

## ORIGINAL ARTICLE

## Female gender disadvantage and its impact on Psychological morbidity: A cross-sectional study among married Indian rural women of child bearing age

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### Abstract

**Background**-Male preference is deeply entrenched in the society. Gender disadvantage predisposes to limited education, employment opportunities and healthcare. **Aims and objectives:** To assess the Gender disadvantage in rural married females and its impact on their psychological morbidity. **Methodology:** Analytical Cross sectional study was conducted in a randomly selected village of a rural health block. All the eligible women were interviewed using Door Knock Procedure. Psychological morbidity was assessed using 20 items Self Rating Questionnaire (SRQ-20). **Statistical Analysis:** Data was analysed using SPSS ver 20.0. Tests of significance applied were Chi square test and ANOVA. P value of <0.05 was considered to be statistically significant. **Results:** Prevalence of Female gender disadvantage was 59.89%. Parental male predisposition and socioeconomic status were found to be statistically associated ( $p < 0.05$ ). The women's own preference for a male child was strongly predicted by their own gender disadvantage from the parents. Statistically significant difference in psychological morbidity was found amongst women who had both parental male predisposition and lack of empowerment in comparison to those who did not have these ( $p = 0.00$ ). **Conclusion:** Psychological morbidity due to gender disadvantage is a cause of concern. Social awareness and strongly enforced laws like PC-PNDT can reduce these preferences.

### Keywords

Female; Morbidity; Mental Health; Social Structure

### Introduction

Childhood and adolescence are crucial phases of development and denial of opportunities like education, health care, autonomy etc prevent a person to thrive to the best of potential often leading to poor mental and physical health. The norms prevalent in the family, community and society result in gender biases at younger ages and are root cause of inequality and discrimination against women.(1) Indian Society is largely Patriarchal, females after marriage are faced with limitations and discriminations which lead to poor mental health. (2) Incorporation of Article 15(3) in Indian Constitution

provides a safe guard to Indian women against discrimination (protective discrimination).(3) Ending discrimination against girls and women is not only a basic human right but also required for sustainable development and economic growth.(4) In 2018, India was at rank 122 for Gender inequality index calculated for different countries.(5) Although strict laws and legislations have been enacted in India, still young girls face discrimination even after marriage. Social structure of the society, norms and cultural factors contribute towards this inequality. Mortality, natality, employment, ownership, schooling, basic facilities and house hold inequalities are seven types of gender inequalities

described in India which have a negative impact on future generations.(6)

## Aims & Objectives

1. To assess the prevalence of Gender disadvantage in rural married women of reproductive age group and its association with socio demographic and reproductive factors.
2. To study the impact of Gender disadvantage on women's own Gender preferences and psychological morbidity.

## Material & Methods

**Study type:** Analytical cross sectional study

**Study population:** All married women in the reproductive age group

**Study Area:** A randomly selected village of the rural health block of Jammu.

**Study duration:** The study was conducted over a six month period.

**Sample size calculation:** All the married women in the reproductive age group in the selected village were invited to participate in the study

**Inclusion criteria-** Married women in reproductive age group, residing in the village.

**Exclusion criteria-** Women who were suffering from chronic diseases, did not give informed verbal consent, bereavement in the family or among near or dear ones in the last one year, on medication for psychiatric disorders, presence of social problems in the family like alcoholism, drug addiction etc. were excluded from the study.

**Strategy for data collection:** All the villages in the rural health block were numbered and using lottery method, a village was randomly selected. Information of was procured from the family folders available at the sub centre located in the village. List of all the eligible women was drawn and they formed our study subjects. The information was collected by face to face interview and for this purpose a questionnaire was developed by the researchers by reviewing the literature available on this topic. The questionnaire was pretested for validation on a group of women with similar socio demographic characteristics in the neighboring village before applying it on the entire subjects.

The following Contact procedure was followed while approaching selected households and the participants to conduct the survey.

1. The household addresses were located with the help of FMPHW/ASHA worker.
2. Door knock procedure was followed to Knock on the door
  - If Someone opened the door then we talked to the first adult we came across in the household.
  - If no one answered the door-knock then we moved around the side of house to see if someone is present or left a message with the neighbour.

In case house hold members were not available at the time of the first visit, at least 3 different visits were made to obtain an interview. We tried to choose appropriate time to ensure availability of study subjects –early morning or late afternoon.

3. Introduced ourselves & exchanged greetings to develop a rapport.
4. Explained the detailed reason for the visit and purpose of the survey.
5. Explained how the information will be collected, the survey process and the time frame.
6. Completed the Household schedule and noted the names and details of all eligible female members starting from the eldest to the youngest.

**Data collection tool:** Information was noted by trained researchers on a pre-tested semi structured Performa.

- a. Information on socio demographic profile including socioeconomic status (using modified Udai Pareekh scale (7) and reproductive history.
- b. **Assessment of psychological morbidity using Self rating Questionnaire-20-(8,9)** The self-rating questionnaire is based on the original 20 questions which indicate non-psychotic mental disorders. The questions are answered as yes or no and try to decipher information pertaining any pains and problems which the subject has undergone in the last 30 days. Hindi version of the questionnaire previously used in India, was used for the interview.
- c. **Parental Male Predisposition:** Preference given to male siblings in the family by the parents of study subjects in the younger ages was asked by inquiring about their feelings like, the male siblings had better access to Education, male siblings were favored with regards to goods and facilities available in the household, in case of sickness better health care facilities were provided to the males.
- d. **Empowerment:** Was assessed by enquiring about freedom a women had in parents or husbands house to go out and work or interact with friends outside their home.

Women who had only parental male predisposition or only lack of empowerment or both i.e. Presence of parental male predisposition and lack of empowerment were characterized as suffering from Female gender disadvantage.

Own Gender Preference of women was assessed by enquiring about the importance of having a male child for them, whether they would prefer to have a male or female child as their first child. Whether they would prefer to have only male children or only female children or both.

**Interview Procedure-** Face to face interview were conducted by a group of researchers who had been previously trained for this purpose. After obtaining informed verbal consent, privacy was ensured by preferably conducting the interview in a separate room or in an open place. Attempt was made to provide an

atmosphere that encouraged the respondents to speak freely, yet keeping a focus on the issues and to explore the deep-seated emotions and feelings.

**Ethical approval:** Ethical Permission was sought from the Institutional Ethical Committee of the college and after due approval the study was commenced.

**Consent:** Informed verbal consent was obtained from the head of the family and the participant.

**Data analysis:** The information collected was coded and analyzed using SPSS ver 20.0. The qualitative and quantitative data were presented percentages and Mean  $\pm$ SD. The tests of significance applied were Chi square test and ANOVA. P value of  $<0.05$  was considered to be statistically significant.

## Results

In the present study, 215 women were invited to participate out of which 197 gave consent and were included. The mean age of women was  $32.31 \pm 8.01$  years and range of 17 to 55 years. Maximum study subjects were Hindu (54%) by religion followed by Sikhs (43%) and others (3%). 83.2% women were housewives and 16.75% were working. 46.2% women belonged to nuclear family while 46.7% followed by 40.6% belonged to middle and lower middle class resp. 80.20% women were literate. Prevalence of Female gender disadvantage was 59.89%.

[Table 1](#) shows that 41(20.81%) women were at Female gender disadvantage with regards to parental male predisposition at younger ages and 58.5% of these women belonged to lower middle class. There was a significant difference between presence and absence of parental male predisposition and socioeconomic status among the study population ( $p=0.04$ ).

The mean age at marriage was  $20.68 \pm 2.75$  years. Those who felt that their parents preferred male child were at Female gender disadvantage and had interestingly developed their own Gender preference for male child (46.34%) and this difference in two groups was statistically significant ( $p=0.00$ ) ([Table 2](#)).

53.6% of those women who were empowered with regards to autonomy from parents/ husbands belonged to middle class and there was a significant difference between those who were empowered and not empowered ( $p=0.00$ ) with regards to Socioeconomic status. ([Table 3](#))

[Table 4](#) shows that those women who faced Gender disadvantage in terms of lack of autonomy from parents/ husbands had a significant ( $p=0.007$ ) bearing on their decision of having number of children, as husbands of 28% of these women were institutional in deciding the number of children. Also 37% of these women thought that it was very important to have a male child as compared to 13.40% empowered women for whom having male child was very important. This difference in two groups for own gender preference of Son was found to be statistically significant ( $p=0.00$ )

There was a significant difference in Psychological morbidity among women who had both parental male predisposition and lack of empowerment as compared to those who had either of these or none of these ( $p=0.00$ ) ([Table 5](#)).

## Discussion

This study elicited Female gender disadvantage by enquiring about two factors among women i.e. parental male predisposition and women empowerment. More than half of women (59.89%) reported to have faced female gender disadvantage. Interestingly, all across the world, preference for male child by parents starts even before a child is born, parents want their first born to be males and this gender inequality or disadvantage towards daughters continues during childhood, adolescent period and adulthood. This is often reflected in providing nutrition, facilities for schooling, opportunities for development and health care spending for sons as compared to daughters.(10) In our study 20.81% women felt that they had faced disadvantage with reference to preference of their male siblings by their parents. In the present study 58.5% of subjects who reported parental male predisposition, belonged to lower middle class, similar findings were reported by Parida SP et al who showed that preference for males was found to be highest among mothers of middle class followed by lower and then higher class (11). Diva Dhar et al have attempted to study the intergenerational transmission of attitudes towards gender in India and concluded that discriminatory gender attitudes were more prevalent among those students whose parents held similar views especially mothers.(12) Similar finding were observed in the present study as 46.34% of those reporting parental male predisposition also had inclination towards gender discrimination as they said that having a male child was very important for them.

A study conducted in Senegal showed that husbands, partners or others made health related decisions for 80.33% women and only 6.26% of women had autonomy to take decisions.(13) In the current study, among those who had faced male predisposition, decisions about reproductive factors like having children was taken by either husbands or others like mother in law (34.14%) as compared to this 25.64% women could not take decisions regarding number of children in the group that did not face parental male predisposition.

An important way to demonstrate women empowerment is by eliciting freedom of movement. In a study by Nayak et al it was found that approx 40% married women in rural areas had freedom to go alone to the market or the health facility and characteristics like age, education, marital status, type of family also affected women's mobility.(14) The similar figures in our study were 49.23% and empowerment was more in those belonging to joint family, middle class and had studied upto secondary level.

A study has demonstrated that 84.6% of those belonging to lower class had low level of empowerment.(15) Previous research has shown that 36.67% women did not have freedom of movement and 41.67% were not involved in decision making of health care.(15)The present study showed that 38% of women who were not empowered and were not institutional in deciding the number of children they should have.

Stephen A et al shows that as compared to less and not empowered women, highly empowered women were less likely to have intention to have more children (16). In our study 77.31% of those empowered had  $\leq 2$  children and among those who were not empowered the similar figures were 66%.

Engidaw et al in a study in Ethiopia reported that females especially in rural areas facing gender discrimination in terms of lesser opportunities for getting education or employment and violence were more likely to suffer from mental disorders.(17) In the current study the women who were at disadvantage had higher scores of SRQ 20. Several studies have reported high prevalence of depression among women in India and among the various reasons cited for this is the social factors and disadvantaged position of women.(18,19) Evidence shows that lack of women's autonomy often has association with poor mental health.(20)

### Conclusion.

Parental male predisposition and empowerment of women were significantly associated with socioeconomic status. The women's gender preference for a male child was strongly associated with their own gender disadvantage. Gender disadvantage had a significant impact on women's psychological morbidity.

### Recommendation

The focus of various social welfare schemes and health programmes should be on counselling not only husbands or male members or couples but also the families especially the elderly females about mitigating gender disparity in the society so that issues of psychological problems especially among females can be tackled. Social welfare programmes should focus on antipathy against daughters and also promote partner support.

### Limitation of the study

Since the sample size is small, extrapolation of the results may be limited. The cross-sectional study design rules out causality.

### Relevance of the study

The study has combined two aspects of gender disadvantage ie. Parental male predisposition and empowerment and has revealed that the long-term influence of these factors has a significant impact on psychological morbidity of females.

### Authors Contribution

BL and RK conceptualized and designed the study. RG and RM developed the protocol under the guidance of BL and RK. BL, RG and RM played a vital role in data collection. All authors have contributed in data analysis and interpretation. BL and RK developed the first draft of the manuscript which was edited by RKG and RL. All authors read the manuscript and approved it for submission to the journal.

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**Tables**

**TABLE 1 PARENTAL MALE PREDISPOSITION AND ITS ASSOCIATION WITH SOCIODEMOGRAPHIC FACTORS IN THE STUDY SUBJECTS.**

Sociodemographic factors	Parental Male predisposition		Total(197)	χ <sup>2</sup>	p
	Present (41) No (%)	Absent (156) No (%)			
<b>Type of family</b>					
Nuclear	20(48.8)	71(45.5)	91(46.2)	1.93	0.380
Joint	11(26.8)	58(37.2)	69(35.0)		
Three generation	10(24.4)	27(17.3)	37(18.8)		
<b>SE Status</b>					
Upper middle	5(12.2)	12(7.7)	17(8.6)	6.36	.04*
Middle	12(29.3)	80(51.3)	92(46.7)		
Lower middle and lower	24(58.5)	64(41.02)	88(44.67)		
<b>Education</b>					
Illiterate	7(17.1)	32(20.5)	39(19.8)	0.81	0.66
Upto middle	13(31.7)	39(25.0)	52(26.4)		
Secondary and above	21(51.2)	85(54.5)	106(53.8)		

\*p<0.05 statistically significant

**TABLE 2 PARENTAL MALE PREDISPOSITION AND ITS ASSOCIATION WITH REPRODUCTIVE FACTORS AND STUDY SUBJECT’S OWN GENDER PREDISPOSITION**

Study variables	Parental Male predisposition		Total (197)	χ <sup>2</sup>	p
	Present (41) No(%)	Absent(156) No(%)			
<b>Age at marriage</b>					
<21	22(53.7)	85(54.5)	107(54.3)	0.009	0.924
≥ 21	19(46.3)	71(45.5)	90(45.7)		
<b>No of children</b>					
≤2	28(68.29)	113(72.43)	141(71.57)	0.27	0.60
>2	13(31.70)	43(27.56)	56(28.42)		
<b>Institutional in deciding no of children</b>					
Self	9(22.0)	16(10.3)	25(12.7)	6.95	0.07
Husband	9(22.0)	29(18.6)	38(19.3)		
Both	18(43.9)	100(64.1)	118(59.9)		
Others	5(12.2)	11(7.1)	16(8.1)		
<b>Own Gender Preference for Son</b>					
Very important	19 (46.34)	31 (19.87)	50(25.38)	20.81	0.00*
Important	14 (34.14)	113( 72.43)	127(64.46)		
Not Important	8 (19.51)	12 (7.69)	20(10.15)		

\*p<0.05 statistically significant

**TABLE 3 EMPOWERMENT OF STUDY SUBJECTS & ITS ASSOCIATION WITH SOCIO DEMOGRAPHIC FACTORS**

Sociodemographic factors	Empowerment		Total (197)	X <sup>2</sup>	P
	Present (97) No(%)	Absent(100) No(%)			
<b>Type of family</b>					
Nuclear	39(40.2)	52(52.0)	91(46.2)	3.59	0.16
Joint	40(41.2)	29(29.0)	69(35.0)		
Three generation	18(18.6)	19(19.0)	37(18.8)		
<b>SE Status</b>					
Upper middle	14(14.4)	3(3.0)	17(8.6)	16.32	0.00*
Middle	52(53.6)	40(40.0)	92(46.7)		
Lower middle and lower	31(31.9)	57(57.0)	88(44.7)		
<b>Education</b>					
Illiterate	13(13.4)	24(24.0)	37(18.8)	4.24	0.11
Upto middle	26(26.8)	28(28.0)	54(27.4)		
secondary and above	58(59.8)	48(48.0)	106(53.8)		

\*p<0.05 statistically significant

**TABLE 4 EMPOWERMENT OF STUDY SUBJECTS AND ITS ASSOCIATION WITH REPRODUCTIVE FACTORS AND SUBJECTS OWN GENDER PREDISPOSITION**

Study variables	Empowerment		Total (197)	X <sup>2</sup>	p
	Present (97) No(%)	Absent(100) No(%)			
<b>Age at marriage</b>					
<21	47(48.5)	60(60.0)	107(54.3)	2.64	0.117
≥ 21	50(51.5)	40(40.0)	90(45.7)		
<b>No of children</b>					
≤2	75(77.31)	66(66.0)	141(71.57)	3.10	0.07
>2	22(22.68)	34(34.0)	56(28.42)		
<b>Institutional in deciding no of children</b>					
Self	13(13.4)	12(12.0)	25(12.7)	12.26	0.007*
Husband	10(10.3)	28(28.0)	38(19.3)		
Both	68(70.1)	50(50.0)	118(59.9)		
Others	6(6.2)	10(10.0)	16(8.1)		
<b>Own Gender Preference for Son</b>					
Very important	13(13.40)	37 (37.0)	50(25.38)	19.32	0.00*
Important	68 (70.10)	59( 59.0)	127(64.46)		
Not Important	16 (16.49)	4 (4.0)	20(10.15)		

\*p<0.05 statistically significant

**TABLE 5 PSYCHOLOGICAL MORBIDITY AMONG DIFFERENT GROUPS OF STUDY SUBJECTS BASED ON GENDER DISADVANTAGE.**

Study variable	No (197)	(%)	SRQ Score
Both Parental male predisposition and lack of empowerment present	23	11.7	8.26±5.48
Only Parental male predisposition present	18	9.1	5.50±3.25
Only lack of empowerment	77	39.1	4.31±3.44
Both Parental male predisposition and lack of empowerment absent	79	40.1	3.29±3.24

F=11.60, p=0.00