Original article

Gender Equity in Health among Hindu Pre-School Children in Maximum Populated District of India

Chitradip Bhattacherjee[1]* & Subir Biswas[2]

ABSTRACT

For quite a long time anthropologists are concentrating on gender related issues and its approaches towards societies. Gender equity is increasingly cited as a goal of health policy but there is considerable confusion about what this could mean either in theory or in practice. Achieving gender equity is critical to sustainable development.

The present study seeks the relationship of gender with the health care practices and nutritional statuses of pre-school Hindu children of the area under study.

500 children below 6 years of age, (250 of each sex) were selected from five randomly selected blocks of North 24 Parganas. Anthropometric measurements were collected from the children along with health care information from the parents. Collected data were analyzed in respect of age and sex with reference to WHO (2006) standardized values. The nutritional statuses and health care practices were statistically analyzed in respect of sex to find out significance level.

The results showed that both boys and girls having same health care facilities from the parents in respect of breast feeding duration, immunization and disease treatment facilities i.e. statistically the data showed no significant difference between boys and girls at '0.05' level. When the nutritional status are concerned the weight-for-age and weight-for-height statuses showed no significant difference statistically but height-for-age status showed significant high rate of stunted boys than girls statistically.

Thus the result depict the fact that both boys and girls are getting similar health care services from parents but somehow boys are suffering from long term malnourishment than girls in the area under study.

Keywords: Gender, Health, Hindu, Children

_____

INTRODUCTION

"To call woman the weaker sex is a libel; it is man's injustice to woman. If by strength is meant brute strength, then, indeed, is woman less brute than man. If by strength is meant moral power, then woman is immeasurably man's superior. Has she not greater intuition, is she not more self-sacrificing, has she not greater powers of endurance, has she not greater courage? Without her, man could not be. If nonviolence is the law of our being, the future is with woman. Who can make a more effective appeal to the heart than woman?"

Mahatma Gandhi, 1930

[1] Former Research Scholar, Dept of Anthropology, West Bengal State University
[2] Professor, Dept of Anthropology, West Bengal State University
*Corresponding author: chitradip2010@gmail.com

Gender is the most puzzling in the grammatical categories. It is a topic which interests' social scientists as well as others and it become more fascinating the more it is investigated. Gender beliefs represent themselves as universal depictions of women and men by a narrow set of features. Alternative gender belief system exists in the culture along with homogenic belief, even for those it is a stubborn part of social reality that must be dealt with or accommodated in many contexts, even if they are not personally endorsed. In our gender belief system physical sex difference are presumed to be the basis of sex categorization, yet in every social relational context we sex-categorize other based on appearance and behavioral cues. Indeed social cognition demonstrates that sex categorization automatically activates gender stereotypes, including gender status distinctions (Ridgeway, 2014). The term gender bias carries different miss-conception to applied researchers; it is taken as synonymous with gender inequality. Inequality arises because of deprivation. Two persons said unequal if one is deprived of a given facility with respect to the other. Gender equality is basically similarity between men and women which entails the concept that, both men and women can freely develop their personal abilities without any limitations caused by gender roles and prejudices. Gender equity approaches recognize that we do not function on a level playing field. In other words, there are historical and social disadvantages which prevent one sex, often women, from benefiting fully from society's resources (NSW HEALTH, 2000). WHO defines equity as "fair opportunity for everyone to attain their full health potential regardless of demographic, social, economic or geographic strata. The developing realization of the right to health involves a concuss effort to improve health across all populations and reduce inequities in the enjoyment health. The Global Gender Gap Report by Hausmann et. al, (2011) suggests that India (ranked 113) and Pakistan perform above average on the political empowerment of women, particularly India, but they lag behind in the other three categories i.e. economic participation and opportunity, educational attainment, health and survival. In particular, the persistent health, education and economic participation gaps will be detrimental to India's growth; India is the lowest ranked of the BRIC economies featured in the Index. After independence in India one of the issues which has attractive the attention of the policy makers was gender issues and concerns. The gender equity became part of country's strategy for eradicating poverty and human misery. The Government of India has taken several measures and also making endeavourer to hoist the status of women in the society in order to promote equality of men and women. The different plans, programmes, and policies have laid emphasis on women empowerment and raising the economic, educational, health and political participation of women to match with that of men, though female infanticide is widely used in rural areas. Son is preferred to maintain family's surname and hire ancestral property. The high maternal mortality, infant mortality, child mortality feticide, infanticide, abortion, low age of marriage social stigma associated with marriage, son preference are responsible for low sex ratio in India. Also under counting of women associated with many social factors is one of the main reasons for low sex ratio in the country (Raju, 2014). Arokiasamy and Pradhan (2005) after analyzing national Family Health Survey-2 data set conclude the presence of gender inequity in India in the form of nutrition, immunization, illness and treatment with some regional differences. There was a study conveyed by Biswas and Mallick (2007) to understand gender equity in nutrition and sex differences in growth among Rajbansis of North Bengal. The result of the study showed that Most of the children are below −2SD irrespective of sex regarding height-for-Age (boys 53.57%, girls 68.75% stunting), weight-for-age (boys 65.17% girls 58.93% underweight) and

weight-for-height (boys 29.46%, girls 21.43% wasting) as per NCHS/WHO normalized reference value.

In this situation the present study has been conducted in the maximum populated district of India to find out the present position of gender among the pre-school Hindu children regarding nutritional status and health care facilities.

METHODOLOGY

The North 24 Parganas District of West Bengal has been selected as the present study area. The district is significant because it is the second maximum populated district of India as according to 2011 census report. Five blocks were selected by random sampling method i.e. Barasat 2, Deganga, Basirhat 1, Basirhat 2 & Hasnabad for data collection which are also Muslim majority blocks. From each block 100 children (50 of each sex) were selected randomly for the present study with maintaining criteria of at least one boy and one girl present in each family below 6 years of age.

General demographic information collected from parents of selected children along with health care practices like breast feeding duration, immunization, disease treatment facilities etc. Beside this children were measured using standard anthropometric parameters like height, weight & arm circumference.

Collected data were analyzed later in two stages. Primarily anthropometric data were tabulated in respect of WHO, 2006 (Onis, 2006) standardized reference values of height-for-age, weight-for-age, weight-for-height and arm-circumference-for-age statuses by means of age and sex.

Later these nutritional statuses and health care data were statistically analyzed in respect of sex to find out if any significant difference exists between boys and girls at 0.05 levels.

RESULTS AND DISCUSSION

Primary analysis of Age group for sex and community clearly exhibit the situation of the study area and their distribution. It is very clear from the Table-1 that in case of below 1-year age group the member of children is less than the other and it continuously increasing through age. May be it is a salient feature of the study area expressing more birth control vis-a-vis less infant mortality in recent years than before.

The next observation is based on the place of birth of the children. Though it does not have a direct impact of gender bias but it definitely affects the health of the children. Thus in the present study it was observed that 27% Hindu children was born at home where as 73% were born at hospital or nursing home (Table 2).

The breast feeding duration is a parameter deals with the health care of the children. It was observed that almost 85% children (87.2% boys & 82.8% girls) are getting breast feeding above one year of age. Though some difference is there between boys and girls regarding the issue but the result is statistically insignificant.

The immunization is extremely important for child health. It was observed that 97.2% boys and 97.6% girls (Table 4) are getting all the doses of immunization where as only 2.6% children have missed some doses. No children found without any dose of immunization. Thus no difference was found between boys and girls regarding immunization status.

Disease treatment facilities are also very important in this context. The present area under study shows a good number of quack doctor practices. Thus it was important to find out how many children are being treated by quack doctors and registered medical practitioners. It was seen that 90.8% boys and 86.4% girls (Table 5) are being treated by registered doctors and other children often taken to the quack doctors. The difference is not statistically significant between boys and girls.

The next phase of interpretation deals with the nutritional statuses of the children under study. In this analysis, WHO (2006) standardized reference values were used to compare the nutritional statuses of the children in respect of age and sex, i.e. to what extent they are normal or mal-nourished. First parameter taken was height-for-age status. The data showed that (Table 6) high rate of children are stunted (32%) which denotes long term mal-nourishment. Beside this it was also observed that 38.4% of the boys are stunted where as 25.6% girls are stunted. The difference is statistically significant at 0.05 levels explain that significantly high rate of boys are suffering from long term malnourishment than girls.

Next is the weight-for-age status of the children. Present data showed high rate of underweight children (32.2%) in the study area. 65.2% boys and 70.4% girls found, having normal weight-for-age status (Table 7). Though statistical analysis showed no significant difference exists between boys and girls regarding weight-for-age status.

Weight-for-height status of the children showed that 23.2% (Table 8) are wasted and only 0.4% having obesity. 78.4% boys and 74.4% girls' posses' normal weight-for-height status. In case of arm-circumference-for-age status the result also project 26.6% children (Table 9) are wasted. 69.5% boys and 77.1% girls having normal arm-circumference-for-age status. Though there are some differences between boys and girls regarding the statuses but in both weight-for-age and arm-circumference-for-age status showed no significant statistical differences between boys and girls.

CONCLUSION

In many parts of Asia and South East Asia, and particularly so within the rural areas in the north of India, there is little provision of social/income security, or pension arrangements. As a result, it is thought children are partly defined and demanded as a means

of transferring wealth into the future, in order to support their parents in retirement. Because female children in the northern kinship systems of India cannot fulfill this role at the level of the family, due to societal laws governing property rights and inheritance, their future economic worth is constrained (Atella & Rosati, 2000).

To draw the conclusion about the present study basic observation can be inferred in to two major phases- first one is the health care of the children and second is the nutritional status of the children. Parents care towards their children in the present area found statistically indifferent between boys and girls. Though it was observed that some of the children are getting low quality of birth and treatment facilities but it is due to their economic conditions and has no deal with gender discrimination. It depicts the fact that parents in the study area does not possess any form of biasness between gender for providing health care facilities.

The second phase that is the nutritional statuses of the children reflected a surprising fact that boys showing significantly high rate of being stunted than girls. Though other cases that are weight-for-age, weight-for-height & arm-circumference-for-age statuses never provided any significant difference between boys and girls under study but stunted or low height-for-age status is a clear symbol of long term malnourishment which is high among boys. May be this is due to engaging boys in labor oriented jobs from a very early stage of life or can be other indirect factors regarding food intake.

Bhargava (2003) evidenced that sex discrimination is focused on higher order births of girls, who are born in an effort to obtain the desired number of sons: Sex deferential in mortality by birth order are shown to be far higher than by socioeconomic status. Target family size considerations are seen to be driving higher order births; if female, the child is thus considered excessive. But a study by Visaria (2015) from the NFHS 2005-06 and other DHS data showed that son preference is not a feature of the Muslim community in either India or Bangladesh. Further, Hindus in India who live in Muslim-majority areas appear to be influenced by the absence of son preference of the majority Muslim community and subscribe to behaviors with greater gender equality.

The present study had been conducted among the Muslim concentrated areas and thus probably does not project any evidence of gender discriminations except long term malnutrition of boys. Hence it can be concluded from all the examples the Gender equity exists among the pre-school children of the present area under study in respect of health and care facilities.

ACKNOWLEDGEMENTS

Our hearty thanks go to those parents who helped in every step by providing proper information's required to conduct this research. Practically without their information and measurements of their children the research would not be possible.

REFERENCES

Arokiasamy. P, Pradhan. J, 2005. Gender bias against female children in India: implications for achieving millennium development goals (MDGs). *IIPS Newsletter*, 45(3 & 4).

Atella. V, Rosati, F.C. 2000, Uncertainty About Children's Survival and Fertility: A Test Using Indian Microdata, *Journal of Population Economics,* 13 (2): 263-278.

Bhargava. A. 2003. Family Planning, gender differences and infant mortality: Evidence from Uttar Pradesh, *India Journal of Econometrics*, 112 (1): 225-240.

Biswas. S, Mallick. G.C. 2007, Excess Female Mortality due to Gender Bias Health Care and Disease Treatment Pattern: A Study on Rajbansis of Darjeeling District, West Bengal, India, *In* R.K. Pathak, A.K. Sinha, B. G. Bannerjee, R. N. Bhasishat and C. J. Edwin (eds) *Bio-Social Issues in Health*, New Delhi: Northern Book Centre.

Gandhi. M, 1930. *To the Women of India*, Young India News Paper, 4th Oct. 1930.

Hausmann. R, Tyson. L. D, Zahidi. S. 2011, *The Global Gender Gap Report 2011*, Geneva: World Economic Forum.

NSW HEALTH 2000, *Gender Equity in Health*, NSW Health Department; New South Walls, State Health Publication.

Onis. M, 2006. *WHO Child Growth Standards*. 1st ed. World Health Organization, Geneva, Department of Nutrition for Health and Development.

Raju. E, 2014. Gender Discrimination in India, *IOSR-JEF*, 2(5): 55-65.

Ridgeway. C.L, Correll. S.J. 2014. Unpacking the Gender System: A theoretical Perspective on Gender Beliefs and Social Relations, *Gender and Society*, 18 (4):510-531.

Visaria. A. 2015. *Son Preference and Group Majority/Minority: Comparing Hindus and Muslims in India and Bangladesh*, PAA Annual meeting Programme, electronic document http://paa2015.princeton.edu/abstracts/153386 accessed on July 4, 2015.

Table 1: Distribution of children by age and sex

Age Group (Year)	Below 1 Year No (%)	1+ To 2 No (%)	2+ To 3 No (%)	3+ To 4 No (%)	4+ To 5 No (%)	5+ To 6 No (%)	Total
Boys	25 (10%)	46 (18.4%)	42 (16.8%)	35 (14%)	42 (16.8%)	60 (24%)	250
Girls	37 (14.8%)	37 (14.8%)	41 (16.4%)	42 (16.8%)	43 (17.2%)	50 (20%)	250
Total	62	83	83	77	85	110	500

Table 2: Place of birth

Place of Birth	Home	Hospital	Nursing home	Total
No (%)	135 (27%)	314 (62.8%)	51 (10.2%)	500

Table 3: Breast feeding duration

Breast Feeding Duration	Sex		Total	Chi-square p-value
	Boys	Girls		
Below One Year	32 (12.8%)	43 (17.2%)	75 (15%)	0.168
Above One Year	218 (87.2%)	207 (82.8%)	425 (85%)	

[p-value Non-significant]

Table 4: Immunization status

Immunization	Sex		Total	Chi-square p-value
	Boys	Girls		
Partial	7 (2.8%)	6 (2.4%)	13 (2.6%)	0.779
Full	243 (97.2%)	244 (97.6%)	487 (97.4%)	

[p-value Non-significant]

Table 5: Disease treatment facilities

Disease Treatment Facility	Sex		Total	Chi-square p-value
	Boys	Girls		
Quack Doctor	23 (9.2%)	34 (13.6%)	57 (11.4%)	0.122
Registered Doctor	227 (90.8%)	216 (86.4%)	443 (88.6%)	

[p-value Non-significant]

Table 6: Height-for-age status

Height-for-age status	Sex		Total	Chi-square p-value
	Boys	Girls		
Normal	154 (61.6%)	186 (74.4%)	340 (68%)	0.002*
Stunted	96 (38.4%)	64 (25.6%)	160 (32%)	

*[p-value < 0.05; Significant]

Table 7: Weight-for-age status

Weight-for-age status	Sex		Total	Chi-square p-value
	Boys	Girls		
Normal	163 (65.2%)	176 (70.4%)	339 (67.8%)	0.213
Underweight	87 (34.8%)	74 (29.6%)	161 (32.2%)	

[p-value Non-significant]

Table 8: Weight-for-height status

Weight-for-height status	Sex		Total	Chi-square p-value
	Boys	Girls		
Normal	196 (78.4%)	186 (74.4%)	382 (76.4%)	0.570
Obese	1 (0.4%)	1 (0.4%)	2 (0.4%)	
Wasted	53 (21.2%)	63 (25.2%)	116 (23.2%)	

[p-value Non-significant]

Table 9: Arm-circumference-for-age status

Arm-circumference-for-age status	Sex		Total	Chi-square p-value
	Boys	Girls		
Normal	132 (69.5%)	155 (77.1%)	287 (73.4%)	0.087
Wasted	58 (30.5%)	46 (22.9%)	104 (26.6%)	

[p-value Non-significant]