

ARE WE STILL DEPRIVING OUR GIRLS IN HEALTH CARE?

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Awareness about gender discrimination in health is relatively recent. As far as medical treatment is concerned, a child is a child. Social reality in many parts of the world is different: A boy is a boy, and a girl is a girl. Gender differentials in infant and child mortality still persist in many countries, and reflect discrimination in the right to health care. Although the female species is the biologically stronger sex, this biological advantage can be eroded by the social disadvantage of being females in societies with strong son preference, and particularly in resource-poor settings. Differentials in access to health care and nutrition account for these mortality differentials. As a source of coming generations, the girl child needs to be better looked after, nutritionally at least. How far is this being done? In this paper an attempt has been made to examine the gender discrimination in the household in terms of food and medical care. The indicators of child-care considered in this study are: immunization, health care of sick, allocation of food among children, quality of food, etc. The present study brings out the gender discrimination in food and medical care provided to the girls. The results revealed that gender discrimination is less likely to occur in the use of health services that are freely available (e.g. childhood vaccination) compared with those for which parents need to pay. Similarly, gender discrimination is less likely for food that is less valued even if it is nutritionally beneficial.

Keywords: *Girl Child, Health Problem, Gender Study, Medical Care*

INTRODUCTION

Women everywhere in the world have to suffer from some inherent disadvantages, compared to man, because of certain biological reasons. They have to put up with menstruation, pregnancy, child-birth, lactation, child rearing, menopause and various other complications. Physically they are less strong. There have been gains in women's health status over the last 4 decades in the country in respect of female infant mortality, female child mortality, life expectancy at birth etc. However, surveys and studies show no substantial improvement in their health and nutritional status. Even today more girls die than boys because they are not as well nurtured as boys. Malnourishment and neglect in the form of less food and less health care for instance is the common fate of girls. Girls receive less immunity vaccines against childhood diseases, less breast feeding and nourishing food like milk or fats. Studies show that at every level, girls are systematically more undernourished.

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Discrimination against them from early childhood is manifested in their conscious and sub-conscious neglect, poor nutrition, denial of nutritious food and absence of provision of health care.

Nutritional and health care insufficiency is thus generic to the girl and woman. Both anecdotal and clinical evidences affirm that in the politics of the household and of food, the male child and adult have the casting vote and the first call on the family's nutrition. That the nutritional needs of the male so easily overpower those of the female is a reflection of several factors, most of which do not originate in nutrition or in food availability *per se*. Access to food, and its quantity as well as quality, are key determinants. But the decisive factor is the food allocator who is usually the mother or the elder women (Sohoni, 1994).

Strong son preference is believed to be responsible for many discriminatory practices against girls in feeding, health care and education. (Ganatra and Hirve, 1994; Riley, 1997; Timaeus *et al.*, 1998; Pande, 2003). Mittal (1995) mentioned that a girl may not be killed at her birth, but she suffers neglect. Generally, in the feeding matters, a son is given more nourishing food. It is a common practice in large number of families including affluent families that the best and most nourishing food is given to boys. It is very common that milk, butter, eggs etc. are given to boys only. Girls who would have to bear children in later life and would require more physical strain are kept deprived of nourishment. They grow up with weak and frail physical conditions. A belief prevails that girls should not be permitted to grow fast to defer the question of marriage.

Macro level NNMB serves across seven states of the Indian union (1981 census) among rural population (Reddy, 2000).

In much of South Asia, sons are preferred over daughters for a number of economic, social and religious reasons, including financial support, old age security, property inheritance, dowry, family lineage, prestige and power, birth and death rituals and beliefs about religious duties and salvation (Arnold *et al.*, 2002).

Making a distinction between survival rates and discrimination, Karlekar (2003) points out that while the former seems to rise with the socio-economic status of the household, there is not enough evidence to suggest that discrimination declines with higher status: observations from the field show that upper caste, upper-middle-class families, discriminate against girls with respect to the access they have to higher education, as well as in matters such as protein intake, games and extra co-curricular activities.

A study conducted by the Department of Community Medicine, CMC on children under five years living in urban slums in and around Ludhiana

revealed that 93 per cent of the girls were found malnourished against 82 per cent boys (Verma, 2004).

Mishra *et al.* (2004) indicates the presence of gender discrimination in childhood feeding, immunization coverage, treatment-seeking, and nutritional status. A consistent pattern is not universally observed; however, the presence and extent of gender discrimination depend largely on the birth order of the index child and sex composition of older living siblings.

In Punjab, girls have much higher mortality risks than boys. All infant and child mortality rates are higher for girls than for boys. Notably the post-neonatal mortality rate is almost twice as high for girls as for boys and the child mortality rate is four times as high for girls as for boys (Patnaik, 2004).

On the heels of the shocking evidence in the Census that the sex ratio is increasingly skewed in both urban and rural areas across communities, comes the alarming statistic on how even well-off parents deny medical treatment to the girl child. The parents of the seriously ill girl children are reluctant to spend money on treatment and would rather plan for another child. In the capital's upmarket Apollo hospital, only 5% of girls were treated for liver failure as opposed to 95% boys in 2003. A similar pattern was evident in the treatment of other life-threatening ailments (The Sunday Times of India, 2006).

Gender, being male or female is an important issue affecting health. Sexism or prejudice and discrimination based on gender, continues to influence health and safety in addition to race, ethnicity, education, socio-economic status and age. (Snooks, 2009).

Pal *et al.* (2011) analysed various aspects of discrimination in the spheres of health, nutrition, and work. Using case studies from India and other South Asian countries, it provides alternative methods for measuring gender differentials and discrimination.

METHODOLOGY

The present research was conducted in Fatehgarh Sahib district of Punjab. According to the 2001 census, Fatehgarh Sahib has the lowest child sex-ratio. The child sex-ratio improved to 843 in 2011, but remains far below the national average. The researcher had chosen four villages viz Raipur, Majri, Saunti and Bhaddal Thua - two from each tehsils of Fatehgarh Sahib. Random sampling was adopted for the present research work. 300 girls (150 Jat Sikh and 150 Scheduled Caste) between the age group 13-19 years were chosen for the study. It was ensured that each girl respondent has at least one brother, either younger or older than her, who would also be interviewed. Among the

Scheduled Castes, Mazhbi Sikhs were chosen. The researchers wanted to find out the status of the girl child in the prevailing situation. 75 girls from each village were interviewed to assess the prevailing condition.

For the study, it was hypothesized that there is a strong and deliberate neglect in terms of food and medical care.

To assess this, the following questions were asked to the girls.

- Do your family members eat meals together? If not, who eats first and who eats last?
- Do you get equal quality of food as that of your brother?
- If food is scarce, who gets less food in your family?
- Do you get milk to drink?
- Do you get seasonal fruits to eat?
- Number of times you suffered from major illness.
- Did you get treatment every time you had fallen ill?
- What was the mode of treatment?
- Are you immunized?

ANALYSIS

In India, the family never sits down to a meal at the same time. The woman is expected to work and serve the men of the family first, then comes the turn of the boys. The women and girls are the last to eat by which time both qualitatively and quantitatively, the food tends to run out. Usually more nutritious and protective items of the day's menu tend to be cooked in a smaller quantity. A survey in India by the National Committee on the Status of Women found that women in 48.5% of the houses eat after men. Today, neglect of a female child leading to its undernourishment, is a bigger killer than infanticide (Yadav and Mishra, 2003).

The present researchers tried to find out if there were any differential trends in food intake of boys and girls in the family. The problem of nutrition is essentially linked to poverty but for women the problem is further compounded by gender discrimination. The girl respondents were asked – Do your family members eat meals together? 80.7 per cent (80% Jat Sikh and 81.3% Scheduled Caste) girls said 'yes' and 19.3 per cent (20% Jat Sikh and 18.6% Scheduled Caste) girls said 'no'. (Table 1).

Table 1
Eating meals together (in per cent)

<i>Respondents</i>	<i>Yes</i>	<i>No</i>
Jat Sikhs	80	20
Scheduled Caste	81.3	18.6
Total	80	20

The respondents who said that their family members do not eat meals together were further asked – who eats first and who eats last? They replied that the father and the brothers are first to eat and they along with their mothers and sisters eat last.

For a young girl, the cause of her malnourishment is not so much the lack of food as lack of access to food. She is given less food, eats less and often gets only the leftovers. This results in the overall attitude that ‘a girl’s health is of minor significance’ (Shiva, 1992). To know about the quality of food, the girls were asked – Do you get equal quality of food as that of your brothers? 98.7 per cent (99.3% Jat Sikh and 98% Scheduled Caste) girls responded ‘yes’ and 1.3 per cent responded ‘no’. (Table 2).

Table 2
Equal quality of food (in per cent)

<i>Respondents</i>	<i>Yes</i>	<i>No</i>
Jat Sikhs	99.3	1.7
Scheduled Caste	98	2
Total	98.7	1.3

When queried about the frequency or inadequacy of the food they received, an overwhelming 95.3 per cent (96.7% Jat Sikh and 94% Scheduled Caste) girls told the researcher that if food is scarce they and their brother get equal share and around 4.7 per cent (3.3% Jat Sikh and 6% Scheduled Caste) girls said that their brother gets the lion’s share (Table 3). There was no significant

Table 3
If food is scarce who gets less food in the family

	<i>Jat Sikh</i> <i>(n = 150)</i>	<i>Scheduled Caste</i> <i>(n = 150)</i>	<i>Total</i> <i>(n = 300)</i>
You	–	–	–
Your Brother	5 (3.3%)	9 (6%)	14 (4.7%)
Both equally	145 (96.7%)	141 (94%)	286 (95.3%)
Total	150 (100%)	150 (100%)	300 (100%)

difference in the responses of the Jat Sikh and Scheduled Caste girls (Value of chi square = 1.199).

Further the girls and the boys were asked - Do you get milk to drink. 84 per cent (86% Jat Sikh and 82% Scheduled Caste) girls responded 'yes' and 16 per cent (14% Jat Sikh and 18% Scheduled Caste) girls responded 'no'. (Table 4).

Table 4
Milk to drink (in per cent)

<i>Respondents</i>	<i>Yes</i>	<i>No</i>
Jat Sikhs	86	14
Scheduled Caste	88	18
Total	84	16

When the same question was asked to boys, cent per cent responded 'yes'. When the girls and boys were questioned whether or not they get seasonal fruits to eat 90.7 per cent (92.7% Jat Sikh and 88.7% Scheduled Caste) girls said 'yes' and 9.3 per cent (7.3% Jat Sikh and 11.3% Scheduled Caste) girls said 'no'. (Table 5) Again cent per cent boys responded in the affirmative saying that they get seasonal fruits to eat. However, the girls also reported that they were neither stopped nor insisted to have milk and seasonal fruits whereas their brothers were insisted to have milk and milk products, eggs, meat etc. as it helps in growing up. The girls also reported that they were nagged on consumption of non- vegetarian foods like eggs, fish, meat, chicken, pickles, ghee, butter and sour food. The reason given to them was that they would grow up early by consuming these things. There was no major difference in the food pattern among the Jat Sikhs and the Scheduled Castes. Sen (1984) rightly opined, "Who eats how much in a family is a part of the private life of a family" and it is difficult for an outside observer to measure differences.

Table 5
Fruits to eat (in per cent)

<i>Respondents</i>	<i>Yes</i>	<i>No</i>
Jat Sikhs	92.7	7.3
Scheduled Caste	88.7	11.3
Total	90.7	9.3

Going into a fairly detailed analysis of gender difference in health and disease treatment, Harris (1990) comes to the following conclusion: girls are less often referred for allopathic treatment, and in fact less often regarded as 'ill'. Mitra (1978) found that gender differences in child mortality rates from

respiratory, gastrointestinal and vitamin deficiency diseases arise not much from difference in treatment, but from the relatively late stage at which girls are brought for treatment. His point should be seen in the context of the view that perceptions of health and discomfort vary: Women do not often have the privilege of reporting 'sick' nor do they view their girl children as being unwell.

The girl respondents were asked the number of times they suffered from major illness (Table 6). 42 per cent responded they had fallen ill once, 43.3 per cent responded they had fallen ill twice, 8.7 per cent responded they had fallen ill more than twice and 6 per cent responded they never had any major illness. When the same question was asked to the boys, 39 per cent said they had major illness once, 44.5 percent said twice, 7.5 per cent said more than twice and 9 per cent said they never suffered from any major illness. There was no significant difference in the response of girls and boys (Value of Chi square = 1.997).

Table 6
Number of times you suffered from major illness

	<i>Girls</i>			<i>Boys</i>		
	<i>Jat Sikh</i> (<i>n</i> = 150)	<i>Scheduled</i> <i>Caste</i> (<i>n</i> = 150)	<i>Total</i> (<i>n</i> = 300)	<i>Jat Sikh</i> (<i>n</i> = 150)	<i>Scheduled</i> <i>Caste</i> (<i>n</i> = 150)	<i>Total</i> (<i>n</i> = 300)
Once	64 (42.7%)	62 (41.3%)	126 (42%)	40 (26.7%)	38 (25.3%)	78 (39%)
Twice	70 (46.7%)	60 (40%)	130 (43.3%)	46 (30.7%)	43 (28.7%)	89 (44.5%)
More than Twice	8 (5.3%)	18 (12%)	26 (8.7%)	4 (2.7%)	11 (7.3%)	15 (7.5%)
Never	8 (5.3%)	10 (6.7%)	18 (6%)	10 (6.7%)	8 (5.3%)	18 (9%)
Total	150 (100%)	150 (100%)	300 (100%)	150 (100%)	150 (100%)	300 (100%)

When questioned about the treatment they received for their illness, cent per cent boys and girls admitted that they received treatment every time they had fallen ill. However, the mode of treatment was a little different - 95.7 per cent girls said they were provided allopathic treatment, 3 per cent said they were provided ayurvedic/homeopathic treatment and 1.3 per cent said they were treated with traditional home remedies unless there was a major illness. (Table 7).

In the case of boys, 97.5 per cent were given allopathic treatment, 2 per cent were given ayurvedic/homeopathic treatment and a miniscule 0.5 per

Table 7
Mode of treatment

	Girls			Boys		
	Jat Sikh (n = 150)	Scheduled Caste (n = 150)	Total (n = 300)	Jat Sikh (n = 150)	Scheduled Caste (n = 150)	Total (n = 300)
Traditional/ home remedies	1 (0.67%)	3 (2%)	4 (1.3%)	-	1 (1%)	1 (0.5%)
Ayurvedic/ homeopathic	4 (2.67%)	5 (3.3%)	9 (3%)	1 (1%)	2 (3%)	4 (2%)
Allopathic	145 (96.67%)	142 (94.7%)	287 (95.7%)	99 (99%)	96 (96%)	195 (97.5%)
Total	150 (100%)	150 (100%)	300 (100%)	150 (100%)	150 (100%)	300 (100%)

cent got traditional home remedies. There was a major gender difference in the nature of allopathic treatment, cent per cent boys were cured by the private practitioners in the city whereas only 31 per cent girls were taken to private practitioners and the rest (69%) were taken to the primary health centre (Table 8). The mode of treatment was not found to be dependent on the number of daughters. However the nature of allopathic treatment was dependent on the number of daughters. 42.5 per cent of the single daughters received treatment from private practitioners, whereas 22.5 per cent girls who received treatment from a private practitioner had sisters. The Value of Chi - square for this was 12.71.

Table 8
Nature of allopathic treatment

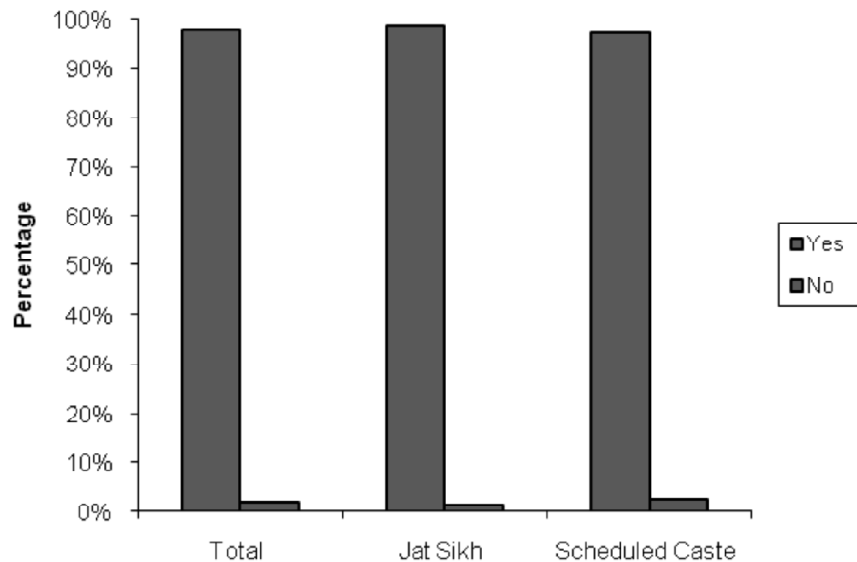
	Girls			Boys		
	Jat Sikh (n = 145)	Scheduled Caste (n = 142)	Total (n = 287)	Jat Sikh (n = 99)	Scheduled Caste (n = 96)	Total (n = 195)
Private practitioners	48 (33.1%)	41 (28.9%)	89 (31%)	99 (100%)	96 (100%)	195 (100%)
P.H.C/Govt. Hospital	97 (66.9%)	101 (71.1%)	198 (69%)	-	-	-
Total	145 (100%)	142 (100%)	287 (100%)	99 (100%)	96 (100%)	195 (100%)

The household survey of health care utilization and expenditure (NCAER, 1993) points out that for non-hospitalized illness episodes, Allopathic treatment is the most preferred form of treatment in both rural and urban areas of Punjab. Table 9 highlights the fact that allopathic system of medicine is preferred more in Punjab than in the country as a whole. For instance, Ayurvedic/Siddha,

According to NFHS (1998-99) a clear-cut gender bias towards the male child has emerged in the immunization trends in Punjab. A look at Table 11 reveals that the girl child is less likely to have received childhood vaccinations than the boy child. It can be seen that as against 5.2 per cent of the boys who received no childhood vaccination, 12.9 per cent of the girls received no vaccination. The only exception to this trend is for oral Polio drops which 15.9 per cent of the girls had received against 7.4 per cent of the boys.

According to NFHS -III, 2005-06, Girls between the ages of 12-23 months in Punjab are 17 percent less likely than boys in the same age group to be fully immunized and are also less likely to have received each one of the recommended vaccinations. There was no apparent discrimination between girls and boys in immunization in the field area. 98 per cent of the girls were immunized and 2 per cent were not immunized whereas 98 per cent boys were immunized. We can say that gender had no relationship to immunization. It should be noted that, to these girls, immunization meant only those vaccinations which were provided by the government free of cost (Bar Diagram 1).

Bar Diagram 1: Are you immunized



A slight gender discrimination in terms of food intake was observed. In terms of medical care also the girls always got treatment whenever they fell ill. However, there was a discrimination in providing allopathic treatment.

Table 11
Childhood vaccination by gender (in per cent)

Background characteristic	DPT				Polio			Measles	All	None	Percentage showing vaccination card	Number of children
	1	2	3	1	2	3						
	92.1	91.9	85.4	94.8	93.4	87.4	79.6	74.5	5.2	-	-	-
Sex of child												
Male	7.4	93.2	81.6	85.4	94.8	93.4	87.4	79.6	74.5	5.2	49.6	142
Female	15.9	82.5	81.6	77.9	85.3	82.6	78.9	72.7	69.2	12.9	34.9	116

Source: NFHS-II, 1998-99

And it could also be seen that gender had no relationship to immunization. There was little discrimination in medical care, but in mode of treatment a clear-cut bias was observed. From the above analysis it was concluded that gender discrimination is less likely to occur in the use of health services that are freely available (for eg: childhood vaccination) compared with those for which parents need to pay. Similarly, gender discrimination is less likely for food that is less valued (both by perceived value and monetary value) even if it is nutritionally beneficial.

SUMMARY

On the basis of the above analysis it was found that there was no discrimination regarding the consumption of food items except eggs, meat, ghee, butter, fish etc. These were only meant for boys and the girls were prohibited from having those items. In the matter of growing children, it is a common practice in a large number of families, including affluent families, that the best and most nourishing food is given to boys. It is a very common practice that milk, butter, eggs etc are given to boys only. Girls who would have to bear children in later life and require more physical strain are kept deprived of nourishment. The hypothesis that there is a strong and deliberate neglect in terms of food and medical care is also partially valid. A slight gender discrimination in terms of food intake was observed. In terms of medical care also, the girls always got treatment whenever they fell ill. However, there was a discrimination in providing allopathic treatment. And it could also be seen that gender had no relationship to immunization. There was little discrimination in medical care but in mode of treatment a clear cut bias was observed. From the above analysis it was concluded that gender discrimination is less likely to occur in the use of health services that are freely available (e.g. childhood vaccination) compared with those for which parents need to pay. Similarly, gender discrimination is less likely for food that is less valued (both by perceived value and monetary value) even if it is nutritionally beneficial. Moreover, there may be a sea of difference between Jat Sikhs and Mazhbi Sikhs but when it comes to gender discrimination they are same.

A large majority of women population in India suffers from 'Deprivation syndrome'; women are denied 'tender loving care' and always kept at a lower platform as a subservient creature, to be subjugated to the will of all around her. Women represent half of the world's population. This double standard for girls and women hurts everyone in society and has a negative impact on economic development. Societies in which women have equal rights are wealthier. These countries prosper more, grow faster and have better governance systems, which are important for growth and development. Today,

when we are at the doorsteps of the 21st century, it is sad to note that the status and role of women in society as a whole has not changed much. By and large, they are still victims of suppression, of stereotype, traditional and rigid roles all over the world – in the beginning as girls and later as women.

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