos (1999) on women and the labor market in the market economies of democratic countries concludes that "market-based development alone can be a weak instrument for reducing inequality between the sexes" (p. 551). The negative impact of the global market economy on social equalities, the escalation of poverty, and an increase in women's disfranchisement contrast sharply with the democratic principle of equality. It also contradicts a claim that "the market economy proves attractive precisely because it is more conducive to individual self-realization than a society controlled the moral economy or largely regulated command economy" (Bratton, Matters and Boardi, 2004). Hence, Walker (2006) responds that democratization and market liberalization do not have to complement each other and, indeed, only a small portion of Democrats favor market reforms in the United States. In summary, in both democratic and non-democratic state, the economic well-being of women is compromised by a neoliberal economic system (McKinnon, B, S. Harper, J. Kaufman and Y. Bergevin, 2014).[5] Women are worse-off, however, in poor, non-democratic countries with a rightist ideology, for example, women are worse-off in not democratic Haiti than in the democratic Dominican Republic than is located on the same island and is economicaly similar (Moon and Dixon, 1985).

Welfare Benefits. Increasing social inequality influence strongly women's social position because women have a greater variety of social roles, the dual role of being producers and mothers, more tenuous employment status than men and lower salaries than men. Therefore, during democratization and the spread of the global market economy, women face several problems that are unique (Kingfisher, 2002; Stycos, Wejnert and Tyszka 2002, Wejnert and Djumabaeva, 2004). As studies indicate, in addition to the general difficulties stemming from rollbacks of state benefits, women experience new difficulties that reflect the

[5] In non-democratic states the conditions can be worse as in China where, in addition to much lower wages and higher job insecurity, personnel cutbacks are used to increase efficiency and more women than men are losing jobs. According to Wu (2014: p. 44), "Women benefitted most from the former planned economy".

elimination of benefits specific to women. Additional challenges include (a) cutbacks to women's benefits by employers, (b) reductions in welfare programs oriented towards mothers and children, (c) lower job security, and (d) lower wages than men (Kingfisher, 2002; Seguino, 2000; Wejnert, Steimetz & Prakash, 2013). For example, the negative effects of the market economy on women's welfare benefits was visible in well-established democracies in the 1980s. To achieve rapid economic growth, Canada, New Zealand, Australia, Great Britain and the United States cut welfare expenditures and boosted the involvement of states or provinces in social benefits moving the responsibility of basic protection and care from the national government to individuals and families. Those most strongly affected by these reforms were already economically and politically disenfranchised—poor mothers with young children (Kingfisher, 2002: 32-49). Since the 1990s in post-communist democracies that embraced the global market economy, an abundance of consumer products became available that eliminates the hours-long waiting time to purchase basic goods, thus saving women's time. Yet, unemployment among women is also disproportionally high, women lost most benefits that were common in communism, and private industry is less interested in providing maternal benefits. Maternity leave, job tenure, paid child-sick leave, day-care facilities on company premises or paid vacation leave ceased to exist in all but state-run companies (Fuszera 1994, Wejnert, Parrot and Djumabaeva, 2008). And in Kyrgyzstan, the democratizing, post-communist Asian country, the state government shifted limited economic resources away from maternal health and closed regional maternity units which resulted in a rapid increase in maternal mortality (Wejnert, Parrot and Djumabaeva, 2008).

Although democracies have the vitality to reverse the negative trend of growing inequality because democratic representation and direct pressure from social groups and individuals from outside of state bureaucracy can lead to welfare provisions (Moore and Dixon, 1985), yet, democracy in itself is not sufficient for achieving an equal society. Rather, it "depends on what the mass electorate does with the franchise" (Hewitt, 1977: 451). As discussed in a prior section, women limited social and political power and limited representation in legislatures *may not be sufficient to overturn embedded structural gender inequalities in global market economies* across the world's societies.

Effects of Women's Characteristics

Additionally, the attributes of women, *per se*, are important contributors to the empowerment process. Of course, as noted above, women interact within the larger societal context and the contextual influences most likely to interact with the political and economic milieu include social movements, gender quotas, women's representation in the legislature, and neoliberalism, education and employment opportunities. Nonetheless, women's characteristics involve factors that determine the perception of the value of empowerment and the actual feasibility to pursue or demand empowerment equal to men. Among such characteristics are women's status, personal characteristics, and behaviors. Women's characteristics play a salient role in modulating the impact of a country's political and economic system and directly influence processes of political decision making about whether to adopt policies, and to what extent those policies are ratified, that secure equality between sexes. Consequently, women's characteristics, together with political and economic factors, contribute to a country's threshold of adoption of actions or policies that could empower women.

The emphasis on women's characteritics is well-articulated by Mahvish Farooq (2015), who discusses the effects of the empowerment behavior of women on women's employment (e.g., control of their life, social mobility, and freedom of movement). In addition, the 2015 victory of Mrs. Ellen Johnson Sirleaf in the Liberian presidential election illustrates well the

significance of the characteristrics of the women, *per se*, on women's empowerment. Mrs. Sirleaf, the first African female president, was elected President mainy due to a high turn-out of women voters (close to 80 percent of Liberian women went to the polls during this first post-war election), the assertiveness and perseverance of Liberian market women, women's unity and strength of character, and the widespread determination of women to elect a female president (Cooper, 2017).

The importance of women's characteristics is most critically observed when considering the temporal rate of women's empowerment. Given equal exposure to information about gender empowerment and equal contextual influences, no other variable than the variation in time to empowerment--the very essence of the temporality of empowerment--so strongly suggests the contributory role of the characteristics of woman in women's empowerment.

CONCEPTUAL MODELING OF WOMEN'S EMPOWERMENT

Women's empowerment correlates with the larger societal context, where, among the contextual influences most likely to impact women's empowerment, there are characteristics of democratization that determine women's opportunity to form laws and policies and undertake actions aimed at women's empowerment and characteristics of the global market economic system (globalization) that affect the probability of women's empowerment. The influences of democratization refer to women's movements and legislative representation and involve: the solidarity and network connectedness of women's movements, foreign aid promoting gender equality, global support of women's equality, and the political inclusion of women. Among the influences of globalization are characteristics that alter welfare benefits and modulate outcomes of the global market economy for women, e.g., women's economic empowerment. Taken together in an interactive manner, the characteristics of democratization and globalization generate permissive conditions of women's empowerment that could to be empirically tested. Thus, empowerment of women could be measured by, for example, increase of women's education, labor force participation, parity of women's salaries, and better health. It could be also measured by the introduction of pro-gender policies that enhance the well-being, social position and decision-making power of women within family and community.

It is important to note that the interactive relationship between democracy and globalization provides a means of representing variables of individual countries determining women's empowerment. Thus, if value of democracy effects for any country is held constant across countries, variation in the adoption of policies that empower women would be highly dependent on a country's value of globalization effects. In any case, a country would have a characteristic threshold value that is subject to modification as a function of the changing effects of democratization, the outcomes of globalization and characteristics of women.

Consequently, such constructed conceptual framework would allow for a modeling of women's empowerment, i.e., an occasion when all the variables above can be quantified and integrated in an attempt to predict the level of women's empowerment. For women in any country, empowerment will depend on the relative values of outcomes of democratization and account for the mitigating impact of globalization effects, and a salient role of women's characteristics per se in modulating the impact of a democracy and globalization in a country.

Therefore, if there is a change in the effects of democracy, e.g. an increase in the intensity and size of women's movements that aims at women's rights, the country may adopt policies that empower women, even if the effects of

globalization are high, which would normally deter women's empowerment. For example, as implied by Tripp et al., (2014), the strong women's movement and increase of women's legislative representation in African countries greatly contributed to women's empowerment, regardless of the introduction of the global market economy that led to closing jobs that were typically occupied by women and led to a decline of economic profit from small farm productions that mainly benefitted women. Increase of oportunities of women's political represenation—one of the outcomes of democracy, increased the probability of adoption of policies that empowered women regardless of higher level of globalization that normally would have weakened the women's position and prevent adoption of policies supporting women.

A good example provides also a comparative evaluation of pro-women policies during the American presidencies of Ronald Reagan and Barack Obama. In both periods, women's legislative representation remained relatively stable and low in the United States. However, President Obama imposed regulations to control the free market economy, while President Reagan was a strong supporter of elimination of control measures of liberal market economy. President Obama adopted policies supporting women's empowerment, e.g., free maternal health screening, an enlarged "Supplementary Nutrition Assistance Program" (SNAP) program that supported many poor women and funded planned parenthood. In contrast, President Reagan introduced several restrictions on women's empowerment: substantial cuts to welfare provisions, no free women's health screaning and restricted abortion.

IMPLICATIONS FOR PRACTICES AIMED AT WOMEN'S EMPOWERMENT

Although, scholars agree that democracy and its principle of social equality is more beneficial to women than non-democracy (e.g., Moon and Dixon, 1985), the mere introduction of a democratic system or globalization does not lead to women's empowerment. Thus, the critical review presented above and resultant conceptual framework*, suggest at least three practical pathways that could* protect women's economic, social, and health benefits and develop equality between sexes in democratic and embracing global market economy countries. These pathways are: a) the strengthening of women's political rights, b) promotion of awareness of global gender disparities, and c) addressing the negative effects of globalized development on women.

First, there must be a pronounced emphasis on the implementation of *women's political rights*--the right to vote and hold public office greatly empowers women (Avdeyeva, 2015; Metelska and Niedzielska, 1993; Paxton et al., 2012). Women's presence in governing institutions secures women's rights, protects their well-being, and prevents the withdrawal of resources from women during economic downturns, as well as during economic and political stability. The former situation is exemplified by the condition in newly democratizing Kyrgyzstan, where the government closed regional maternity units when faced with limited economic resources causing maternal mortality to skyrocket to the point of requiring help from the World Health Organization. At that time, women constituted only 3% of the members of the Kyrgyz Parliament, the Duma (Stephenson, 1998; Wejnert and Djumabaeva, 2004). On the other hand, there is an amazing increase in gender equality and prosperity in Uganda and South Africa, where today there are more women in politics than in most well-developed countries (Goetz, 1998). Furthermore, Rwanda ranks first in the world in the number of women representatives in the elected lower house of parliament as of 2014 (Hunt, 2014:152). All three countries, with gender inclusive policies, are rapidly developing economically. Hence, creation of inclusive political space helps to create responsive democratic governance.

Second, it is crucial to disseminate an *awareness of gender disparities* and disfranchisement of

women globally and, at the same time, to *promote knowledge about women's achievements* and contributions to the development of countries. Through such actions traditional gender-biased practices that undo the achievements of gender mainstreaming would be circumvented. This calls for a focus on increasing public recognition of the enormous potential of the empowerment of women for the development of a country and for global development. Social equality is fundamental to global progress, prosperity, peace, and to future improvements in societal life. As Kofi Annan, Secretary-General of the United Nations noted in referring to women, "…study after study has shown that there is no effective development strategy in which women do not play a central role. When women are fully involved, the benefits can be seen immediately: families are healthier; they are better fed; their income, savings, and reinvestment go up. And what is true of families is true of communities and, eventually, of whole countries" (Annan, 2002:3). And what is true of women may be equally true of other disfranchised groups. Recognition of the impact of women and other less privileged groups on the overall development of countries could not only defray the short-term negative outcomes of democratic and market economic transitions, but also hasten the processes of consolidation of democracy and global development (e.g. Paxton et al.; Walsh, 2012; Wejnert, 2015).

Third, an emerging economic gap between social strata that results from the interaction between democracy and the global neoliberal economy may foster discrimination against women, which departs sharply from the democratic value of equal opportunity for all citizens. This seems especially true for countries that democratize while simultaneously embracing a global free market economy. Costs such as unemployment, unequal access to financial and other resources and the resulting poverty can be substantial and overshadow the positive outcomes of democracy (Bourquiquon, 2016; McKinnon et al., 2014). To aid women during countries' economic downturns, protective measures securing women's economic and social position need to be implemented.

Despite the many ways in which democracy and globalized development enhance people's well-being, as critical reviews show, there are several challenges to positive outcomes for women. These differing effects of democracy and the global economy to women's empowerment need to be considered as policies develop in emerging as well as established democracies.

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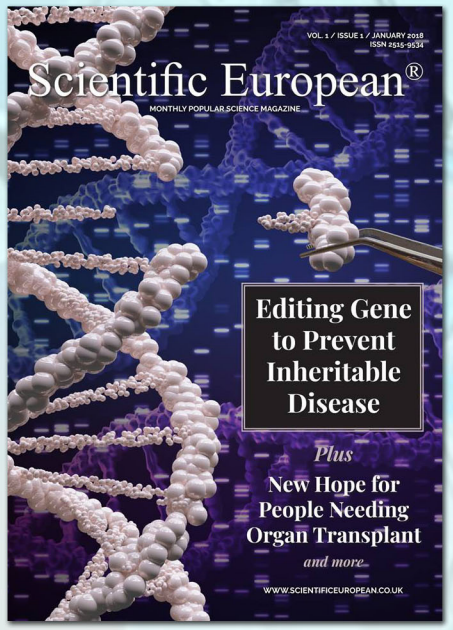

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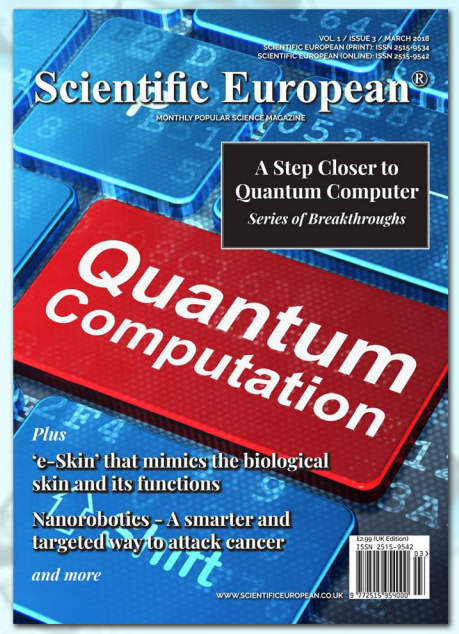

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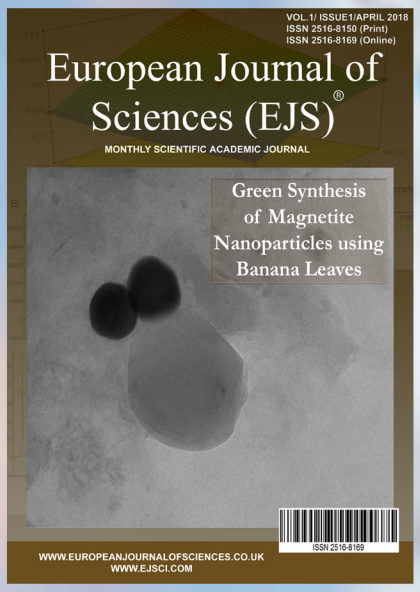

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