

Original Research Article

Factors influencing gender preference among women of Ambala, Haryana: a cross-sectional study

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ABSTRACT

Background: Preference for male child is well known phenomenon from ages. Sex ratio is an important social indicator measuring extent of prevailing equity between males and females in society. Changes in sex ratio reflect underlying socioeconomic, cultural patterns of a society. The situation has seemed to have gone out of hand in North India. The objectives of the study were to determine the factors influencing the gender preference of a child among women in reproductive age group; to assess the knowledge and practice about female feticide and pre-natal sex determination among them.

Methods: A community based cross-sectional study was conducted by interviewing married women of reproductive age group (15-49 years) attending general OPD and antenatal clinics in rural and urban health centers which are the field practice area of MMIMSR Mullana, Ambala district, Haryana. Data was analyzed using SPSS 21.0.

Results: Out of 400 women, 353 participated in the study. Preference towards male child was observed among 47% of women while only 14.2% preferred female child and 38.8% don't state any specific preference. Literacy level and type of family significantly influenced gender preference among women $p=0.0007$ and $p<0.0001$ respectively.

Conclusions: Female feticide is still in practice in spite of awareness programs and existing law. There is a dire need to gear up the efforts against this social malady of son preference by intensive IEC campaigns about rules forbidding pre-natal sex determination and strict implementation of PC-PNDT Act especially in rural areas.

Keywords: Gender preference, Female feticide, PCPNDT act

INTRODUCTION

Preference for male child is well known phenomenon from ages. India shares distinctive features of South Asian population with regards to the sex ratio with century old deficit of females. UNICEF states that systematic gender discrimination has resulted in up to 50 million girls and women 'going missing' from Indian population.¹ Changes in sex ratio reflect underlying socioeconomic, cultural patterns of a society. The preference for son and discrimination against the girl child is almost universal in India and is manifested in

many ways.² Most alarming is decrease in child sex ratio (CSR: 0-6 age group) which was 976 in 1961 and fell down to 940 according to 2011 census. Sex ratio in Haryana is 877 which are below national average of 940 as per census 2011.

The problem is getting worse as scientific methods of detecting the sex of the fetus and for termination of pregnancy are improving.³ The technology revolution which fueled the decline in birth rate, initially it was through amniocentesis which soon gave way to the relatively safer non-invasive technique viz.

ultrasonography this was lapped up by people at large so enthusiastically that it seemed that this fulfilled a long felt need of people. With the pressure from health activist building up and census (1991) showing further decline in female: male ratio, the government of India enacted PNDT (prenatal diagnostic techniques-regulation and prevention of misuse) Act in 1994. However, alarm bell started ringing for planners with census 2001 results which revealed the sex ratio of 933 females :1000 males which failed to improve much above the previous census data of 927 female:1000 males. The situation seemed to have gone out of hand in North India. Against this background and owing to declining trend in child sex ratio, a community based cross sectional study was carried out among married women in reproductive age group of 15-45 years to determine the factors influencing the gender preference of a child and also to assess the knowledge and practice about female feticide and pre-natal sex determination among them.

METHODS

A community based cross-sectional study was conducted among all married women in reproductive age group (15-49yrs) attending the OPD's at rural and urban health centers which are the field practice area of MMIMSR Mullana, district Ambala, Haryana from November 2012 to February 2013, after obtaining a written informed consent from each respondent who wished to participate in the study. At a confidence interval of 95%, considering the population of rural and urban health centres, the sample size using "survey system" software was calculated $n=250$ and $n=150$ for rural and urban areas proportionally, respectively (i.e., total sample of 400). Women were interviewed by using a pretested and semi-structured questionnaire and information on their knowledge and attitude towards gender preference, female feticide and sex determination technique was collected. Female patient attending the clinic were interviewed by lady medical officer and where lady medical officer was not present female health worker who was trained for the particular work was collecting the data. Single mother, widows and divorced females were excluded from the study. Cross checking of at least two completed forms daily was done randomly by the investigators on regular basis to ensure good quality data collection. Strict confidentiality of the data and privacy of the patient was maintained. Data was entered in Microsoft excel and analyzed using SPSS 21. Categorical data were summarized using percentages. Chi-square test was used to test the association between various study variables and $p<0.05$ was considered significant.

RESULTS

In the present study a total of 400 women in the reproductive age group from both rural and urban training health centers were interviewed. Out of 400 women, 353 willing consented to participate in the study. Out of 353, 219 (62%) were from the rural areas and 134 (38%) were

from the urban areas. Preference towards male child was observed among 166 (47%) of women while only 50 (14.2%) preferred female child and 137 (38.8%) doesn't state any specific preference. (Figure 1) The percentage of women who gave preference to male child was more among illiterates 56 (64.4%) and women educated up to primary school 61 (43.3%) as compared to women having education up to secondary school or graduation 49 (39.2%) and was statistically significant ($p=0.0007$). The preference for male child was observed to more in women belonging to rural areas 106 (48.4%) as compared to women from urban area 60 (44.8%) but there was no significant difference. Also, no significant association was observed among religion and gender preference of the child. Nearly two third 140 (65.7%) of women belonging to joint family gave preference to male child as compared to women belonging to nuclear family 39 (27.9%) and the difference was statistically significant ($p<0.0001$) (Table 2). The most common reason cited by the participants for the male preference was propagation of family name (89), support of old age (63) no dowry burden will be there if it is a male boy (56) and earns money for the family (51). There were multiple answers for this question and also some non-respondents (Figure 2). Majority 127 (94.7%) of urban women were aware of sex determination as compared to rural women 198 (90.4%) and the difference was statistically significant ($p=0.016$). Similarly, majority of women both in urban 123 (91.8%) and rural areas 192 (87.7%) knew that ultrasonography was used as technique for sex determination but the difference was not statistically significant. Maximum number of respondents replied that sex determination was done at private hospitals, urban 110 (82.1%) and rural 189 (86.3) women, most of the women from urban area 125 (98.42%) knew sex determination as crime as compared to 134 (61.2%) women from rural area also, urban women 82 (61.2) were better aware of the consequences of female feticide compared to the rural women 88 (40.2) and were found to be statistically significant with $p=0.03$, $p<0.0001$, $p=0.001$ respectively. In the present study, 15 (11.2) of women from the urban area and 12 (5.5) of women from the rural area had undergone sex determination with significant difference ($p=0.049$) (Table 2).

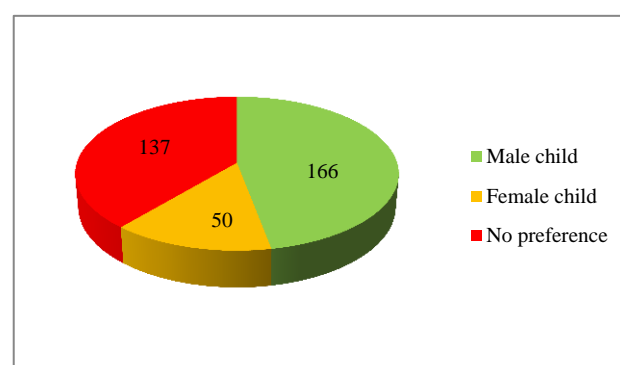


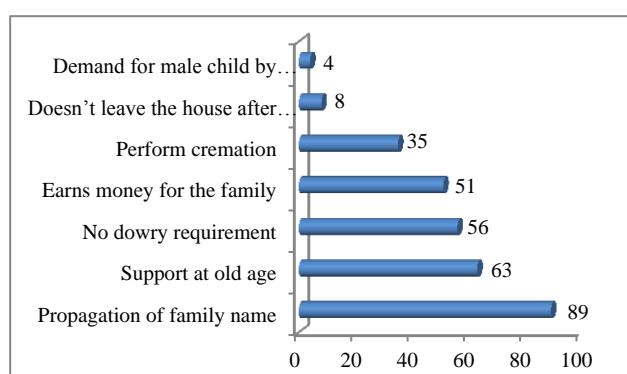
Figure 1: Distribution of women according to their gender preference.

Table 1: Distribution of women according to the factors determining their gender preference.

Variable	Male child preference (%)	No preference (%)	Total	P value
Literacy status				
Illiterate	56 (64.4)	31 (35.6)	87	$X^2=14.38$; df=2; p<0.0007
Primary/High school	61 (43.3)	80 (56.7)	141	
Secondary school/ Graduation	49 (39.2)	76 (60.8)	125	
Religion				
Hindu	84 (43.7)	108 (56.3)	192	$X^2=1.134$; df=2; p=0.567
Sikh	49 (39.5)	75 (60.5)	124	
Muslim	18 (48.6)	19 (51.4)	37	
Residence				
Rural	106 (48.4)	113 (51.6)	219	$X^2=0.4387$; df=1; p=0.5078
Urban	60 (44.8)	74 (55.2)	134	
Type of family				
Nuclear family	39 (27.9)	101 (72.1)	140	$X^2=48.47$; df=1; p<0.0001
Joint family	140 (65.7)	73 (34.3)	213	

Table 2: Distribution of women according to their knowledge and practice regarding sex determination.

Variable	Urban (n=134) N (%)	Rural (n=219) N (%)	P value
Aware of fetal sex determination			
Yes	127 (94.7)	198 (90.4)	$X^2=5.83$; df=1; p=0.016
No	07 (5.3)	21 (9.6)	
Technique used for sex determination			
USG	123 (91.8)	192 (87.7)	$X^2=1.469$; df=1; p=0.221
Don't know	11 (8.2)	27 (12.3)	
Places where sex determination is done			
Government hospital	13 (9.7)	7 (3.2)	$X^2=6.837$; df=2; p=0.0327
Private hospital	110 (82.1)	189 (86.3)	
Don't know	11 (8.2)	23 (10.5)	
Determination of sex of child is considered crime			
Yes	125 (93.3)	134 (61.2)	$X^2=43.83$; df=1; p=0.0001
No	9 (6.7)	85 (38.8)	
Implication of female feticide			
Yes	82 (61.2)	88 (40.2)	$X^2=14.7$; df=1; p=0.001
No	52 (38.8)	131 (59.8)	
Ever undergone sex determination			
Yes	15 (11.2)	12 (5.5)	$X^2=3.843$; df=1; p=0.049
No	119 (88.8)	207 (94.5)	

**Figure 2: Distribution of women according to reasons given for male child preference (*multiple answers).**

DISCUSSION

In our study, preference towards male child was observed among 166 (47%) women while only 50 (14.2%) preferred female child and 137 (38.8%) of women doesn't state any specific preference. Similarly, community based study conducted among women of Belagavi showed, male preference among 137 (34.3%) women, 250 (62.5%) considered both equal and only 13 (3.2%) preferred daughters.⁴ A comparative study conducted in Madhya Pradesh revealed that 50.75% primigravida didn't show any preference towards specific gender but 58 (43.28%) preferred male child and only 8 (5.97%) preferred female child.⁵ Our study showed that gender preference for a male child was more among rural

women when compared to urban women but the difference was not statistically significant which was contrary to a study conducted in Jamnagar, Gujarat which showed preference to male child was higher among rural (70.68%) than urban women (53.28%) and was statistically significant.³ Our study showed illiteracy and joint family were the factors influencing gender preference among women. Socio-cultural factors like religion, occupation of women, literacy status, socioeconomic status influenced son preference according to a study conducted in Belagavi.⁶ Unlike other similar studies conducted, religion and type of residence, were not found to be significantly associated with gender preference. The most common reason cited by the participants in our study for the male preference was propagation of family name, support of old age and no dowry burden which was similar to studies conducted in Madhya Pradesh⁵ and Belagavi.⁶ Similarly a study at Bareilly revealed that 80% females were aware of prenatal sex determination and 67% unaware of PNDT Act.⁷ A study which was conducted by found that 95% of the pregnant women were aware of the availability of a method for intrauterine sex determination. When they were asked whether female feticide was punishable, 53% of the participants said that they were aware that doing so was punishable under the law. In our study son preference was seen more among rural women indicating an association of education with son preference in the participants. Also the increased awareness about the illegality and immorality of gender selection may be a reason for not having or not disclosing so strong bias toward son preference in urban women as seen in the other studies.

CONCLUSION

Female feticide is still in practice in spite of awareness programs and existing law. There is a dire need to gear up the efforts against this social malady of son preference by intensive IEC campaigns about rules forbidding pre-natal sex determination and strict implementation of PCPNDT Act especially in rural areas. Also educational and occupational opportunities for females are important components to be addressed if girls are to be perceived as desired in our society. Also, with the up-liftment of the moral and ethical values of service providers from the beginning of their medical training can prevent female feticide. To answer the issues of declining sex ratio not only acts and rules are sufficient but we also need a strong social fabrication process to start from grass root level to curb the problem of female feticide.

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