CHAPTER-7

CONCLUSION AND POLICY DISCUSSION

7.1 OBJECTIVES OF THIS STUDY:

Gender inequality is a far-reaching societal impairment, not merely a special deprivation of women (Sen 2005: 250). Gender inequality of one type tends to encourage and sustain gender inequality of other kinds (ibid: 220). Health being one of the most basic capabilities, the reduction and removal of gender bias in child health can go a long way in achieving gender parity in many other dimensions of human development, not only for the present generation but also over the generations.

The present study made an attempt to look at the existence of gender gap in child health, to identify the pattern of gender gap in child health in India, to find out its socioeconomic and demographic determinants and to explore the possible role of female education and women's agency in reducing the gender gap. It focussed on selected indicators of health outcomes (e.g., post-neonatal mortality, child mortality, prevalence of malnutrition) and health-seeking behaviour [e.g., immunisation coverage (preventive health care), medical treatment in diarrhoea and medical treatment in fever/ cough (curative health care) and breastfeeding (feeding practice)]. The study performed some exploratory analysis of the three rounds of National Family Health Survey data. Children under three years of age were the units of analysis.

7.2 SUMMARY OF RESULTS:

The study selected thirteen indicators of health-seeking behaviour in immunisation, diarrhoea, fever/ cough and breastfeeding and eight indicators of health outcome in malnutrition and mortality for children age less than three years. With the help of 21 selected indicators of health-seeking behaviour and health outcome, in Chapters Two and Three, it was shown that there is ample evidence of varying levels of
gender gap in all the states of India over almost one-and-a-half decades. (For a particular state it might so happen that for a particular indicator, gender gap (and/or its sign) changes over time and gender gap (and/or its sign) changes for different indicators in a particular time period.) This evidence of gender gap in a wide array of child health indicators calls for urgent attention and need for gender-aware health policy design in India.

In Chapter Four it was shown that any consistently robust pattern across states of gender bias against girl children in child health is not present. But there is a consistent pattern of girl children’s absolute health achievement. This is true irrespective of the number of indicators we use or the number of states we select or the measurement of gender bias or the method to reduce dimensions. The result remains valid even when it is performed at the regional level instead of state level. Concentrating on the consistent state-wise pattern of girl children’s health achievement is justified on the Rawlsian premise as in the social valuation function it assumes the degree of inequality aversion tending to infinity. Assuming the Rawlsian theory of justice, which gives complete priority to the worst off group’s gain, one should focus on the absolute health achievement by the girl children only, even when reduction in gender bias in child health is the ultimate motto. As a policy measure, to reduce gender bias in child health, we need to focus on the states with low health achievement by girls, viz., Rajasthan, Punjab, Haryana, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa, Assam, Andhra Pradesh, Tamil Nadu and Gujarat.

In Chapter Five it was found that the gender gaps in various health outcomes are not much related to the gender gap in various indicators of health-seeking behaviour. The gender gap in health-seeking behaviour does not transform much into the gender gap in health outcome for the children in the states of India. However for girl children’s health achievement, the indicators of health-seeking behaviour are significantly
related to the indicators of health outcome. Full immunisation rate for the girl children has a consistently significant impact on all the indicators of health outcome. Increases in vaccination coverage rates for girl children will reduce post-neonatal mortality, childhood mortality and childhood malnutrition rates for girl children. Girl children’s health outcome tends to be worse in the major states compared to other (non-major) states.

In Chapter Six we focussed on the girl children exclusively as there is a robust pattern for girl children’s health achievements and tried to identify the determinants of health achievements for girl children. Given the Rawlsian theory of justice with degree of inequality aversion tending to infinity (purely subjective), the same determinants will, in turn, be able to reduce gender bias in child health in India. In this Chapter we analysed the effects of selected demographic and socioeconomic predictor variables on the chance of full immunisation as a measure of preventive health care, chance of medical treatment in diarrhoea and medical treatment in fever/cough as a measure of curative health care, chance of at least six months breastfeeding as a measure of feeding practice, chance of malnutrition and chance of child mortality for girl children as measures of health outcome. The study focused on health achievements for girl children (a) in all India, (b) in rural areas in India, (c) for demographic factors only in India and (d) for socioeconomic factors only in India. The study applied binary bivariate and multivariate Logistic regression model to the three rounds of National Family Health Survey data. Except for a few cases, the results were consistently robust across the different models as well as across different dependent variables.

**ROBUST RESULTS:**

- Increase in birth order of a girl child reduces the likelihood of health achievement. It seems that the negligence effect more than offsets the learning effect. The result perhaps shows greater apathy
on the part of parents to take care of subsequent children. Also higher order birth children are more and more constrained by household resources.

- The likelihood of health achievement is higher for girl children from urban areas. The rural-urban disparity in child health is not due to demographic factors but due to socioeconomic factors.
- The likelihood of health achievement for girl children increases with mother's education level, mother's age and mother's exposure to mass media. These variables tend to enhance the mother's autonomy or agency within the household and raise the value ascribed to girl children, which in turn helps mothers to take greater care of girl children.
- Some antenatal care during pregnancy raises the chance of health achievement for girls significantly. Having antenatal care increases the possibility of meeting health personnel who help mothers to raise their awareness by disseminating information regarding child health. This information spill-over or learning-by-doing raises health care for girl children.
- Among the religious groups, Muslim girl children are the least likely to be fully immunised and the most likely to be malnourished, in comparison with girl children from Hindu households.
- The likelihood of health achievement is less for girl children from backward caste/tribe households compared to girl children from general caste households.
- Household income measured either by the standard of living index or wealth index raises the likelihood of health achievement for girl children. With higher household income, parents are more likely to spend more money and time for girl children.
The gender of the household head has no effect on the likelihood of health achievement for girl children.

The likelihood of health achievement for girls increases with the mother's empowerment index. Higher MEI raises mother's autonomy or agency within the household and raises value of girl children and hence the possibilities of greater care for girl children.

The likelihood of health achievement for girl children increases in households with electricity. Household electrification indirectly raises awareness about the value of girl children and helps parents to take greater care of them.

7.3 **Emerging Policy Issues:**

Gender gap in child health has continued to prevail in all the states of India over almost one-and-a-half decades that are covered by this study. The finding supports Sen's (2005) claim that 'we have to look beyond material prosperity or economic success or GNP growth...'. The non-existence of any consistent pattern of gender bias in child health implies that there are many pathways of gender injustice. However, the consistent pattern in girl children's health achievement calls for some policy interventions to reduce and hopefully to remove gender bias in child health on the Rawlsian premise.

The above results suggest that a synergistic effort incorporating a number of other sectors is needed to reduce the gender gap in child health. The need of the hour is an equitable, participatory and intersectoral approach to health and health care (Bose, 2001). Policies and programmes in other sectors such as education, welfare, industry, labour, information, environment, etc. have also to be informed and influenced by public health considerations (Gopalan, 1994). To bring gender justice, we need coordination and convergence in the programmes of various Ministries of the Government. The policy managers should
also try the following means to reduce gender gap in child health in India:

- Focus on female education and raising the female literacy rate.
- Step up information, education and communication (IEC) to enhance media exposure of mothers.
- Generate enough gainful employment opportunities to raise household’s standard of living. Also there is a need to create jobs for women to raise empowerment of mothers.
- Ensure quality antenatal care focusing on supply-side issues.
- Promote small family norm and discourage early marriage.
- Focus on girl children from Muslim households and backward castes.
- Provide electricity to every household particularly in rural areas.
- Provide basic facilities that are commonly available in urban areas universally in rural areas.

7.4 Discussion of Gender-blind Health Policy in India:

In the new millennium, nations are judged by the well-being of their people; by levels of health, nutrition and education; by the civil and political liberties enjoyed by their citizens; by the protection guaranteed to children and by provisions made for the vulnerable and the disadvantaged. Here we will discuss the extent of concern of Government policies about gender bias in child health and how they can remove it. The following documents are sourced from the websites of the Ministry of Health and Family Welfare¹ and the Planning Commission² of Government of India. We will see that there is hardly any mention of gender bias in child health in these official documents, leave alone the elaboration of policies to take care of it. The focus appears to be on mothers and children generally rather than specifically on girl children.

¹ http://mohfw.nic.in/
² http://planningcommission.nic.in/
Let us start with the *National Health Policy* (NHP-1983/2002). It was concerned about ‘persistent incidence of macro and micro nutrient deficiencies’ with a special mention of women and child. It also noted the ‘multiplier effect’ in the vulnerable sub-category of women and girl child. It also recognised the need for ‘synergistic functioning of the various sectors in the socio-economy’. The NHP-2002 aimed at ‘achieving an acceptable standard of health for the general population of the country. Special attention was given to the health of marginal groups like adolescent girls, women, children..., with due recognition to gender issues, as the cross-cutting theme across all schemes’. NHP-2002 envisaged an IEC policy based on inter-personal communication of information as public policy and communication strategies influence both individual and collective change. Under the Central Government Health Scheme (CGHS, started in 1954), Central Health Education Bureau (CHEB) is actively involved in development of health education materials both for print and electronic media and dissemination of health information to the masses.

The *National Population Policy* (NPP-2000) had the long term goals of promoting delayed marriage for girls and small family norm to achieve replacement levels of total fertility rate (TFR). It also argued for bringing convergence in implementation of related social sector programmes so that family welfare becomes a people centred programme. It asked for strict enforcement of Child Marriage Restraint Act (1929, amended in 1976) and strict enforcement of Pre-Conception and Pre-Natal Diagnostic Techniques (PC & PNDT, prohibition of sex selection) Act, 1994. Within the domain of NPP, the *Balika Samridhi Yojana* (BSY) run by the Department of Women and Child Development promotes survival and care of the girl child by giving a cash incentive of Rs. 500 awarded at the birth of the girl child of birth order one or two. *Janasankhya Sthirata Kosh* (National Population Stabilisation Fund, 2000/2002) devised
Prerna Strategy: it identifies and awards young married couples from backward districts who have adopted Responsible Parenthood Criteria as role models for other young couples in the district. The criteria of the couple is: girl marrying at or after the age of 19 years, having the first child two years after marriage, keeping a gap of three years between first and second child followed by sterilisation of either parent. The couples are awarded with a certificate and Kisan Vikas Patras at a widely publicised and well attended function in the district.

The National Rural Health Mission (NRHM, 2005-12) was launched on 12th April 2005 to provide and improve accessible, equitable, effective, affordable and accountable quality primary health care services to the poorest households in the remotest rural regions, especially poor women and children. The NRHM is about increasing public expenditure on health care from the level of 0.9 percent of the GDP to three percent of the GDP by 2012. The Mission adopts a synergistic approach by relating health to determinants of good health viz., segments of nutrition, sanitation, hygiene and safe drinking water. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organisational structures, optimisation of health manpower, decentralisation and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system and operationalising community health centres into functional hospitals meeting Indian Public Health Standards in each block of the country. The goals of NRHM are universal access to public health services such as women’s health, child health, water, sanitation and hygiene, immunisation, nutrition, population stabilisation, gender and demographic balance. Though there is a mere mention of gender balance, it does not have any specific strategy to achieve it. The Janani Suraksha
Yojana (JSY, 12th April 2005) is a safe motherhood intervention under the NRHM being implemented in all states and Union Territories with special focus on low performing states with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. Large scale demand side financing under the JSY has brought poor households to public sector health facilities on a scale never witnessed before.

Since the Seventh Five Year Plan (FYP, 1984-89), the family welfare programmes have evolved on the health needs of the women in reproductive age group and children below the age of five years. During the Ninth FYP, the *Reproductive and Child Health* (RCH, 1997) programme integrates all interventions of child health of the related programmes of the previous Plans. The concept of RCH is to provide need based, client centred, demand driven, high quality and integrated RCH services to the beneficiaries. The RCH-II (2005-10) Programme as a part of NRHM is based on the principle of convergence, both inter-sectoral as well as intra-sectoral to optimise utilisation of resources and infrastructural facilities.

In the *Annual Report* (2009-10) of Ministry of Health and Family Welfare, it attributes improvements in health indicators to the well structured network of three-tier public health infrastructure. It also acknowledges that ‘the progress has been quite uneven across the regions (large scale inter-state variations), gender (male-female differences) as well as across space (with significant rural-urban differences)’. A major initiative is being finalised to have in place a system of tracking pregnant women and children to ensure timely antenatal and post-natal care, safe delivery and universal immunisation of children. The major child health programmes are: *Navjaat Shishu Suraksha Karyakram* (NSSK, essential newborn care), Integrated Management of Neonatal and Childhood Illness (IMNCI), Facility based IMNCI (F-IMNCI),
Sick New Born Care (SNBC), Infant and Young Child Feeding, Vitamin-A and IFA Supplementation, Nutrition Rehabilitation Centres, School Health Programme, Home based New Born Care, Universal Immunisation Programme.

In this Report, gender issues are discussed in an entire chapter, albeit in the last one. It notes the important role of women’s education to reduce gender bias. To check female foeticide, the introduction of PC and PNDT Act (1994) with stringent punishments is a welcome move but better implementation of the Act needed. The same Report also acknowledges that ‘mere legislation is not enough to deal with this problem that has roots in social behaviour and prejudices’. The GoI has launched the ‘Save the Girl Child’ campaign with a view to reduce son preference by highlighting the achievements of young girls. Unfortunately, the chapter on gender issues as well as the Report is generally silent on gender bias in child health. There is not even a single mention of gender bias in an array of child health indicators, leave alone the policy to reduce and remove them. It seems through the Report that the Ministry of Health and Family Welfare does not wish to acknowledge the widespread gender bias in various child health indicators and remains naïve on these issues.

The 10th FYP (2002-07) document notes that ‘an aware and informed population, actively participating in programmes aimed at promoting health, preventing illness, accessing health care at appropriate level is an essential prerequisite for improvement in health status of the country’. But, as ever, there is no mention of gender bias in child health in India.

In the Report of the Working Group on Health of Women and Children for the 11th FYP (2007-12) of Planning Commission, it notes that the design of RCH-II is based on the premise that ‘female children
have an equal right to health... and to live with human dignity’. However, it remains quiet on gender bias in child health.

The Report of the Working Group on Integrating Nutrition with Health for the 11th FYP under the Ministry of Women and Child Development noted that ‘good nutrition is a fundamental requirement for positive health, functional efficiency, and productivity’ and ‘...is an indicator of national development’. The Report also mentions that ‘nutrition is a crucial, universally recognised component of the child’s right to the enjoyment of the highest attainable standard of health as stated in the Convention of Rights of the Child’. The document has a mere mention of ‘gender discrimination’. There is no mention of gender bias in child health or nutrition in the 10th FYP as well as 11th FYP goals. Though it talks about adolescent girls in the age group of 10-15 years, it is consistently quiet for the girl children aged less than three years separately. However, the Report once mentions that ‘gender sensitive nutrition indicators need to be adopted in the health services as well as in NRHM’. It also accepts that ‘malnutrition is a complex problem, the determinants of which vary from food adequacy, literacy levels, conditioning infections, access to health care, empowerment of women, access to safe drinking water and sanitation to economic growth’.

The Report of the Steering Committee on Empowerment of Women and Development of Children for the 11th FYP, in its approach to child rights, mentions that ‘special focus on the girl child is essential’. The Balika Samriddhi Yojana (BSY, Oct 1997) scheme provides a post delivery grant of Rs 500 to mothers of girl children belonging to BPL families and later scholarships to girl children when they go to school. The larger objective of BSY is to enhance the status of girl child by helping society to change negative attitudes about the girl child, and ensure her survival. It mentions that the 11th Five Year Plan will address child rights through the lens of gender justice. It will set out pro-active, affirmative
approaches and actions necessary for girl children to realise their rights and equality of opportunity. Though it talks about gender budgeting and child budgeting, it remains silent over gender bias in child health for the age group of less than three years.

The Report of the Working Group on Development of Children for the 11th FYP under the Ministry of Women and Child Development expressed concern at the continuing wide gender gaps in child health among others in the Mid-Term Appraisal of the 10th FYP. It notes that 'development of children is at the centre of the 11th FYP'. Gender bias has been mostly seen as female foeticide or pre-natal sex determination and declining sex ratio.

The 11th Five Year Plan (2007-12) document mentions that it will give special attention to the health of marginalised groups of children below three years of age among others. It will view gender as the cross-cutting theme across all schemes. It acknowledges lack of convergence with other sectors affecting health as a system. The GoI has taken several policy measures to reduce gender bias in general. The practice of gender budgeting in Health will be made mandatory in all programmes of the Centre and the States. The performance of different health programmes will be judged on the basis of gender disaggregated data. But, as before, it remains silent on acknowledging gender bias in child health or the way out to reduce it.

7.5 LIMITATIONS OF THE STUDY:

The data sources used here do not permit us to see why gender gap is low or why absolute health achievement is low in a particular state at a particular time. In this regard, a small exercise was done but not presented in the study for IMR for all children for sixteen major Indian states (see Tables A7.1-A7.3 in appendix). The regression analysis was performed with the explanatory variables of female literacy rate, NSDP per capita (at constant prices), poverty rate (URP), per capita health care
spending, GINI index of income inequality (based on household expenditure of 2004-05 NSS data). Apart from female literacy rate, no other variable turned out to be statistically significant. The study can also be further extended to see why the relative rank of a particular state improved or declined over time.

Another effort has been made to calculate the exact magnitude of decline in gender bias in childhood immunisation and childhood malnutrition for a certain percentage rise in mother’s literacy and mother’s employment, *ceteris paribus*. For this, state-level regression analyses have been performed to see the marginal effects but not incorporated in the study as in most of the cases the coefficients are insignificant (see Tables A7.4-A7.15 in appendix). This may be due to small degrees of freedom in the data. A positive result of this kind could have very strong policy implications.

The Rawlsian theory of justice assumes the degree of inequality aversion tending to infinity in the social valuation function. This assumption is purely subjective. For other positive values of inequality aversion, the logistic regression analysis would have been more difficult.

It is also seen that gender gaps in health-seeking behaviour do not transform much into gender gaps in health outcomes. So there remain some other yet unknown channels of gender bias that finally lead to huge numbers of missing women. Randomised experimental research in this area could be very effective. It could more efficiently judge the effectiveness of women education and women empowerment.

Longitudinal data analysis would also be very helpful for better understanding from a policy perspective. For example, a study to see if gender bias is declining due to the impact of an income generating programme like National Rural Employment Guarantee Scheme (NREGS) could be immensely helpful in devising national policies.
7.6 **Concluding Remarks:**

The persistent gender bias in an array of indicators of child health in almost all the states of India over one-and-a-half decades calls for devising a gender-aware child health policy. To reap the benefits of the demographic dividend, first we have to ensure that our children are healthy and capable of being healthy human capital. We need to ensure that girl children are effectively benefited by the government health schemes that would penetrate traditional social and cultural norms in large parts of the country. We need to raise awareness of the people to make them understand that women are no longer ‘patients’, but the ‘agents’ of growth and development of a country. Such an awareness campaign will help parents to demand healthcare facilities for their children; not only for their sons but for their daughters too. We have to ensure gender-justice in child health by ensuring that there is no discrimination on the basis of gender. Government as well as the civil society has to oversee the enforcement of gender justice in health schemes and also ensure that they effectively reach all children irrespective of their class, caste and religion. Removal of gender bias in child health is one of the early hurdles that the country needs to overcome. Universal access to the health schemes will hopefully put India on a double-digit growth path in a foreseeable future.

The study shows that it is high time that policy makers acknowledge gender bias in child health and act to curb this menace. It pleads the policy makers to design health policies by taking note of some of the way outs mentioned here to reduce gender bias in child health in India. The policy makers must keep in mind that improvement in the lives of girl children will actually be able to improve lives of all—men, women and children. They should ensure that the girl children are not left unattended by the health policies so that in future they are able to ‘hold up half the sky’.