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Original Article

COMPARATIVE STUDY OF SELECTED PARAMETERS OF GENDER DISCRIMINATION IN RURAL VERSUS URBAN POPULATION OF AHMEDABAD, GUJARAT

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ABSTRACT

It was a population based cross sectional study done with the objective of comparing some parameters (attitude & practice) of gender discrimination (GD) in rural and urban areas of Ahmedabad district. A population of 963 (446 urban & 517 rural) showed alarmingly adverse sex ratio (SR) as low as 562 among urban preschoolers. GD was prevalent in both study areas but manifested differently. Preference of male child by both partners an indicator of gender discrimination was seen in both areas, It correlated with female literacy, their low mean age at marriage and first conception. While urban areas showed more adverse sex ratio coupled with awareness and use of Ultrasonography (USG) for sex determination and poor employment status, rural areas exhibited (along with adverse sex ratio) poor literacy and employment status of females and poor contraceptive use.

Key words: Gender discrimination, sex ratio, rural and urban areas

INTRODUCTION

"Biggest disease today is not leprosy or tuberculosis, but rather the feeling of being unwanted" (Mother Teresa).

"You can tell the condition of a nation by looking at the status of its women" (Pandit Jawaharlal Nehru).

'Women's rights are the edifice on which human rights stand' (Dr APJ Abdul Kalam).

Above statements by great human beings find an echo in a comment by United Nations that discrimination against girls anywhere in the world is a social ill and violation of human rights which must be stopped.[1] Gender describes the socially construed roles, activities and responsibilities assigned to women and men in a given culture, location or time. Gender is defined as a social construct of the set of qualities and behaviors expected from male and female[2]. While an individual's sex does not change, gender roles are socially determined and change over the time period. A child's sex is determined before birth but gender is learned[3].

The word discrimination means **treat differently** and gender discrimination (GD) means relatively different treatment to the persons (by society) on the basis of gender. Females in our society meet inferior treatment and this discrimination is widely prevalent in all areas including health care and in both rural and urban areas. It reflects through many direct and indirect parameters. "Son preference affects all aspects of women's life, including child care, health education, employment, because she is discriminated sine the moment she is born and sometimes even before if sex selection procedures are available". [4]

Sex Ratio (number of females per 1000 males) and preference of male child are two indicators from Gujarat which reflect the GD situation in the state. Data from Census 2001 depicts a decline in overall sex ratio from 934 (1991) to 920 (2001) and more so for urban areas (from 907 in 1991 to 880 in 2001). This decline is more

pronounced in children up to 6 years of age (45 points from 928 in 1991 to 883 in 2001) against the drop of 18 points (from 945 in 1991 to 927 in 2001) for entire nation[5]. The proportion of couples in Gujarat who currently have 2 sons or 1 son and 1 daughter and do not want any more children varied between 90 – 95 percent while this proportion for couples with 2 daughters was only 49 percent[6]. We believe that GD is prevalent in both rural and urban areas of Gujarat but manifests differently. Therefore this study was conducted to document the gender discrimination and compare rural and urban differences reflected by various parameters.

MATERIALS AND METHODS

A population based cross sectional study was carried by trained medical social workers under the direct supervision of us (RS) with the help of structured questionnaire using interview and observation technique during October to November 2006 in the catchments areas of rural health training center (Santej) and urban health training center (Sanand) of the institute. A house-to-house visit to cover 100 eligible couples (married couples with the age of female partner ranging between 15 and 44 years) each from both areas was carried out through stratified sampling. Sample of 100 couples for each area (total 200) was considered adequate for the logistic reasons. In order to ensure the fair representation of entire study area, each area was divided into 4 quadrants and 25 eligible couples from each quadrant were taken and first house was selected randomly, if last house had more than one eligible couple than all couples from that house were covered. Verbal consent was obtained from all the respondents prior to interview. Subjects were explained objectives of the study and assured of confidentiality. Data was analyzed in EpiInfo and wherever found necessary tests of significance such as chi square for qualitative and Z test for quantitative data were applied to check the statistical validity of observed differences.

RESULTS

Populations of 446 from urban and 517 from rural areas were covered which yielded 101 (urban) and 104 (rural) eligible couples (against the sample size determined as 100 from each area) from 107 and 120 families respectively. Based on mean family size, families were slightly larger in rural (4.3) than urban areas (4.2). Eligible couple rates were high in urban (226.5/ 1000) than in rural (201.2/ 1000) areas. Overall unfavorable sex ratio was observed in both study areas. It was alarmingly adverse among urban under fives (562.5) and favorable for > 45 years in both areas (table 1).

Table 1: Sex ratio (SR) as per the age of study subjects (N=963)

Age (Years)	Rural		Urban	
	Number	SR	Number	SR
0 – 5	53	1028.3	50	**562.5**
6 – 15	112	836.1	113	1017.9
16 – 45	279	910.1	240	983.5
> 45	73	1085.7	43	1263.2
Total	517		446	

SR = number of females per 1000 males

Literacy status of female partners amongst these couples was significantly high in urban than rural areas ($X^2 = 49.6$; df = 3; $p < 0.001$). Higher education too was more in urban areas (table 2).

Table 2: **Education status (percentage) of studied women**

Education Status	Rural (104)	Urban (101)
Illiterate	42.9	9.1
Up to primary	18.1	11.5
Up to SSC	12.4	19.2
SSC & above	26.7	60.4

Very few women (5.0% in urban & 10.6% in rural) were employed. However, rural females were engaged in menial jobs, while in urban areas they were engaged in other jobs as well. Ages at marriage, first conception & first delivery for females were low in general but all three were significantly low in rural areas ($p < 0.01$) (table 3).

Contraceptive use is largely perceived as responsibility of females while the decision in this regard is largely taken by male partners or even other family members such as mother in law. Ever Contraceptive use rate which is based on contraceptive use by either of the partner and includes of past and/ or current use was significantly high ($P < 0.001$) in urban (68%) than rural (55%) areas. Dominant reason for poor contraceptive use in rural areas was

"husbands don't want it". Ultrasonography (USG) is a common test performed during pregnancy for sex determination of fetus. Based on the recall, more women in urban (29) underwent USG than in rural areas (19) and the difference was statistically significant ($p < 0.05$). When asked about the indication for USG, majority women in both areas mentioned "advice of doctor", while 5 and 4 women from urban and rural areas respectively confessed of undergoing it for sex determination of fetus. USG rates rose with education of women in both areas. Male child preference (son syndrome) was there and was more in female partners from rural (50 %) than urban areas (41.5 %).

Table 3: Some parameters showing gender discrimination in rural and urban areas

Parameters	Rural (N = 104)		Urban (N = 101)		Statistical analysis	
	Mean	SD	Mean	SD	Z Value	Interpretation
Age at marriage	17.7	2.8	19.6	2.8	3.2	Significant
Age at first delivery	18.6	5	20.1	4.1	2.3	Significant
Age at first conception	18.3	4.9	20.6	4.3	3.7	Significant
No. of live birth	2.2	1.3	1.9	1.1	0.53	Significant

More females in urban areas were either unclear or not particular (or diplomatic?) about gender of child (25.7 % compared to 11.5 % in rural areas). Large numbers of male partners (more in rural) were unavailable during the survey. However, their preference for male child too was high in both areas but was even higher in urban areas

Table 4: Preference child's gender (percent) by female partner

Sex	Percent response	
	Rural (104)	Urban (101)
Male	50	41.5
Female	35.6	32.6
Any one	11.5	25.7
Not replied	2.8	0

DISCUSSION

In the absence of any recognizable pressure, studies world over suggest a SR (number of females per 1000 males) at birth as a biological constant with a value of about 943 – 945 females per 1000 males[7]. SR in our study was alarmingly low (562) for urban preschool children (table 1). It is an accepted fact that the impact of differential sex selective undercount, age reporting and migration is negligible in this age group and the SR here are principally influenced by sex ratio at birth and to some extent on sex selective mortality in this age group. Higher SR favoring elderly females seen in both areas (table 1) are due to the excess male mortality in this age group as a result of occupational exposure in males, longer life expectancy for females and cardiac and respiratory diseases which affect more males (missing males!). Current adverse sex ratio among under-fives if remain unchecked, will take little time to show its impact in higher age groups, as it has cumulative effect. Adverse SR has been linked with low status of women in communities which in turn is determined by her position in industry, occupation, economy, education and decision making power in the family[7]. Female literacy as well as the proportion of women with high education was high in urban areas in the present study. Education especially female education is a major factor influencing health. It leads to better utilization of health care and greater community/ political participation[8]. Because of low literacy only 5 to 10 percent women in this study were employed. Though female employment rate was high in rural areas, they were engaged mainly in unskilled job but in urban areas due to better education were engaged in variety of jobs. Literacy status does not seem to be beneficial for improving sex ratios in this study as there were stronger factors other than literacy in causation of decline in female population. Despite the fact that proportion of women with higher education was high in urban areas, the adverse sex ratio was more in urban areas. Pre-conception and pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) act has not worked as a deterrent. Improvement in literacy and subsequent improved education and employment opportunities will take time to develop the favorable attitude and reflect in practice. Mean age at marriage, first conception

and first delivery all three were significantly low in rural areas, which deprive these women from educational and job opportunities. More number of live births in rural areas shows high-unregulated fertility and poor contraceptive use. Contraceptive use was significantly low ($p < 0.001$) amongst rural couples (55.0%). Dominant reason for non use of contraceptive was husband do not want in rural and no need perception in urban areas. Contraceptive use depends upon education, attitude and availability of services[8]. Desire of male child was more in rural indicates prevailing gender discrimination. Male child preference was more overtly prevalent in rural females though the difference was statistically not significant ($P > 0.05$), but literate women in urban areas are sometimes diplomatic in stating as aware of the current facts. Renu from Chandigarh had four abortions in five years says that according to her husband having a son is more important than having a child[9].

Five women in rural and 4 in urban in this study underwent USG for sex determination but under reporting cannot be ruled out and it was observed elsewhere[10] that USG rate rose with education of women. Here 13 percent women had undergone sex determination and there were two female feticides. It also revealed the fact that despite the ban on sex determination the practice still continues in north India through private clinics[10]. Son syndrome is a reflection on the low status of females in our society. Important reason for this are social responsibilities perceived to be undertaken by males such as propagation of family name, support in the old age, perform cremation and dowry[11]. Ironically, USG which is one of the most beneficial diagnostic tools to monitor fetal health but in connivance of some of the doctors is widely misused in sex determination leading to female feticide leading to the skewed SR in children.

CONCLUSION

Historically India had a deficit of women compared to most other countries. Until the 1980s, women and girls were dying either of neglect or were killed soon after they were born (infanticide). Today, thanks to 'advances' in medical technology, they are now eliminated while still in the womb. Female feticide has become an organized crime and the ultrasound machine has turned into an instrument of murder. This study explores GD as prevalent in both areas and is evident by alarmingly low sex ratio (SR) among urban under fives (562), high USG rates in urban especially in educated ones. Low education and high dropouts (female), poor quality/ quantity jobs, low contraceptive uses reveal gender discrimination in rural population. Main causes of non-use of contraceptive – "**husbands do not want** or "**desire for son**" summarizes the scene in rural and urban areas respectively. More women and men everywhere preferred male children.

RECOMMENDATIONS

- Gender discrimination is deep-rooted so women empowerment through better education, employment opportunities and reservation at various places only, in long term can eliminate this problem.
- Intensive and sustained Information, Education and Communication (IEC) campaign to masses through all channels with the incorporation of rural and urban specific messages.
- Monitoring of sex ratio at birth through civil registration system must be intensified. Complete registration of births and deaths especially of girls, pregnancy and abortion should be pivotal function of village/ nagar panchyats to safeguard against the evil practice of feticide.
- Implementation of PNDT act should be more meaningful and realistic. As such the legal measures can play limited role in correcting this imbalance and discrimination. Still the persons whether from community or amongst care providers once found guilty should be severely punished.
- Removal of GD cannot be achieved by the health department alone, therefore, each one from the society such as parents, teachers, social scientists, doctors, lawyers, journalists, political and religious leaders within their own domain have to play a role to curb this practice.

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