SUMMARY AND CONCLUSION

The present study has been carried out in order to know about the gender discrimination shown between the male and female children. The study, conducted in Coimbatore taluk, covered a sample of 335 married women with at least one male and one female child. Data were collected using the structured interview schedule and by face-to-face interview. Analysis of the data yields the following findings.

Socioeconomic Background

As for the age of respondents, it ranges from 20 to 54 years. Moreover one third of the respondents belong to the age group of 31-35 years and about another third of them fall between 26 and 30 years of age. The average age of the respondents is 31.5 years. More than half of the respondents belong to the backward communities and more than one third of them belong to the scheduled castes. Very few are from the forward communities. Except a few, majority of the respondents are Hindus.

With regard to the educational status of the respondents, three out of ten respondents are illiterates. Two fifths of the respondents are educated upto secondary level. Very few have higher secondary or college education. About two fifths of the respondents are working as agricultural landless labour, while about two fifths are housewives.

As far as the educational level of the spouses is concerned, more than two fifths have studied up to secondary level education. Three out of ten are illiterate. Very few have higher secondary or college education. Nearly half of the husbands are working as agricultural coolies and nearly one fourth of them are non-agricultural coolies.
The respondents have a monthly family income ranging from Rs. 500 to Rs. 20000. However, very few have such high incomes. Two fifths of the respondents have income of Rs. 2001 to Rs. 4000. One-third of the respondents have up to Rs. 2000. The average family income for these respondents is Rs. 3386. The vast majority of the respondents do not save any money since they have very minimum income to meet the family expenses and lack of awareness about importance of saving money. A very few respondents save money for their child’s education and marriage and to pay the loans.

The analysis on family size indicates that nearly three fourths of the respondents have small family with up to 4 members. The minimum family size is 4 while the maximum is 8. The vast majority of the respondents have only two children and only one male child. It is also the same in the case of the female child. That is, except for some, all are having one male and one female child. A few less than one tenth of the respondents have two male children. Again an equal proportion of the respondents have two female children. Having three or more children of the same sex is rare among these respondents. A few more than half of respondents have their first child as male while a few less than half have female as their first child.

To summarize, the migration status of the respondents nearly two thirds are non-migrants and the rest are migrants from various parts of the state moved mainly to have the better jobs and wages.

**Housing**

Regarding housing status, a few less than two thirds of them own the house while a few more than one third (34.6 percent) of the respondents live in rented house.
Over three fourths of the families reside in tiled houses while some are living in concrete houses. With regard to the number of rooms, more than half of the respondents have only one room. A few less than one third of them have two rooms. Seven out of ten houses have no toilet facility. Public tap is the only source for seven out of ten respondents for drinking water. With respect to availability of electricity, most of the respondents have such facility through free electricity scheme.

**Immunization Awareness and Child Care**

The Universal Immunization Programme, targeted to cover at least 85 percent children against these vaccine preventable diseases. Children are required to be immunized against some of the childhood diseases, which can turn out to be fatal in the absence of timely vaccination. To reduce the incidence of morbidity and mortality, Government of India has made arrangements for free vaccination services of the required doses of BCG, DPT, polio and measles vaccines to protect children against tuberculosis (BCG); diphtheria, pertussis (whooping cough), tetanus (DPT); polio and measles respectively (Ministry of Health and Family Welfare, 1991).

With regard to immunization awareness, except for a very few, all the respondents have knowledge about immunization. As for the sources of information on immunization, the majority of the respondents mention the village health nurses as their source of information. For three out of ten respondents, doctors are the source. Some also mention the village teachers as the source. With regard to awareness about diseases prevented by immunization, seven out of ten have full awareness and the rest are either partially aware or not aware of the diseases prevented by immunization. Similar observation has been reported by Saha (2003) that large proportion of mothers
had knowledge of immunization in urban areas; among them a very high percentage
had knowledge of eradication of polio.

Regarding the immunization status of the children, the respondents show some
evenness in vaccinating their male and female children at all stages from birth to 9
months. Thereafter is a steady decline in immunizing children in the age group of
under 5 years. The percentage of unprotected children rises from one percent at birth
to 21.5 percent at nine months. As the age of the children progresses, their vaccination
status declines. Though there is a steady decline, there is no perceptible difference
between the male and female children in vaccinating them irrespective of their age.
This is not consistent with the National Family Health Survey-3 and Saha (2003) who
find boys are slightly more likely than girls to be fully vaccinated and boys are more
likely to receive each of the individual vaccines than female children.

With respect to nature of immunization status of the child later, the male
children in the age group of 5-9 years and 10 years and above were fully immunized
than the female children. In the age group of less than 5 years, however, more female
children were fully immunized than male. Thus, there is less concern for female
children in the age groups above 5 years in vaccinating them.

When the child care component is taken into consideration, the vast majority
(94.3%) of the respondents discuss about their children’s health with husband. As for
making decision regarding treatment of children, in four fifths of the households the
husband alone makes decision. Yount (2005) also comes out with similar findings in
their study conducted in Minya, Egypt that women do not often report having the final
say about decisions related to children’s health rather someone else has the final say
especially the husband.
With regard to care given to the children when they fall sick, nearly half of the respondents say that their parents only take care of children. In some cases, the respondent alone takes care of the sick children. With regard to place of treatment, more than two fifths of the respondents go to government hospitals and nearly three out of ten respondents go to the Primary Health Centres. Another three out of ten go to private hospitals, but in the findings of the Saha (2003) study, mothers felt home remedies were sufficient to cure the illness of the children and financial constraints and supernatural beliefs also prevent them from utilizing the allopathic treatment. About three fifths of the respondents have health cards for their children, issued by the Primary Health Centers and government hospitals.

With regard to the availability and accessibility of health services, nearly two fifths of the respondents have primary health centers in their village itself; the rest of them have to travel from 0.5 kilometer to 15 kilometers. Three fourths of them visit primary health centers to relieve from minor illnesses; about one fifth of them do not prefer primary health centers for treatment because they feel that treatment is not up to their expectations and also because of non-availability of medicines and other health care facilities. More than two fifths of them have to cover a distance of 0.5 kilometer to reach medical shop while more than one fourth of them have it in their village. More than half of the respondents go to private clinics to treat minor illnesses and the rest do not prefer private clinics due to lack of affordability and accessibility.

With regard to initiation and duration of breastfeeding, almost all the respondents breastfed their children on the first day itself irrespective of the age group of the children. The statistics on initiation of breastfeeding shows no observable discrimination between male and female children. Premrajan and Srinivasan (1991)
have found no difference existed and 90 percent of both male and female infants were breast fed from the first day. Saha (2003) also asserts that higher percentage of children, both male and female was given breast milk on first day.

Majority of the children were breastfed for up to 9 months and beyond in all the age groups. There is no identifiable difference between the sexes of the children in duration of breastfeeding. Whereas National Family Health Survey-3 shows that the median duration of breastfeeding is two months shorter for girls than for boys. For very small number of children breastfeeding was not continued for up to the prescribed age due to insufficient milk among the respondents, or because the child refused to take breast milk or because of illness of the respondents. Saha (2003) findings state that pregnancy was the leading cause of discontinuing breastfeeding followed by custom and child refusal. As regards the discontinuation of breastfeeding, the data do not reveal any difference between the male and female children of all the three age groups.

Regarding initiations of supplementary feeding, three fifths of children who are over five years were initiated to supplementary feeding between six months to one year of age. The respondents did not show any discrimination between sons and daughters. Premrajan and Srinivasan (1991) also come out with similar findings that no difference existed between time of introduction of supplementary feeding. Only a very marginal difference in initiating supplementary feeding is observed in the age group of under 5 years.
Reproductive Health

The ideal age at marriage for men according to these respondents ranges from 21 years to as far as 30 years; for the vast majority, however, the ideal age is 25 years. As for women, the ideal age at marriage starts from 18 years and goes up to 28 years; for the majority of the respondents, the ideal age at marriage for women is 21 years. The average ideal age at marriage desired for men is 25 years and for women it is 21 years.

More than three fifths of the respondents got married at the age of 20 years or below. Around one third of the respondents got married when they were between 21 and 25 years of age. The minimum age at marriage of this sample is 12 years and the maximum is 35 years. The average is 20 years. The age at marriage of the husbands of the respondents was 25 years or below for more than half of the respondents. For around one third of the respondents, the age at marriage of the husband was between 26 and 30 years. The minimum age at marriage is 19 years and the maximum is 40 years, the average being 25.85 years.

The vast majority of the respondents feel that the ideal age for conception is from 21 to 25 years. The minimum is 19 years and the maximum is 31 years. The average is 22.76 years.

In the case of more than half of the respondents, the decision on reproductive health of the respondents was made by both the respondent and the husband. In more than two fifths of the cases, the husbands were the sole decision makers. A Western Guatemalan study by Becker et al. (2006) and the Colombian Demographic and Health Survey by Pallitto (2004) also brought out similar findings. The results of both studies show that men prefer to see themselves as the senior partners in all decisions
including reproductive health decision making and further they say lack of communication between partners as a reason for low decision making role of women.

With regard to the household work performed during pregnancy, the vast majority of the respondents (95.5 percent) were doing all the household works till the last stage of pregnancy. A few less than half of the respondents were cared by their mothers during pregnancy; about one third of the respondents were cared by their husbands. The vast majority of them were discussing their health status during pregnancy with husband. About three fourths of them had taken rest during pregnancy. More than two fifths of them stopped doing heavy work just one month before delivery; one fourth of them were working till the very end of their pregnancy. A study conducted in rural China disagree with study findings and reveals that women's position within the family is positively associated with the likelihood that a woman receives prenatal examinations, stops heavy physical work before birth (Li, 2004). With respect to immunization status of the respondents during pregnancy, almost all the respondents were immunized.

With regard to the nature of care received by the respondents during pregnancy, majority of the respondents consulted with doctors 9 or 10 times. Three fifths of the respondents were accompanied by their husband to hospital for regular checkup during pregnancy while three tenths of them were taken by their mothers. With regard to diet during pregnancy, about three fifths of them had special diet and more than two fifths did not have special diet due to poverty though they desired to have, very small number of them felt that special diet was not needed and they eat whatever available. In the case of nine out of ten respondents, they were visited by the health workers when they were pregnant, since visiting mothers during pregnancy is
mandatory that every village health worker should visit each house periodically to give them education about the diet during pregnancy and the importance of regular health checkups and taking immunization.

**GENDER DISCRIMINATION**

The data depicts that with regard to mean score of male and female children in provision of food there is small difference shown in the allocation of fruits and vegetables. This, however, is not remarkable. Otherwise, there is no considerable difference between the male and female children in the provision of food items.

**Initiation of Breastfeeding**

As for the relationship of the various dimensions of gender discrimination with other variables, discrimination in initiation of breastfeeding is found to be relatively more among the youngest age group respondents, i.e. those belonging to the age group of up to 25. Otherwise there is no difference among the various age group respondents in this regard. There is no difference among the respondents belonging to BC, MBC and SC communities in showing bias against the female children in initiation of breastfeeding. Only those belonging to the FC community show some partiality.

As far as educational level of the respondents is concerned, there is no marked difference among the respondents with varying levels of education. Only the illiterate respondents show some discrimination against female children in initiation of breastfeeding compared to the educated respondents. Family income does not have any significant relationship with discrimination in initiation of breastfeeding. Neither does family size.
The respondents who have male as their first child show relatively more inequality between the sexes in initiation of breastfeeding. However, such a relationship of birth order of the sexes with discrimination in initiation of breastfeeding is not significant. Migration also does not have any bearing on discrimination in initiation of breastfeeding.

**Duration of Breastfeeding**

As for discrimination in duration of breastfeeding, age of the respondents does not have any influence. Ghosh et al., (2006) observed that duration of breastfeeding continued to decline linearly in mothers more than 35 year of age compared to mothers of less than 25 years of age group. It is found relatively more among the backward communities. The forward communities show a different picture wherein the female children were breastfed for longer duration than the male children. However, such differences are not statistically significant. National Family Health Survey-3 shows notable difference that the duration of breastfeeding is relatively longer for children from scheduled castes and schedules tribes. Educational level of the respondents does not show any determinative pattern of relationship with discrimination in duration of breastfeeding, though the most educated breastfed their female children for a longer duration than the male children. National Family Health Survey-3 made contrary observation that the duration of breastfeeding decrease steadily with mother’s education and wealth index but the Basu and Stephenson (2005) suggest that breastfeeding duration tends to fall with a little education and rise again women with high level of schooling.
When family income is considered, the lower income group respondents breastfed their female children for a longer duration than the male children, while the middle and higher income group respondents did it the other way. However, these differences are not statistically significant. Victoria et al., (2008) have also found that there was no marked difference in terms of median duration between family income groups. In small families the male children were breastfed for a longer duration than the female children, compared to the large families. This again is not statistically significant.

The respondents who delivered male as their first child show some discrimination in duration of breastfeeding against female children. Similar findings observed by the National Family Health Survey-2 (1988-89) that the median duration of breastfeeding is two months shorter for girls, because mothers may stop breastfeeding a girl at a younger age to increase their chances of having another child earlier. The respondents who had female child as their first child rather display favoritism towards the female children in the duration of breastfeeding. This is statistically close to the desired level of significance. There is no difference between the migrants and non-migrants in discrimination in duration of breastfeeding.

**Initiation of Supplementary Feeding**

Discrimination against female children in initiation of supplementary feeding is relatively more among the youngest, i.e. up to the age of 25 years, of the respondents. Those who are aged between 26 and 35 years rather show favoritism towards the female children in this regard, while the old do not show any discrimination. Such differences, however, are not conclusive.
The backward communities and the most backward communities show partiality against female children in initiation of supplementary feeding. However the forward community and scheduled caste respondents do not show any bias in initiation of supplementary feeding. This finding is close to the desired level of significance. Educational level and the family income of the respondents does not have any relationship with discrimination in initiation of supplementary feeding.

Discrimination against the female children in initiation of supplementary feeding is more among those respondents having small family than among those having large family. Family size has a bearing on discrimination between male and female children in this regard.

There is a marked difference between the respondents who had male as first child and who had female as first child. More discrimination in initiation of supplementary feeding is found among those respondents who had female children born second to the male.

Migrant and non-migrant respondents do not show any significant difference in the discrimination in initiation of supplementary feeding.

With regard to the initiation of supplementary feeding, the use of all types of supplements decreases with increasing birth order and increases with mother’s education and wealth status of the household. Among caste groups, feeding practices are worst among scheduled tribes and scheduled caste. Girls and boys are about equally likely to receive all supplements (NFHS-3)
Allocation of Food

Almost all the age groups show some discrimination between the male and female children in allocation food, except the respondents who are over 40 years. Age does not have any bearing in this respect. Likewise, the caste status of the respondents also does not have any relationship with discrimination in allocation of food.

Those respondents who are educated up to higher secondary and graduate level do not show any discrimination between their male and female children in the allocation of food. The illiterate and the primary educated respondents show relatively more discrimination. Vani (2004) also brings out similar findings that there was no gender discrimination between children of literate mothers in allocation of nutritious diet, when the mothers were illiterate; girls were less likely to be well fed. However, study finding shows such differences are not significant as Sudipta (2007) found in his study on intra-household allocation of food nutrition among Santhals of West Bengal that under nutrition has a strong negative relationship with the mother’s education.

The respondents belonging to the lower income group (below Rs. 2000) show more discrimination against the female children than the higher income groups in the allocation of food but a differing observation was made by Kimhi (2000) in his study conducted in Southern Ethiopia that poorer family children tend to be in a better nutritional status. Further he explains that the adult female children are in a better nutritional status than male. The present study wraps up that as the family income of the respondents increases, discrimination between the male and female children in the allocation of food decreases.
Size of the family does not have any bearing on discrimination in the allocation of food.

Birth order of the sexes and discrimination in the allocation of food are related with each other. When the first child is male, discrimination against the female child is more and when the first child is female such discrimination is less. Ghosh (2007) and Kimhi (2000) found under nutrition is generally lower for first births than for subsequent birth and consistently increases with increasing birth order but found no observable gender equality but Bratati and Bandyopadhyay (2005) observed in their study conducted in urban slum of Kolkata that a significant increasing trend of malnutrition was observed with increase of birth order in the girls, but no such trend was observed in boys.

Discrimination against female children in the allocation of food is more among the non-migrant respondents than among the migrants.

**Immunization**

Age and caste status do not have any relationship with discrimination in immunization of children. Vani (2004) made diverse comment that likelihood of boys and girls being fully vaccinated would fall if they are dalits and also embedded a gender bias in lower propensity. The illiterates and those who have studied up to primary level show some discrimination between genders, but the level of discrimination is not markedly high. As the level of education of the mother rises the discrimination in immunization status decreases. The observations of Vani (2004) and NFHS-3 depicts that a strong positive relationship exists between mothers’ education and children’s vaccination coverage. From the present study we even find favoritism for the female children in this regard among the graduate respondents. However, the
differences in immunization among the various educational level groups are not significant.

Irrespective of monthly income, all the respondents show some discrimination in immunizing their female children but comparatively lower income group respondents show more discrimination. Larger families comparatively show more discrimination in giving vaccines against preventable diseases than smaller families. This difference, however, is not statistically significant.

Discrimination is shown against female children in giving them vaccines if they were born first to the respondents. The study findings of the Pande (2003) and Yu (2004) reveals that boys who were born after multiple daughters have the best possible outcome in receiving immunization. But the respondents who have male child as their first child do not show any partiality between male and female children and gave them all vaccines. NFHS-3 data, Sharma et al., (2008), Premarajan and Srinivasan (1991) and Saha (2003) suggest that the relationship between vaccination coverage and birth order is consistently negative for all vaccinations and a uniform tendency of increase in coverage rate in each vaccine from higher age group and to lower age group, among both sexes.

There is no significant difference between the migrant and non-migrant respondents in discrimination shown in vaccinating their male and female children.

**Duration of Treatment**

Age and caste status of the respondents do not have any decisive role in the discrimination between the male and female children in the duration of treatment in the case of illness. Respondents having higher secondary and graduate level
education treat both male and female children for the same period. Those who are educated up to primary, secondary as well as the illiterates treat their male children for long duration than female children. It is found that the discrimination in duration of treatment does decrease when the educational level of the respondents gets higher. However, the mean difference analysis does not confirm that respondents having different educational levels vary in their level of discrimination in duration of treatment. Yount (2005) says that there is tendency for providers to give care more often to the boys than the girls of uneducated mothers. On contrary Bhan et al., (2005) study conducted in New Delhi confirms that gender bias is highest amongst highly educated mother and decreases steadily for the children of mothers with a middle and primary education and is lowest among mothers with no formal education.

As income of the family increases, discrimination against the female children decreases. Here again the mean difference analysis does not confirm the role of family income in discrimination in duration of treatment. Anson and Sun (2002) andPokhrel et al., (2005) accept the study findings and describe that there is no interaction between the utilization of medical services and sex of the child and the income of the family.

Family size, birth order of the sexes and migration do not have any significant influence on discrimination in duration of treatment of male and female children.

**Overall Gender Discrimination**

As far as the overall gender discrimination is concerned, age and caste status of the respondents do not have any bearing. The illiterate and primary educated respondents show relatively more discrimination between the male and female children. The more educated respondents, i.e. those studied up to higher secondary
and graduate level do not show discrimination against the female children. Rather they show favoritism towards the female children.

The lower income group respondents show comparatively greater discrimination than the middle and higher income group respondents. The overall gender discrimination decreases when the income level of the respondents goes up. However, such differences are not statistically significant. Family size is not related with the overall gender discrimination.

As for birth order of the children, those who had their first child as male have a higher mean score for overall gender discrimination than those who had their first child as female. This shows that the former show more gender discrimination than the latter. However, this difference between the two groups of respondents is not significant. The non-migrant respondents show relatively more gender discrimination than the migrant respondents. This difference between the migrants and non-migrants, though not significant, is close to the desired level of significance.

**Correlations of Discrimination with Select Variables**

Correlation analysis further shows that age of the respondents does not have any correlation with any of the dimensions of discrimination. Neither does it have any correlation with the overall discrimination. While educational level of the respondent does not have any correlation with the dimensions, it has a significant negative correlation with the overall gender discrimination. When the educational level of the respondents is high, the overall gender discrimination is low.
Family income is negatively correlated with discrimination in allocation of food. Inequality shown on female children is considerably less when the families have more income.

Family size has a positive correlation with discrimination in immunization. The bigger the family size the greater is the neglect of female children in giving immunization.

As far as the number of children is concerned, discrimination against the female children in initiation of breastfeeding is found to be higher in the families that have more number of children. It is the same in the case of discrimination in immunization too. When the number of children increases discrimination also increases in these two respects.

CONCLUSION

The value of children is a social psychological construct referring to the values attributed to children by parents. As such, they reflect the motivations underlying child bearing and child rearing. Different values are attributed to the child in different socioeconomic contexts, and these values are differentially related to the outcome variable of child bearing too.

There are three main value types attributed to children by parents: utilitarian, psychological, and social values. Utilitarian values have to do basically with the economic-material benefits of children, adult offspring old-age security to their elderly parents. Psychological values have to do with such satisfactions as the joy, pride, love, and companionship that children provide to their parents. And social values of children refer to general social acceptance that married adults gain when they have children, in the sense that especially in traditional society people are
considered to be adults when they have children, not necessarily when they get married (Kagitcibasi, 1997).

In India, gender dimension in value and preference of children is highly pervasive. Singh (2001) asserts that a strong desire for a son often leads to high fertility and larger family size. Daughters are accepted reluctantly and considered a liability for the family. In the transition from large to small family and the desire for a ‘balanced family’, the sex composition of the children is influenced by a large set of factors.

Sons are valued for future patriarchal status and their kinship role in continuing the family name. Daughters are more likely than sons to be relied upon for financial support at old age, and are cherished for their potential roles as future mothers (Togunde and Newman, 2005). Patrikar et al., (2008) found that if the first child is a male then it hardly matters whether the second child is male or female, but if the sex of first child is female then the families land up with bigger family size.

Son preference is closely associated with fertility, because high fertility assures that at least some sons survive. Schutjer et al., (1983) and Cain (1985) have highlighted the supply effect of land on fertility. Income from land could increase the supply of children by improving health and nutrition through improved food availability, access to medical care, and by increasing infant and child survival. Besides health and nutrition, cultural practices like prolonged breastfeeding could be more common among poor- resulting in wider birth spacing and lower fertility.
The present scenario is totally contrasting with yester years that the parents revolve around their children and not showing any bias in allocating resources to them irrespective of the sex of the child. The parents not seeing their children as an economic advantage like earlier rather observe them as pride and value them equally.

Greater linkages with the system of modern health care delivery as of consequences appear to be a perceptible transformation in attributing value to children. Eventually there might have resulted in greater investment in a child irrespective of its gender. All other region comparable with greater development may also incorporate greater value of and investment in children.

Allocating resources is not consciously planned any inequality in providing them timely and appropriate care and in the process of promoting their health as well. The nature of work, economic position, educational level and fertility behaviour of the mother, availability of the resources and the family size are the major determining factors of health care allocation and value to their children. When the education level and the family income of respondents raise the gender discrimination shown against female children reduces considerably. Unequal allocation against female children tends to be more pronounced when the size of the family is large and having more children.

The analysis of gender discrimination shows that education of the mother, network composition in providing childcare when services are delivered at their door steps have played a positive role in reducing the gender inequality.

The results indicate that overwhelming percentage of mothers have knowledge of eradication of diseases through vaccinations, which is attributable to government
efforts towards universal immunization and mass awareness campaign followed by service campaigns conducted at various levels such as community health centre and primary health centre level. All resources at the command of the state have been mobilized for effective delivery.

The study finding further leads us to conclude that respondents do not manifest any preference towards their children even though the position of the mothers considerably lower in decision making on their own health. The reproductive components clearly show that the respondents do not have any great say in determining their health during pregnancy which space is occupied by the husband. The contraceptive awareness is very low among the respondents. The reasons cited by them are menstrual problems, spousal disapproval, and not needed. The contraceptive behaviour of the women is a major determining factor of the composition of the population of the country which in turn influences the health status of the children as well as their own.

India’s goal for achieving replacement level of fertility is the year 2010. While Tamil Nadu has achieved zero population growth in 1991 and replacement level of fertility in the year 2000. This feat has been accomplished through the efforts of a concerned and committed family planning program, improvement in maternal and child nutrition, especially female children, girl children’s stay in school for more years, which in turn delayed their marriage and exposure to conception, near universal immunisation coverage, more than eighty four percent institutional deliveries and hundred percent antenatal registration (Aiyer, 1993). Tamil Nadu has emerged as a model state for family welfare and health care. Kerala model is viewed as triggered by remittance from abroad and not representative.
Tamil Nadu, with the third highest Human Development Index among Indian states, is well on track to achieve the major Millennium Development Goals. The state's above-average performance in increasing female literacy and female life expectancy, and reducing female infant mortality and lowering the fertility rate have given Tamil Nadu a Gender Development Index (GDI) of 0.654 (in 2001) as against the all-India average of 0.560 (The World Bank, 2009). Though the state’s GDI is high against national average but the form and severity of gender inequalities in basic needs are not uniform. Hence there is an imperative need to improve awareness of people especially women and exploring gender equality in relation to human development by looking at outcomes: the extent to which women and men, boys and girls achieve equivalent levels of well-being.

Gender ideology is age old and persistent. It both reflects the existing gender inequalities and also influences gender-based behaviors, which, in turn, help sustain gender ideology. It is this vicious circle which perpetuates gender issues. Of particular importance are the perceptions and values of women, since their orientations have an impact on how they rear and socialize their children. Also, as long as women accept the "natural" superiority of men, they would not resist patriarchal views and behaviors which put the girl child at a disadvantage in every walk of her life. Although gender disparity is strongly related to social development, level of living and female autonomy, it is governed increasingly by government policies towards child education and health, and implementation of policies.