CHAPTER - 1

Introduction
According to the National Policy for Children, "Children are supremely important assets and according to this, the state shall provide adequate services to all children before and after birth and during growing stages for their physical, mental and social development. Early childhood is an important delicate period. Growth and developmental deficiencies during this stage lead to permanent retardation in physical and mental growth. Even a small positive change can generate long term social benefits (Siwal, 2001). Child's needs are his physical, mental, intellectual, emotional, social, cultural and recreational all of which are important for his growth and development at all ages.

Although the process of health and well being of an individual starts even before birth, the importance of health during the early years forms a basis on which adult life is reflected through the state of heath in later years and in this age, child starts developing his own individual personality. It strengthens the learning potential and well being of children. The majority of children in India are underprivileged. They live under such social, economic and environmental conditions which hamper their growth and development, hence need for health guidance should be highest.

The primary school children of (6-12) years age form the vulnerable segments of population as they represent a section of community having surmounted or prevailed over the hazards of infancy, early childhood and preparing for the important phase of adolescence. It includes those years of life where a child progresses from dependent, vulnerable, immature to independent teenagers who are bold, self confident, distinct, individualistic, untrammeled and thus there is need for special attention. Many
development processes takes place during this period. The motor and social developments are at the peak, though physical growth is somewhat slower. But resources are being laid for rapid adolescent growth and this has been called the call before the storm (Williams, 1997).

The child is a member of social groups as his family, school, neighborhood and peer groups and develops likes, dislikes, tastes regarding foods. Children in this age are very active, play more games and thus require adequate and well balanced diet for growth and if neglected many health problems crop up. Children should grow and develop to become robust citizens, physically fit, mentally alert and morally healthy, endowed with skills and motivations needed by the society (Vaida, 2000).

Since early years are the most plastic and impressionable years of an individuals life and thus during this period child should require optimum nutrition, adequate clothing, satisfactory housing conditions and a stimulating environment with a provision of love and affection and for this reason both sexes (boys and girls) should receive equal attention and treatment both by the society and family. School age is a period for mixed dentition, a critical stage from the point of view of development of normal occlusion. During this period oral hygiene is poor because of care free age and emotional stress and also because of frequent intake of refined sugars, soft and sticky foods (Munshi, 1985).

If children are fed well, they learn better. They carry new ideas and information into the community. Orientation of work can be established during primary years. The skills of learning, reading, and writing are learnt at school as early childhood is a
time of opportunity and learning. Good health and nutrition are needed to achieve one's full educational potential because nutrition affects intellectual development and learning ability. This school age has been called the latent age of growth and the rate of growth slows down and body changes occur gradually and girls out distance boys by the latter part of this period (Lakshmi, 2000).

Children are a precious natural resource and the future of a country, so their welfare is linked with socio economic development and long term investment for their upliftment is sure to pay rich dividends in future and the quality of a nation which depends on physical and intellectual development of children. Thus protection is the responsibility of all as they set limits for future development (Navreet, 2003).

The socio economic status (SES) of family shows a direct bearing on health of children as children of low SES lack the availability of adequate food which gives rise to malnutrition. Malnutrition results in physical infirmity, decrease mental and psychomotor competence, poverty, ignorance and disturbed emotional status due to maladjustment in schools are some of the factors which produce malnutrition among school children (Massarath, 1999).

The conceptual difference between gender and sex was first developed by Ann Oakley. Sex is connected with biology and considered to be based on hormones, gonads, and genitals, whereas the gender is considered as psychologically and socially constructed and historically and culturally determined difference between man and woman. The internationalization of these differences is called 'Gendering'. Thus gender differences are created, artificially, partly through socialization.
means internalization of values, norms, and behaviour patterns of a group into which a child is put. It is a continuous life long process (Siwal, 2004)

Eleanor Macoby and Carol Jacklin reviewed and integrated research literature on psychological sex difference reading 2000 books and articles in the process. Most studies were comparison of male and female behaviour in infancy and childhood. On the basis of the reviews, they concluded that many differences between male and female are in fact myths e.g. there is no good evidence that boys are more independent, ambitious or achievement oriented than girls or girls are more nurturing, sociable or suggestible than boys. On the whole they concluded that male and female are much similar to one another than they are different and they share the same fundamental needs, emotion and abilities (Sharma, 2000).

Gender bias has been identified in the ways in which female child and male child are treated by family members as well as parents. The impact of discrimination on the social factors are education, child abuse, child labour and can be identified in different places and the discriminatory treatment in morbidity, mortality and health services can be traced and this dis-treatment denies the females the basic rights and opportunities for full growth and development. Society that discriminates on the basis of gender pays a significant price in great power, slower economic growth, weak governance and lower quality of life.

According to UNICEF and WHO there is a excess of female deaths both in childhood and child bearing years and most can be attributed to material discrimination against girls and women in India, Pakistan and Bangladesh. The pattern of gender bias
varies slightly between age group and across societies as may the different factors causing them (Gulzar, 2006). Despite all the provisions, the girl child in India has not been given equal status and needs to be seen as a special group suffering from several disadvantages. The girl child experienced discrimination throughout her life and existing socio and cultural practices make it difficult to overcome the handicaps posed by her unequal status. A life cycle approach may be taken to examine the situation of girls in India from conception and birth, through early childhood into the school going years, adolescence and womanhood.

A very strong gender bias is entrenched in the cultural heritage of Indian society. It is a society that idolizes sons, an obsession that cuts across all differences. Sons are considered ritually and economically desirable, essential not only to light the funeral pyres of their parents in order to release their souls from the bondage of their bodies but also to ensure construction of the lineage and family name. They also become the economic support of their parents in old age. Thus a girl is viewed as a burden and a liability and is given a meager share of the family’s affection and resources. Investment brings to return but she has to take a sizeable dowry on her marriage.

Basic education is denied to many girls and there is a gap in enrolment in schools. The social barriers standing in the way of girls attending schools are poverty, compulsion of girls to look after young ones, misconception that girls do not need education and what is taught in schools is irrelevant to them and above all they are meant for producing children. Lack of women teachers, non availability of separate school for girls, lack of supportive facilities like clean and adequate toilets and transport facilities etc. to take to school, all these inhibit parents from getting girls
enrolled. The gender discrimination in schools is an extension of what we think in family, society, community in which we live. Education of girls thus is a crucial input to National development. In India barely 53 percent children reach class -V and even less than half the children in the age less than 12 years do not go to school. This will result in India having the world's largest population of illiterates in the 21st Century. India has the largest number of children out of school between ages (6-14) years in the world. Out of every hundred who join class-I barely complete Class-V (Mukta, 1995).

Gender differences result in lower health standards among girls as she has secondary consideration next to males in distribution of food, provision of health care, utilization of services, immunization, access to basic facilities at home. According to some analysis the male health environment differs from that of the female, the former being more out of doors, and the latter centering round the dark smoke filled kitchen in such a way as to suggest that exposure to infection may be gender specific. In India discrimination begins right from birth. A girl is breastfed for a shorter period, less cared for and given the least priority in the matter of nutritious foods. Since girls are fed improperly, a wide difference in nutritional status of male and female children is observed (Baltimore, 1993).

Male children are fed for almost 10 months longer than female children (Gulzar, 2006). Gender differences in medical care as well as nutritional care exist in almost all societies. Good medical care for boys is high and is the main factor accounting for higher survival rates among male children. These trends demonstrate that discrimination at home against female children is much and this continues in adulthood. Food distribution favour
males and females receive disproportionately small share. Hospital records show more boys being brought for treatment. Female children suffer loss of life in all age groups from birth to age of 34 years. Age specific death rates for rural areas are twice as high as those below 4 years in urban areas. Cause of higher mortality range from female foeticide, female infanticide, conscious neglect of health, nutritional needs of female from birth through adolescence to youth. There is considerable direct and indirect evidence of higher morbidity among female children even though hospital and clinic attendance show preponderance of males. In Safdarjung Hospital admissions are 65 percent for male and females 35 percent of the total.

The theory of demographic transition established a clear linkage between mortality and fertility decline. In the developed countries, mortality decline had started first making away for the decline of fertility. One of the major determinants of such decline is the overall socio economic development. Apart from development, public health improvements in health and hygiene, sanitation and protected water supply and significant discoveries of medicines are other significant determinants. The mortality declines in developing countries are the transfer of technology of medical care from developed countries. Structural changes in the social, economic and cultural fields can be traced. In India, the improvements in the allopathic, medical care, better food supply and better household living standards, better transport, communication facilities, water supply expansion, and educational facilities are some factors responsible for the decline in mortality. However, infant mortality has not come down significantly with regard to morbidity.
Essential factors responsible for disease occurrence in children are lack of safe drinking water, malnutrition among pregnant and lactating mothers and children, absence of personal hygiene, poor environmental sanitation, poor housing conditions and poor health services and their utilization. Health practices are influenced by social and cultural factors. Determinants of nutritional status include income, food, schooling, employment, availability of food and technological development in food products, education level of mothers, family size and environment, tastes and preferences, customs, taboos, beliefs, methods of preparing food and habits are some of the most important determinants.

While socio economic factors are known determinants of nutritional levels, their role in determining differences in nutritional status between males and females has also been documented. The synergistic effects of socio economic levels and gender on nutritional status have been demonstrated less frequently. In Punjab in 1972, Levison found that gender was the most statistically significant determinant of nutritional status. It had a highly significant effect on calorie intake among the population and diarrhea infections with females exhibiting higher rates of disease and this was more in low socio economic group and better among high socio economic status. (Levinson, 1974) found that both income and gender exhibited effect on nutritional status. High and low socio economic groups discriminated against females in breast feeding practices. Narangwal population study collected data which showed higher infant mortality rates (IMR) among females (Kilemann, et al, 1983). Levinson ascribed the care and upbringing of sons and daughters and these differences
reflect economic as well as cultural premium. Daughters are unproductive and expensive economic drain ‘as dowry’.

Micro level studies show higher rate of malnutrition among girls and women. Discrimination in feeding results and effects on nutritional status during infancy and these effects persist through childhood (CARE, 1974).

A major consequence of girl’s nutritional deprivation in early childhood and adolescence is their future to achieve full growth potential. A majority of girls from low income families reach adolescence about (12-15) cms shorter than well to do peers in the same society. Girls who bear a child before the close of adolescent growth spurt may remain physically underdeveloped and are at greater risk of obstetric complications, obstructed labour or maternal death, as well as of bearing low birth weight infants. During pregnancy, woman’s access to food is often restricted through taboos and rituals observed in India. Besides low maternal pre-pregnancy weights and inadequate weight gain during pregnancy, low birth weights are also related to low Hemoglobin (Hb) levels, so that the high prevalence of anaemia adds to the negative outcomes of child bearing although child nutritional status is the outcome of a host of factors with nutritional status of pregnancy. Several micro studies have shown anthropometric differences in infancy, which persist through childhood. Girls are breastfed less frequently, for shorter durations and even shorter periods than boys. Girls are weaned earlier. The differential feeding of girls is accompanied by lower levels of health care, so they are exposed to higher rates of malnutrition and longer periods or more severe morbidity, ultimately resulting in high mortality and the inferior social status is seen by the inadequate dietary intake. In order to address
concerns for the girl child, interventions need to be designed for adolescent girls which will break the intergenerational life cycle of nutritional disadvantage beginning in childhood, through adolescence and continuing through child bearing period which commences often before growth has ceased and consist of a continuous cycle of pregnancy and lactation all too often resulting in premature death.

A few studies have demonstrated determination in nutritional status as females grow older, the combined result of socio cultural, economic and biological processes. Gender difference appears to be exacerbated by poverty.

Child maltreatment is the physical emotional abuse of a child and detrimental effects on the physical, psychological cognitive and behavioral development of children and these adverse effects accumulate over time. In families where child abuse does exist, they may be hiding the abuse as it now carries a public condemnation (Gomango, 2006). This child abuse and neglect can result permanent and serious damage to children in physical, emotional and cognitive development. Thus the nurturing of young children’s development and ensuring them future success is the duty of the parents, teachers and society. Failure to provide child’s basic needs as clothing, food, shelter, refusal to seek health care in sickness, immunization, failure to enroll a child, upbringing of child properly all depends on us. Parental treatment for sibling is unequal or lack of concern, physical punishment and depression. Thus a protective environment for child should be built where they are taken care off.

The state of Jammu and Kashmir is the most charming state in the world. It is situated in extreme north between $32^\circ$ -15$^\circ$.
to $37^\circ-05'$ latitude north and $72^\circ - 35'$ to $80^\circ -20'$ longitudes east. The state comprises of two capital headquarters viz Jammu in the winter and Srinagar in summer. Morphologically the state of Jammu and Kashmir is divided into three regions i.e. Jammu, Kashmir, and Ladakh. These three regions can be separated from one another on geological, geographical, historical and linguistic grounds. The valley of Kashmir forms an important geographical region called the lesser Himalayas or the Jhelum valley region. Jammu and Ladakh regions are known as the outer Himalayas or the southern mountain region and the great central Himalayas or the Indus valley respectively. Studded with many snow capped mountain peaks, lofty mountain chain of the Pir Panchal forms the southern and south western boundary of Kashmir and thus separated the valley of Kashmir from Jammu region on the other side, the Zojila mountain peaks of Zanskar range forms the eastern and north eastern boundary and the valley of Kashmir off from the Indus valley (Ladakh).While Jammu region has both plain and hilly areas, Ladakh has very high altitude and remains frozen through most of the year. (Sharma, 2001) reports that Ladakh is isolated from the outside world when heavy snowfall blocks all the passes connecting Kashmir, Jammu, Sin Kiang and Tibet with it for 5 months, and this adversely affects the material wellbeing of the people. Major portion of the state is hilly and altitude from sea level varies between 1000 feet and 28500 feet.

The total area of Jammu and Kashmir state, as per Census, 2001 is 222,236.0 sq. kms and the population is 10,069,917 persons and the percentage of child population to total population is 14.21 percent. The percentage of rural-urban population to total population is 75.12 persons rural and 24.88 persons urban. Jammu and Kashmir rates 19th in population, 33rd
in literacy and 26\textsuperscript{th} in sex-ratio among the states of India. The State has recorded a decadal growth rate of 29.04 percent in 2001.

The systematic analysis of gender discrimination of children (6-12) years are really found in Jammu and Kashmir. Data from small and infrequent studies on gender discrimination, health status, and nutritional status in this age group suggest that they are at vulnerable risk as they face acute problems and much work has not been undertaken in this aspect in the Jammu and Kashmir State. Although studies have been carried in pre-school age, adolescence, but school age years have been given less attention. Hence it was felt to go into the study gender differences in health and nutrition among primary school children of (6-12) year’s age group to reflect the panoramic view of child’s health in Jammu and Kashmir. This study will help to improve the health and nutritional status of children on the whole and to remove deep rooted gender bias which is practiced knowingly and unknowingly. Gender discrimination prevails more or less in parts with intensity varying. Difference in degree is because of education, mass media, socio-economic conditions, cultures, traditions and social factors. The problems of low literacy in females, increased drop out rates, increase in morbidity and mortality, preference for sons, female foeticide, differential parental attitude, difference in feeding and weaning effects girls and societies at large. The welfare of the entire community depends on children where the foundation of physical and mental health is laid in early life. Girl child is discriminated at all levels and the adverse attitude towards the girl child, talks of the imbalance of socio-economic conditions. The childhood neglected in terms of proper education, health and nutritional care needs to
be addressed for changing and improving health of girl which is important for development and survival of not only the girl child but the entire humanity.

Since the indices of health and nutritional status have been widely accepted as measures of development and affluence, an attempt is made to study the gender difference in health and nutrition among primary school children. The present study is a pioneering effort to make people aware about the status of girl child and provide some insight on the issue of gender discrimination.

**Objectives of the study**

The study has been undertaken with the following objectives:

- To assess the nutritional status among primary school children in relation to gender differences
- To study the weaning and feeding practices and their differences among boys and girls.
- To study the morbidity and sibling mortality pattern among male and female children.
- To make an attempt to determine the utilization of services by the girl child.
- To assess social, economical and educational factors in determining these differences.
- To present a scenario relating to the discriminatory position of the girl child in local setting.

The present chapter dealt with the introduction of the study undertaken wherein aims and objectives were also laid down. Since secondary data forms an important documentation of any research work, accordingly 'Review of Literature' forms the second chapter of the study.