Gender differences result in lower health standards among girls as they stand next to boys in distribution of food, provision of health care, utilization of services, immunization, schooling and access to basic facilities at home. The environment differs for them as they stay indoors and are not given more freedom by parents. Discrimination begins right from birth. A girl is not allowed to come into this world due to female Foeticide, infanticide, neglect of health in terms of increased morality and morbidity. Failure to provide child’s basic need on clothing, shelter, food, refusal to health care in sickness, upbringing, parental treatment for sibling is unequal, physical punishment which leads to detrimental effects are all concerns of parents, family, teachers and society, hence all should be taken care off.

Careful systematic analysis of gender discrimination of children in the age group of (6—12) years is not 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 and various problems and so far much work has not been undertaken in this aspect in Jammu and Kashmir. Hence it is felt to go in to the study “Gender Differences in Health and Nutrition among Primary School Children of (6-12) years in Jammu, Kashmir and Ladakh regions of the state”. to reflect the panoramic view of child health in the state. This study will help to improve the health and nutrition of children on the whole and remove deep rooted gender bias which is practiced knowingly and unknowingly from the community and also is felt by children in their hearts. Gender discrimination prevails more or less in many parts of Jammu and Kashmir State with intensity varying.
Differences in disparities are due to the degree of education, mass media, socio economic conditions, religious, cultural and social factors. The problems of low literacy in females, increase in drop out rate, increase in morality, morbidity, preference for sons, greater economic dependence of old age, difference in parental attitude, difference in feeding and weaning affect girls and societies. Improper social and moral upbringing is also observed in female children.

Since the welfare of entire community depends on children where the foundation is laid in early life, the needs of the girl child have to be addressed for change and improvement, development and survival by the society by improving the living standards. The indices of health and nutritional status have been wildly accepted as measures of development and affluence. Nutritional status is the result of the complex interaction between the food we eat, our state of health and the environment we live in. An attempt is made to study the gender differences which can establish the local baseline data relevant to health and nutritional status of primary school children in the three distinct regions of Jammu, Kashmir and Ladakh. The study will serve as a reference for comparing the health status of children. The present study was 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 study has been carried on nine hundred primary school children (6 –12) years by multistage random sampling in three regions of Jammu and Kashmir state. The preponderant bias was prevailed over by an equal representation from Jammu, Kashmir and Ladakh regions respectively to get information on gender differences in health and nutrition among primary school children. Information was collected with the help of questionnaire cum interview method. Each child was interviewed covering information on all factors relevant to the study. Some information was collected from the parents of children as well. Information on feeding and weaning practices was collected from parents. Data on nutritional status was collected through clinical assessment schedule. Nutritional anthropometry and dietary assessment using 24 hours food recall method. Health status was assessed by collecting information regarding sickness, morality among sibling, utilization of health services and immunization. Gender differences have been quantified by using a scoring method which was devised by the researcher alongwith a few experts. Information regarding hygienic practices, abuses, habits like pica, bedwetting were also elicited. Information regarding parental preferences for a particular gender, family plan, history of any abortion etc was also collected. The sample comprised of 55.44 percent rural children and 44.56 percent urban children. The nuclear family trend setting was seen in the state with 63.4 percent from nuclear families and large family size was the most focal point in our study with 61.18 percent dwelling in these families. The literacy rate of parents was 37.4 percent being attributed to the non ending turbulence. Majority of the fathers had unskilled and semiskilled occupation and mothers were unskilled, also including house wives. Majority children i.e. (73.33%) belonged to middle income group and overall more male children belonged to this group.
On looking at the health status of children it was observed that 9.6 percent children suffered from illness during three months prior to the survey and this incidence was similar for male and female children. ARI was more prevalent among male children belonging to Kashmir and Ladakh regions showing significant differences. At the time of survey 6.9 percent children had complaints about sickness and 8.3 percent were females as compared to 5.1 percent male children. Female children from Jammu region were the worst sufferers. ARI was reported by 50 percent of children with significant differences for Jammu region. Out of the total deaths 68.51 percent were below one year of age and significant differences were found in Kashmir region between male and female children. The major cause was diarrhea and vomiting being more pronounced in female children. The sibling death rate in children of less than one year was 13.35 per thousand and in children above one year age, it was 19.48 per thousand. Equal percentage of children availed the health services in all the three regions showing no discrimination. Though only 4.95 percent availed these services at private institutions but more males received such services. Parasitic infection is another major problem in this age group. It affects nearly 1/3rd of children.

Deworming was not a common practice, with only 30.33 percent children being dewormed and percentage was similar for both male and female children and lowest practice was observed in Jammu region. Breast feeding and supplementary/complimentary feeding practices for male and female children were found to be identical with 98.7 percent being breast fed in infancy with similar percentage for male and female children. The duration of breast feeding was (6-24) months in a majority of 67.3 percent male children and more female children being fed among all three regions. Male children were breast fed even for a longer
period i.e. above 24 months. Significant differences were observed in Jammu region where discrimination was highest. Overall mean length of breast feeding was $25.25 \pm 9.09$ months for male and $23.93 \pm 9.39$ months for female children. Exclusive breast feeding was seen in 46.8 percent and was equal for male and female children. Weaning was proper in 81.4 percent children being similar for both males and females. Marketed foods were consumed by male from Jammu region showing significant differences. Solids were introduced at the age of one year in 84.3 percent and again it was slightly higher for male children, but difference was insignificant.

Nutritional status as assessed by clinical signs showed 47.5 percent children with 54.2 percent male and 42 percent female children showing these signs of deficiency. About 38.7 percent had 1-2 sings, more than four signs were observed in 1.2 percent children with male children forming a higher percentage. Significant difference was observed among male children from Kashmir region.

As per weight for height criteria 43.1 percent were malnourished being similar for male and female children. 23.8 percent showing mild malnutrition again similar for boys and girls. Moderate malnutrition was observed in 13.9 percent and severe in 5.4 percent children. Moderate malnutrition was higher in male children from Jammu and female children from Kashmir region. Severe malnutrition was observed in higher proportion of male children in all the three regions showing significant differences.

The 24 Hours food recall of food consumption was used to assess the dietary intake of children. Children were divided into three age groups i.e. 6 years, 7-9 years and 10-12 years. Calorie, protein, fats, calcium, vitamin-A and iron was below normal in most of the children. Overall the intake of nutrients was less than R D.A. Thus the
need for nutrition intervention programme in this age group is suggested. School lunch was identical for both male and female children as 85 percent took lunch in all the three regions of Jammu, Kashmir and Ladakh.

There was a strong son preference in all the regions showing significant differences and the reasons were that boys were bread earners, old age support, decendency of family. The preference for the first three children to be a male was observed in all the three regions with significant differences.

History of abortion was reported by 19.2 percent and this was highest in Jammu region (39.9%) followed by Kashmir region (15.7%) and Ladakh region (12.3%) respectively. Induced abortion was carried by 60.7 percent with Jammu showing the highest figures followed by Ladakh and least in Kashmir region. The reason was sex determination in 63.8 percent again being highest for Jammu region. Male children from all the three regions were observed to be having unsatisfactory hygiene as compared to female children.

Child abuse was not a major issue in the state but depression was observed in higher proportion in male children belonging to Kashmir region which can be attributed to the fact that conflict situation since 1989. The conflict has disturbed the economy, source of earnings of families, social fabric and children and women have gone through a crushing trauma because of this situation.

As per the perception of the parental attitude children felt discrimination in different aspects. Male Children were given preference in freedom as they were allowed to play outside freely. They were apprised of naughty activities. Type of clothing was different for male and female children. Male children were assisted in home tasks and were given desired toys. Thus the girl child is subjected to inequality.
disparity, neglect in social and cultural environment and lesser entitlements in parental attention.

In case of food intake children did not find any discrimination and incase of sickness both children’s parents got equal panic. Effect of various social factors was assessed and it was found that improper morbidity schooling, utilization of health services, incomplete hospitalizations were prevalent among female children. However, predominance of nutritional deficiencies, improper feeding, and improper immunization was observed in female children. Improper social and moral upbringing was observed in higher proportion in female children and the difference was significant. Parental literacy status had an impact as female children from illiterate parents formed a majority. Schooling was improper in lower socio economic class showing significant differences.

Children opinion with regard to irrational attitude of parents was assessed in 174 children (19.3%) out of which 124 (25.2%) were female and 50 (12.3%) were male children. Kashmir region showed discriminatory parental attitude towards girls in general followed by Jammu region. Significant differences were observed only towards social and moral upbringing among all the girls in Kashmir. Discriminatory practice among urban girls during sickness was observed in 88.46 percent and towards social and moral upbringing, it was 86.56 percent. These were significantly more compared to differences in feeding and schooling of rural girls. The irrational attitude of parents with regard to religion was assessed and muslim girls, hindu girls, buddhist boys faced discrimination. Improper feeding pattern of hindu, improper social and moral upbringing of muslims was observed showing significant differences. Significant differences were observed in schooling status as parents showed discriminatory attitude towards female children. Females from nuclear families showed irrational
attitude towards morbidity. Feeding, social and moral upbringing was improper in female children from joint families. Female children from small, large, extended families were discriminated in feeding, morbidity, social and moral upbringing and schooling. Significant differences were observed in feeding only. Insignificant differences were observed with mothers and fathers occupation although all showed discrimination. Insignificant differences were observed with different socio-economic classes as parental attitude towards female children showed discrimination during sickness. With regard to literacy status, significant differences were observed in morbidity and feeding only by female children from illiterate parents.

Thus on comparison of discriminatory attitude of parents with child's opinion, it was observed that the female child were discriminated in our society also. Although this deep rooted discrimination in the subconscious minds of people is decreasing, yet it has not vanished and a female child is still not equal to a male child. There is a strong need to bring attitudinal changes among parents, families, schools, functionaries and among girls themselves to improve the self image and self perception. Overall the health and the nutritional status of children is better and comparable to most of the North Indian children and the nutritional status, feeding, weaning was better off for girls, yet the social factors affecting these differences was on the rise. Sex detection tests have been used to prevent female's birth. The travails of the female child continue and are unwanted and her arrival is not considered as a joy and discrimination begins immediately after birth. Girls get medical treatment at last, school enrollment though similar but drop out rate among sibling was high among female children. The girl child should be allowed to be borne and not aborted, has a right to remain alive and not to be killed by indifference, right to live with dignity and grow normally and freely, has a right to nutrition, education, health services and child
care, right of protection and right to be free from work and not to be abused. Gender differences need to be removed from the state as health and nutrition varies across different regions with intensity varying.

The efforts of various institutions at state, national and international level be networked to show their visibility towards upliftment of women and children in general and the girl child in particular. Recurrent evaluation can help in making changes whenever required which will help in bringing down the level of gender discrimination. Thus the study concluded with the fact that gender bias is prevalent in all the three regions of Jammu and Kashmir State.