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International Journal of Collaborative Research on Internal Medicine & Public Health
Vol. 4 No. 3 (March 2012)

International Journal of Collaborative Research on Internal Medicine & Public Health (IJCRIMPH)

ISSN 1840-4529 | Journal Type: Open Access | Volume 4 Number 3

Journal details including published articles and guidelines for authors can be found at:
http://www.iomcworld.com/ijcrimph/

To cite this Article: Aras RY, Veigas I, D'souza N. Gender Variables and Reproductive Behaviour of Women from Rural Mangalore, South Karnataka, India. *International Journal of Collaborative Research on Internal Medicine & Public Health*. 2012; 4(3):167-179.

Article URL: http://iomcworld.com/ijcrimph/ijcrimph-v04-n03-01.htm

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Paper publication: 08 March 2012

Gender Variables and Reproductive Behaviour of Women from Rural Mangalore, South Karnataka, India

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ABSTRACT

Introduction: There is a growing sense that health and development programs can contribute to transforming gender norms and achieving good health and gender equality. Married women in India lack control over decisions related to their sexual and reproductive behavior due to gender inequities, cultural norms, limited economics and social autonomy. Gender disparities in the form of adverse sex ratio, wage differentials and various health and education dimensions are still prevalent in the Karnataka State. Hence a cross-sectional study was conducted in a rural community of Mangalore, Karnataka, India.

Objectives: This study was conducted to assess the reproductive health of women and their associations with gender variables prevailing in the community.

Methods: A cross-sectional study was conducted in a Shantibagh and Vaidyanath Nagar Community in a Kotekar Panchayat at Mangalore from December 2009 to January 2010. A pretested semi structured interview tool was used to collect the information on the epidemiological variables related to reproductive health and gender issues. By systematic random sampling techinique, 214 women in the reproductive age groups were interviewed. Results were analysed using Statistical Package of Social Sciences (SPSS) 15.0.

Results: There is a strong association between religion and type of Family as well as religion and women's education status ($p < 0.001$). Average age at marriage is 21 years and average age at first pregnancy is 22.75 years. Average family size is 2.66. Prevalence of home deliveries is 11.5%. 91% of home deliveries are attended by Dai (Birth Attendants) (26% of Dai's are not trained). 57% of women (n=114- 91 Hindu, 17 Muslim & 6 Christian) are using family planning measures and 90% of them decided with joint consultation (both husband and wife). Practice of family planning and traditional misbelief that "every couple must have a son" are strongly associated with type of religion ($p < 0.001$). Variables related to her decision making and freedom for education, wearing dress, sexual relation with husband, visiting parent's place, going out with friends / coming home late etc show very poor figures. 37% of women in this study reported violence by husband or other family members.

Conclusions: This study shows that there is a correlation between religion, some gender factors and reproductive health behavior of women in rural Mangalore, India; thus highlighting the need for women empowerment by involving both men and women for Behaviour Change Communication.

Keywords: Gender variables, religion, reproductive behavior, decision making

Introduction

Women often remain marginalised from mainstream economic, political and social opportunities: recent data from SocialWatch (2009)[1] shows that while progress is being made, particularly in political empowerment, economic equity between men and women continues to show disparate results, with as many countries regressing as those where there is progress[1.]

Gender inequality is a significant concern in India. A woman's status and perceived status in the household have important implications for her ability to access and control resources. Women tend to have limited say in decisions other than those on small household expenditures, often face severe restrictions on their mobility and are subject to domestic violence[1].

Gender influences the control men and women have over the determinants of their health, including their economic position and social status, access to resources, and treatment in society[2]. Examples of gender disadvantage are the experience of intimate partner violence, lack of autonomy in decision making, lack of support for daily activities, and being married and bearing children during adolescence. Reproductive health is one of the major priorities in global public health, and is a fundamental and inalienable part of women's health.[3]

Women experience unique social roles related to menstruation, childbearing, and infertility. Reproductive tract infections (RTIs) are common and pose a heavy burden of physical ill health on women [4]. Anemia, typically associated with heavy menstrual bleeding and poor nutrition, is common in developing countries.

While considerable improvement in the status of women has occurred in recent decades, most South Asian cultures continue to be characterized by a dominant patriarchal social matrix. Thus, for example, boys are often favored over girls, a value system that is largely to blame for the growing sex imbalance in the population.[5] The birth of a girl, especially when a mother has already borne girls, is associated with an increased risk of depression in mothers [6]. Boys are more likely to access various opportunities, from education and employment to control over financial resources, than girls. Girls are often married during adolescence, and childbearing is the primary social role for married women; children are borne early, and often in quick succession, following which contraception is most often through female sterilization.[7] Married women in India lack control over decisions related to their sexual and reproductive behavior due to gender inequities, cultural norms, limited economics and social autonomy [8,9]. Gender disparities in the form of adverse sex ratio, wage differentials and various health and education

dimensions are still prevalent in the Karnataka State[10].

Methods

- **Study design:** A cross-sectional epidemiological study.
- **Study Period:** The study was carried out from December 2009 to January 2010
- **Study Area:** A survey was conducted in a Shantibagh and Vaidyanath Nagar Community in a Kotekar Panchayat at Mangalore. To begin with a pilot study was done on 30 married women in the reproductive age group from the same community. This helped to revise the study tool.
- **Study Tool:** Semi-structured interview schedule was used as a tool for data collection. This tool is comprised of socio-demographic profile, the variables related to gynecological morbidity, reproductive health behavior and woman's ability in decision making. It was validated before application at community level.
- **Study Population:** Systematic random sampling technique was applied and the house was the sampling unit. 214 married women in the reproductive age groups were interviewed. **Inclusion criteria** were married women (married for more than one year) in the age group of 15 to 45 years and willing to participate in the study.
- **Data Analysis:** Data was entered in MS Excel sheet and was analysed by using Statistical Package of Social Sciences (SPSS) 15.0.

Results

The average age of women in this study is 21.8 years. As seen in table 1, religion-wise distribution shows that 63 percent are Hindus, 29.5 percent are Muslims and 7.5 percent are Christians. Only 13.5 percent of women from this study belong to joint families; 77.8 percent of them are Muslims and 22.2 percent are Hindu ($\chi^2 = 35.24$, $P < 0.001$). There is also strong association between the religion and educational status of these women ($\chi^{2=}29.62$, $P < 0.001$) - 73.3 percent of Muslim women are illiterate. 57.5 percent of women and 64.8 percent of husbands of all the women are educated up to higher secondary level and above.

Average age at marriage for women in this study is 21 years (Minimum=14 years, Maximum =29 years, SD = 2.744). The average age at first pregnancy is 22.8 years (Minimum=17years, Maximum =32 years, SD = 2.977). The average number of children per family is 2.66; however the maximum number of children recorded in a single family is 8. The prevalence of Home deliveries is 11.5 percent in this study. 91 percent of home deliveries are attended by Dais (Birth Attendants), however 26 percent of these Dais are not trained.

In this study 52 percent of women are from class IV as per Modified Prasad's Classification [11]. 57 percent of women and 64.8 percent of husbands of all the women are educated up to higher secondary level and above. 60 percent of women in this study are occupied; major occupation being beedi rolling (28%).

Prevalence of abortions among married women in this study was 18.3 percent and 18.75 percent from them gave history of 2 abortions. 1.7% of women gave history of stillbirths. The gynecological problems were observed among 19.9 percent of women

(Dysmenorrhoea-32.4%, Bleeding problems-29.7%, White discharge- 18.9% , Prolapsed uterus – 10.8% , Urinary infection- 8.2% of total problems); 92% of them have undergone the treatment. During sickness, 35 percent of women did not get rest and they continue working at home. However in 18 percent of women, their husband and in 47 percent of women, other family members help them.

Table 1 also shows that family planning is practiced by 63.9 percent of couples and in 89.6 percent of them, the decision is taken jointly by both husband and wife ($P < 0.001$).The reasons given for not practicing family planning are --44.8 percent of women reported that they or their husband and other family members are not willing and 27.4 percent either had no knowledge **or** on religious ground **or** considered that "*children are God's gift*."

Gender factors are very relevant in this study. 42.5% of women in this study were of opinion that "*when husband wants to have sex, wife should never refuse.***"** 31 % of women said that every couple must have a son. ----reasons being security, support during old age, financial help etc. Among those women who opined that every couple must have a son, 58.1 percent were Muslims.

Table 3and 4 depict the variables related to her autonomy in decision-making and freedom for education, wearing dress, sexual relation with husband, visiting parent's place, going out with friends / coming home late etc. show very poor figures. 46.5 percent of women in this study had to participate in sex with husband without their wish. 24 percent of women still discriminate between a daughter and a son. 37% of women in this study reported violence by husband. This practice of violence by husband further continues even during pregnancy (47.3%) and after delivery (54%) as shown in table 5.

Discussion

Gender norms are some of the strongest social influences shaping men's and women's lives. Men and women experience poverty and vulnerability differently [1]. Women face greater time poverty due to domestic and caring tasks, household decision-making power is often concentrated in a husband's hands, and this is sometimes reinforced by physical violence [1].In our study, 87.2 percent women are from poor class families. ie class III and above (with monthly family income Rupees 1825 and below, Table 1) and 43 percent of women before marriage and 53.5 percent of women after marriage have no freedom for taking decision on how to spend money (table 3).Though 91 percent of women get money for household expenses, 24.6 of them get it after repeatedly asking the husbands. In another study conducted by Hussain (2003) it is mentioned that Women continue as always to be treated as objects in families and communities, as well as in policies and programmes. The entire reproductive process from pregnancy to childbirth is a complex phenomenon that is socially and culturally determined, and women are excluded from decision making on issues concerning their own lives and bodies. Further, state policies and contraceptive technologies are mostly targeted at women. The implications of both social norms and state policies are reflected at the micro level of household. Based on a larger study, the paper shows that religion is a less influential factor than male dominance and cultural norms [12].

Gender norms provide the values that justify different and often discriminatory treatment of one or the other gender. In this study, there is strong association between the religion and educational status of these women (χ^2=29.62, $P < 0.001$)—73.3 percent of Muslim women are illiterate (Table 2). Table 3 depicts that only 48.5 of women before marriage and 32

percent of women after marriage had freedom to decide about her own education. 68 percent of women before marriage and 69.5 percent after marriage can eat food with other family members. 64.5 percent of women before marriage and 71percent of women after marriage have freedom to decide about the health care during their illness. 43 percent of women before marriage and 53.5percent of women after marriage have freedom to spend money as they want. After marriage, though 91 percent of women get money for household expenses, 24.6 percent of them get it after repeatedly asking. (not easily)(Refer Table 4). Das Gupta M (1987), Leslie, J., E(1997)and Leach (1998) in their studies have reported that widespread social discrimination against women is visible in lower levels of investment in health , nutrition and the education of girls and women respectively [13, 14,15].

Sexual and reproductive health is strongly affected by gender norms. Norms favoring male children and promoting women's economic dependence on men contribute to high rates of fertility in many settings [16]. In this study, 31 % of women said that every couple must have a son. 42.5% of women in this study were of opinion that "*when husband wants to have a sex, wife should never refuse.*" In another study at Ghana (Biddlecom et al. 1997) 43 percent of female and 33 percent of male respondents agreed that beating a wife is justified if she refuses to have sex [17]. In a study at Mumbai (George A, 1998) the women considered sex to be coerced if they felt they had to have sexual relations with their husbands against their wishes. The men in contrast, felt they had a right to sex in marriage and saw this as the reason why their wives had to consent to have sex. [18] Abraham (2000), Khan, (1996) and Khanna et al (2000), for example, found that patriarchal values are prevalent and that they suppress expression of sexual autonomy [19,20, 21]. However, in this study, 41.5 percent women responded that they can have sex according to their wish and in 46.5 percent of women, their husbands agreed for Not to have sex – if she is not willing. This is a positive sign towards gender equity.

While considerable improvement in the status of women has occurred in recent decades, most South Asian cultures continue to be characterized by a dominant patriarchal social matrix [22]. Boys are more likely to access various opportunities, from education and employment to control over financial resources, than girls. Girls are often married during adolescence, and childbearing is the primary social role for married women [23]. Average age at marriage for women in this study is 21 years.

Another study carried out in Tanzania (Schuler et al,2009)to examine the role of gender norms in decision making among young married women and men on issues of family planning and contraceptive use; reported that gender factors such as men's dominance in decision-making and cultural norms that condone a man beating his wife if she uses contraceptives secretly are barriers to use of modern contraceptives.[24] In a study conducted at Nigeria(Anthony et al , 2009) Husband's disapproval (36.8%), fear of side effects (28.9%) and religious beliefs (14.8%) were the main constraints to the use of contraceptives[25]. On the contrary, in this study, family planning is practiced by 63.9 percent of couples and in 89.6 percent of them , the decision is taken jointly by both husband and wife($P < 0.001$). The World Population Data Sheet (2006)reported that In 2003 the total fertility rate—the total number of children a woman would have by the end of her reproductive life if she met the prevailing age-specific fertility rates from age15 to 49 years—was 2·6 in Asia (including China) thanks to contraceptive use by 52% of married women[26].

Violence against women is an important contributor to ill-health of women, especially to their sexual and reproductive health. Such violence is a human rights abuse and a consequence (and a cause) of gender inequality [27]. WHO's Multi-country Study on Women's Health and Domestic Violence,19 in which specially trained teams obtained data from 24 000 women in ten countries reported that between 13% and 61% of women who were or had been married reported physical abuse by an intimate partner in their lifetime[28]. In this study 37% of women reported violence by husband. National Family Health Survey data, India also reported that nearly two in five (37 percent) married women have experienced some form of physical or sexual violence by their husband[29.] Prevalence of domestic violence among married women from lower socioeconomic class in another Indian study is 38 percent [30]. Rural women are more likely than urban women to have ever experienced physical violence since the age of 15 [29].

In our study, the practice of violence by husband further continues even during pregnancy (47.3%) and after delivery (54%) as shown in table 5. In North America, most estimates of prevalence of such violence during pregnancy fall between 4% and 8% [31]. In developing countries these rates are estimated to be as high as 32% [32]. Unfortunately, most women remain silent about violence by an intimate partner and do not seek help. They frequently think that this violence is normal or even justified; more than 20% of women in seven sites participating in the WHO study,[28] thought that wife-beating was justified if a wife disobeyed her husband, and in five sites a wife's failure to complete her housework was believed to be justification for a beating[33]. 46.5 percent of women in this study had to participate in sex with husband without their wish and 42.5% of women in this study were of opinion that "*when husband wants to have a sex , wife should never refuse.*" In similar study done in urban slum of India, 92.4 per cent of married women were helpless and have not taken any action [30].

Conclusions

Over the years, the thinking about gender inequities and their impact on health has advanced considerably. There is a growing sense that health and development programs can and should contribute to transforming gender norms and achieving good health and gender equality [34]. As also seen in this study, there is a need of the gender transformation approaches in the programmes that try to shift harmful gender norms and promote an equitable environment by redressing power disparities among men or women.

Gender-transformative approaches actively strive to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health as well as gender equity objectives. Gender-transformative approaches encourage critical awareness among men and women of gender roles and norms; promote the position of women; challenge the distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community, such as service providers or traditional leaders [35].

Much good work has been done in gender-transformative programs with one sex or the other[36]. But more could be accomplished by working in a synchronized manner with both. What is generally missing from every single-sex approach is the broader awareness of how gender norms are reinforced by everyone in the community. Both men and women shape and perpetuate gender norms in society, and, therefore, true social change will come from work with both sexes using gender synchronized approaches.

Gender-synchronized approaches are the intentional intersection of gender transformative efforts reaching both men and boys and women and girls of all sexual orientations and gender identities.[34]

They engage people in challenging harmful and restrictive constructions of masculinity and femininity that drive gender-related vulnerabilities and inequalities and hinder health and well-being. Such approaches can occur simultaneously or sequentially, under the same "programmatic umbrella" or in coordination with other organizations. Gender-synchronized approaches seek to equalize the balance of power between men and women in order to ensure gender equality and transform social norms that lead to gender-related vulnerabilities. Their distinctive contribution is that they work to increase understanding of how everyone is influenced and shaped by social constructions of gender. These programs view all actors in society in relation to each other, and seek to identify or create shared values among women and men, within the range of roles they play (i.e., mothers-in-law, fathers, wives, brothers, caregivers, and so on)—values that promote human rights, mutual support for health, non-violence, equality, and gender justice[34].

Acknowledgement

The authors are grateful to Chancellor, Vice-Chancellor and the Registrar of Yenepoya University for their encouragement for this research study. We also thank Director Research and Principal Yenepoya Medical College for permitting us to publish this paper.

We appreciate the help rendered by the health workers from the community and the interns & paramedical workers of the Department of Community Medicine, Yenepoya Medical College; during this study.

Conflict of Interest: The authors have no conflict of interest to report.

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Table 1. Distribution of Socio demographic variables

Socio demographic variables		Number(%)
1. Religion (n=200)	Hindu	126(63)
	Muslim	59(29.5)
	Christian	15(7.5)
2. Socio-economic status* (n=196)	Rs.3653 & above-class I	3(1.5)
	Rs3652 to 1826 -class II	22(11.3)
	Rs.1825 to 1096-class III	58(29.6)
	Rs 1095 to 548-class IV	102(52)
	Less than 547-class V	11(5.6)
3. Type of Family (n=200)	Nuclear	173(86.5)
	Joint	27(13.5)
4. Education self (n=200)	Illiterate	15(7.5)
	Primary	33(16.5)
	Secondary	37(18.5)
	Higher Secondary	64(32)
	PUC+	51(25)
5. Education Spouse (n=195)	Illiterate	22(11.3)
	Primary	12(6.2)
	Secondary	48(24.6)
	Higher Secondary	70(35.9)
	PUC+	51(22)
6. Practice Family Planning (n=180)	Yes	115(63.9)
	No	65(36.1)
7. Decision for FP taken (n=115)	Jointly	103(89.6)
	Only husband	7(6.1)
	Only herself	5(4.3)
8. Place of Delivery (n=168)	Hospital	145(72.5)
	Home	23(11.5)
9. Should every couple have a son (n=191)		
	Yes	62(32.5)
	No	129(67.5)

*Modified B. G. Prasad's classification in India

Table 2: Distribution of variables based on religion

Variables		Religion			P
		Hindu(%)	Muslim(%)	Christian(%)	
1. Family type	Joint	06(22.2)	21(77.8)	-	
	Nuclear	120(69.4)	38(22.2)	15(8.7)	<0.001
2. Education (women)	Illiterate	04(26.7)	11(73.3)	-	
	primary	14(42.4)	17(51.5)	02(6.1)	<0.001
	Secondary	26(70.3)	08(21.6)	03(8.1)	
	Higher Secondary	45(70.3)	15(23.4)	04(6.3)	
	Puc+	37(72.5)	08(15.7)	06(11.8)	
3.Family Planning Practice(Decision)	Wife only	04(80)	01(20)	-	<0.001
	Husband only	02(29)	05(71)	-	
	Jointly	85(82.5)	12(11.7)	06(5.8)	

Table 3: Freedom of Women for taking decisions

Freedom for	**Before marriage** (in percent)	**After marriage** (in percent)
Education	48.5	32
Way to dress	75.5	64.5
Going out with friends	63.5	57
Coming home late at night	5.5	8.5
Eating food with others	68	69.5
Spending money	43	53.5
Health care during illness	64.5	71

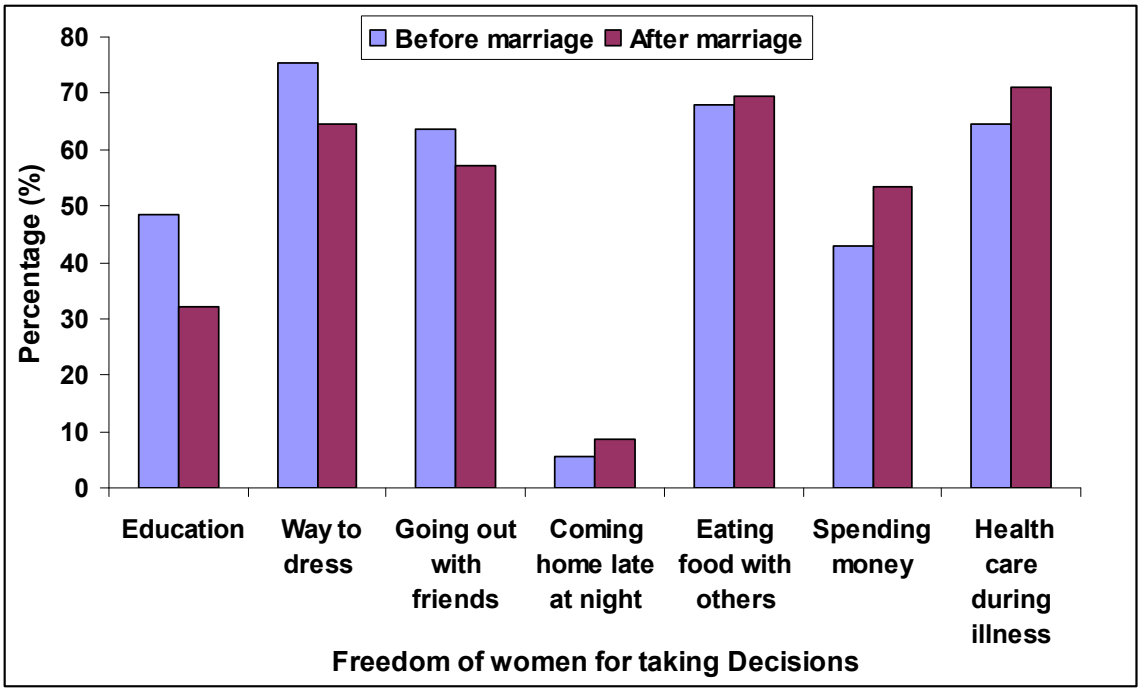

Table 4: After Marriage- Freedom / Decision making

Freedom of Decision making	Percentage
To go to parents place	66 %
To have sex according to her wish	41.5 %
Not to have sex – if she is not willing	46.5 %
To feed children	79 %
Treat son and daughter equally	76 %
To use family planning methods	51.5 %
To decide the family size	53 %
To get money for expenses *	91 %

*24.6 percent of the women, who get money, get it after repeatedly asking. (Not easily)

Table 5: Some Factors during Pregnancy and After Delivery

Factors	During Pregnancy	After Delivery
Enough Rest	77.6 %	68.2 %
Enough Food	86.2 %	86.2 %
All types of food	69.5 %	67.5 %
Registered for ANC	89.2 %	----------
Continuation of violence (if Yes before)	47.3 %	54. 04 %
Special care by family	70.7 %	72.3 %