

Boys Treated as Gold, Girls as Silver: Obstacles to Gender Equality in Health Care for Children Under Five Years of Age in Bihar, India

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Introduction

1. 'Our children are our most precious resource.'^[1] This statement, often shared in political meetings about child rights, demonstrate both the awareness and importance of children. Today's children will build the next generation and they are the leaders, dreamers and makers of society in the future.^[2]
2. In low-income countries, approximately 18,000 children under the age of five, die every day as a result of diseases that could be prevented if basic health care services were provided.^[3] Although accessibility to basic health care is the right of every child, it is not a reality. Instead, the life of children in developing countries is marked by poverty with limited access to basic health care, nutrition, clean drinking water, as well as limited possibilities to an adequate education. Growing up under such conditions affects lifelong cognitive development and can impair children physically and emotionally.^[4]
3. The United Nations Children's Fund (UNICEF), in its report entitled *State of the World's Children*, suggests that children are not cared for in the way they deserve.^[5] Anthony Lake, executive director of UNICEF since 2010, states his concern that 25 years after the Convention on the Rights of the Child (CRC) was adopted: 'The best aspirations codified in the Convention on the Rights of the Child remain only words on paper'.^[6] To achieve change, child rights need to be taken seriously and put into action by every country. Although improvements have been achieved, the realisation of the rights, especially for the most vulnerable disadvantaged children, and the ones that are difficult to reach, remains a challenge.
4. Elementary deprivations of child rights are concentrated in two regions in the world, namely sub-Saharan Africa and South Asia.^[7] In these regions, the realisation of children's rights faces many challenges—poverty being one of the primary issues.^[8] Northern India is a complex example, characterised by dramatic gender disparities in the country. In northern India not only is an overall high mortality rate in children documented, but also there is specifically a higher mortality rate of female children as opposed to male.^[9] This indicates an existing gender inequality in children, which influences their development.

Background

5. In 1997, the government of India submitted its first country report on the CRC. It demonstrated that the rights approach to child development was gaining importance and had shifted from welfare services to a development approach.^[10] In addition, various policies have been developed to

implement child rights and promote child survival and child development.^[11]

6. In 1994 the Indian Parliament prohibited sex determination procedures before birth, but it appears that enforcement of the law has been neglected.^[12] It is widely known that prenatal sex selection and other methods of female infanticide take place all over India.^[13] According to the United Nations, it is estimated that 780,000 girls per year, are aborted illegally in India.^[14]
7. Furthermore, in India there is evidence that suggests female children are discriminated against in preference to male children with regard to the provision of adequate health care and nutrition.^[15] Between 2001 and 2012, Usha Ram et al. found that female mortality at the ages one to fifty-nine months is higher compared to male mortality at the same age, resulting in about 74,000 excess deaths of girls. Girls were 25 per cent more likely to die under the age of five in nearly all states of India.^[16]
8. Female discrimination and neglect limits individual personal development and deprives girls of their basic capabilities, which then increases the risk of poverty^[17] in the next generation. Adequate health care for children of both sexes is required to break this cycle of poverty extending from generation to generation.^[18] However, in rural North India, which is a male-preference society, higher household income and improved education of women did not automatically mean that these additional resources would be committed to female children.^[19]
9. The reasons leading to the preference for sons are rooted in the socio-cultural structure of the society.^[20] Traditionally families benefit economically from sons. Common Indian sayings reflect the desire to give birth to a son: 'May he elsewhere afford the birth of a female, but here he shall bestow a man!'^[21] In contrast, investments in a daughter will benefit someone else, since 'Bringing up a daughter is like watering a neighbour's plant'.^[22] Boys will earn a salary in the future and stay with their parents after marriage. Therefore, by raising a son a family will be blessed with wealth and a daughter-in-law.^[23] In addition, sons will care for their parents as they age and are seen as security. A daughter instead, is considered rather a burden to the family^[24] and seen as an 'object' that will be married and sent away.^[25]
10. Although under the Dowry Prohibition Act, the payment of dowry is a punishable offence, it remains a common practice in North India.^[26] Moreover, despite the laws on protection of women, dowry deaths are still a widespread phenomenon.^[27] In many communities, female babies are killed immediately after birth to relieve them of suffering and the family of dowry demands later in life. The value of the life of a girl is illustrated in the metaphor of a 'candle in the wind'. It can flicker and be extinguished at any time.^[28]
11. There is substantial research into gender inequality in South Asia and in India in particular. However, little research has been done to examine the determinant reasons for parental decision making in seeking health care for their children. This knowledge gap calls for an exploration of the complex factors that contribute to the decision-making process in seeking health care for children under five. The overall aim of the people involved in this research was to explore reasons for persistent gender inequality in the right to health care for children under five years of age in East Champaran District, Bihar, North India.

Methodology

12. The research for this paper was conducted in the three blocks of Raxaul, Ramgarhwa and Adapur in East Champaran District, Bihar, North India, from May to June 2015. These blocks were selected because they are part of the Community Mother and Child Health Programme (CMCH)

implemented by the Duncan Hospital of the Emmanuel Hospital Association (EHA). They include 8.8 per cent of the total population in East Champaran.

13. Data were collected by in-depth interviews and focus-group discussions. The rationale was that interviews and focus-group discussions reflect on the behaviour of guardians seeking health care for their children. In addition, it was hoped that a picture of individual experiences, beliefs, concerns and practices would develop concerning obstacles to gender equality. The methodology was informed by a qualitative approach to elicit greater depth of meaning of the subjective reality of participants so that single conditions led to generalised norms or theories. [29]

The research team

14. One research assistant and two fieldworkers who used to work on the CMCH programme and are able to speak the local language, Bhojpuri, were recruited for data collection. They were trained in interviewing techniques and facilitation of focus-group discussions. All data were collected in either Bhojpuri or English.

Sampling and recruitment procedure

15. Guiding principles for participant selection for interviews included recruiting female and male health workers who had been living in the area for at least one year and who had first-hand knowledge of the community. Ten participants were people, aged between twenty-two and sixty-eight years, who either worked in the CMCH programme as health practitioners in the area or as health personnel at a health facility in the study area. This included two female medical doctors (MD), one male and one female nurse, two male and three female community health workers (CHW) and one male local health care provider (LHCP).
16. Pre-existing networks and snowball sampling for recruitment were used for focus-group discussions with mothers, fathers, grandmothers, grandfathers and community health workers. Nine focus group discussions with five to seven participants each were conducted. While participants in the three mothers' and two fathers' groups were between eighteen and forty-five years old, two grandmothers' and two grandfathers' groups were aged from forty-five to sixty-five years.
17. The focus groups were audio recorded and transcribed from Bhojpuri into English, because Bhojpuri is not a written language. Two people who worked in Duncan community health projects were chosen to transcribe the interviews because of their proven language skills in the local Bhojpuri language and in English. The key informant interviews were carried out by the researcher when the participant felt confident in speaking fluent English. The interview process was audio recorded and transcribed accordingly. The transcriptions of the English interviews were completed by the researcher herself. The interviews in Bhojpuri were transcribed and translated into English.
18. The data analysis process was carried out using grounded theory. [30] It involved multiple stages of coding. The interrelation of categories and subcategories, with the aim of generating core categories using deductive as well as inductive approaches, were derived from codes that appear similar. The advantage of inductive coding is that new topics appear during the interview process, meanings from the collected data can be generated and patterns and relationships identified. This involved open, axial and selective coding. [31]
19. Three types of triangulation—data triangulation with respect to place and people, methods and

researcher triangulation— were applied to allow the development of a complex picture of obstacles to gender equality in East Champaran District, and to enrich knowledge. The study was approved by the UNISA Research Ethics Committee, South Africa and the Emmanuel Hospital Association Institutional Review Board, India.

Results

Patrilinear kinship system

20. Society in North India is characterised by a patriarchal culture, which implies that sons are preferred as they bring wealth, strength and blessings to the family (Female CHW).^[32] Gender discrimination is so deeply ingrained and regularly reinforced by social norms and traditions that the parents do not realise that their practices are discriminatory. Male participants stated that the son, as the descendant of the family and heir of the generation, is highly valued (FGD-Father). A family is recognised by society only when they have a son and he has the responsibility for the family line to continue (MD). While the boy is compared to 'gold', girls are considered to be as 'silver', reflecting that they are less valued, and therefore deserving of less care (FGD-Grandfather).
21. The neglect of girls starts at birth. A celebration is organised and paid for by the relatives when a boy is born. In contrast, mothers explained, if a girl is born, relatives would not even come to visit since 'it seems like a burden to them. This happens in our society!' Traditionally, parents benefit more from a son. It is the son's responsibility to provide and care for the parents when they are old (FGD-Grandfather). The birth of a boy means the family will acquire financial gains when the son marries and, at the same time, a daughter-in-law will join the family to assist with the domestic cores (MD). The girl, on the other hand, leaves the house to get married and henceforth belongs to her husband's family. In addition, the strong desire to have a son is also demanded by traditional cremation practices. Only the son can start the fire for the cremation when the parents die (Male CHW).

Socio-economic situations

22. The majority of the population in Bihar lives below the poverty line.^[33] According to male participants, a family in East Champaran earns less than 200 rupees a day when the father works as daily labourer. Therefore, the socio-economic situation of families influences when and where they seek health services for their children. Although mothers claimed the economic condition of the family would not unequally influence the choice of accessing health services for boys and girls, participants working in health institutions did not confirm this claim. A medical doctor put it: 'They will not say that, but in their action you see that it is different'.
23. Daughters are perceived as an economic burden due to the common practice of dowry payment in East Champaran. Men in a focus group clearly expressed that 'there is reason behind people getting disappointed at the birth of a girl child. The reason is dowry'. Although a father expressed that for him girls and boys are equal, he perceived the main problem to be the dowry practice. Daily survival and struggle for living expenses is a struggle for many parents. They are unable to save money for dowry expenses. This puts them under enormous social and financial pressure.
24. A grandfather confirmed the economic liability for a family with daughters, calling it the 'biggest disease in Bihar'. Therefore, the economic and social implications for these families are high especially if financial or other support by the grandparents is withdrawn and the family feels it is being 'pushed aside'.

The value of women

25. The value of a mother in North Indian culture is influenced by the sex composition of her children. This means, in a broader sense, that her personality, character, education and developed skills are not seen as important. If she gives birth to a large number of girls, she will experience disadvantages and discrimination.
26. Participants revealed that women are considered responsible for the sex of the child. As one woman pointed out, the worst case may be that she is killed by her husband if she gives birth to another girl. For the husband, taking a new wife is perceived as the way to receive the desired son (MD). This demonstrates the vicious cycle of discrimination against women in the society: a woman has no value, and therefore, a girl has no value. Later in life, her value will depend on whether or not she bears a son. Guardians explained that in case of sickness of a child only male family members decide which health services to use. Women have no voice or decision-making power when it comes to choosing a health service provider. A reason given by grandmothers is that women are not able to contribute financially to the costs of treatment.

Availability of health services

27. Health care in East Champaran is provided through a formal health-care system, including the government health services, and registered health care providers, such as the EHA Duncan Hospital. There is also an informal health system, which offers a range of services provided by local health practitioners, who provide health care practice in unregistered small private clinics. Traditional healers also provide health-care services. Local health practitioners are often the only health-care option guardians can afford for their children (Male CHW).

Accessibility of health services

28. Timely access to health services seems to depend on the sex of the child. Grandmothers explained whenever a boy falls sick they would run to a health institution whatever the sickness. On the other hand, as CHWs stated, for a girl, guardians would wait at least one day and see whether the child recovers by herself. In a FGD with fathers they expressed that there was no need for girls to receive treatment immediately. A local healthcare provider confirmed this statement explaining a girl would be left without any treatment for about five days and put it this way:

Gender, yes, gender is an important reason because if there is a family where four or five girls are being born, the ones who are sick are left to God's mercy. If the child survives the first five days of illness, then it will be taken for good treatment, because it has managed to survive the first days without any help.

29. The close accessibility of local health practitioners in rural areas is a huge advantage since it saves money and time for transport to a formal health institution. Mothers expressed their fear of treatment costs which may cause lifelong debt and place the families in poverty and deprivation. However, financial constraint in a family seems not to be a significant reason for neglecting a girl's health care provision. As mentioned by a CHW the boy would be favoured no matter if the family is rich or poor.
30. The decision whether to access a health service is determined by the sex of the child. A local health care practitioner explained, sons are given preferential treatment and

parents usually don't want to take the risk of home remedies or of buying drugs at a local shop. They will straight away take the child to the local health practitioner at the beginning of the illness itself. If it doesn't get better at the second or third day they will take the boy to the hospital.

Daughters are deprived of the same level of care. The consequence of this neglect of care seems to be accepted as a mother stated: 'People will care less, if a girl dies'. However, some participants, both mothers and fathers, insisted that they care for their children equally, since they love their daughters and sons and 'we have mercy for them both; how can we leave our daughter behind?'

Acceptability of health services

31. The way health workers deal with patients influences the utilisation of health services. Health workers at government facilities are perceived as unfriendly, impolite and often absent from work (Male CHW). Injustice in the health-care system seems to be reinforced by privately practicing medical doctors who bribe health workers to refer patients to their private clinics (LHCP). Although the Duncan Hospital's vision is to serve the most vulnerable of society and people living in poverty, participants perceived the hospital as not being accessible to the poor. A medical doctor admitted that it remains a challenge for the hospital to identify those who deserve charity.
32. Local health practitioners are known in the community and enjoy acceptance and trust by the community. Although they have no or limited medical training and work without a licence, they are the first choice of contact in case of disease.

Quality of health services

33. Due to difficult living conditions and the remoteness of the area, a medical doctor reported that there is a lack of qualified health staff in East Champaran. Most doctors prefer to work elsewhere in India. This affects the quality of health services that are provided for patients. Medical doctors are anxious about the fact that local health practitioners have no formal training, and therefore their treatment seems of doubtful quality. However, guardians too are aware of the poor quality provided by local health practitioners. Therefore, they choose to seek health care for their sons at the hospital or go to a formal health institution as soon as they feel the treatment by local health practitioner is not effective.

Preventive health care for children

34. Guardians' knowledge of prevention of common diseases influences child survival. They admitted partial knowledge of ways to prevent children from becoming sick and only some basic hygiene practices are known in the community. Moreover, guardians talked about their limited knowledge of the signs and symptoms of diseases, and it appears difficult to recognise danger signs that affect the survival of a child. Moreover, the benefits of immunisation are not well known. In terms of routine health check-ups for children under five, mothers admitted that they are more likely to attend them with their sons.

Nutrition

35. Some participants, fathers and mothers alike reported feeding their children equally and giving the same amount of food to boys and girls. Guardians even mentioned the importance of a well-nourished girl so she can grow properly. While there might be no difference in the amount and type

of food given, a local health care provider pointed out:

If it is a boy, she [the mother] would encourage the boy to eat well, 'Come, my child, please eat well,' and she would speak lovingly to him. None of this is done for the girl.

Moreover, male and female guardians also articulated that boys deserve more food—'what is the point of feeding girls?' In other words, there is no reason to nourish a girl well. While proper food is required for child development and growth, the survival of girls does not seem valuable and relevant.

Strategies used by guardians: Gender-specific differences in seeking health care for children

36. The various complex factors concerning the context and intervening conditions influence guardians in seeking health care for children. There is a difference in seeking timely health care when a child is sick. While it is important for boys to receive treatment immediately, for girls it is not considered urgent. In addition, boys will be brought to accepted quality health care providers, whereas for a girl, drugs are bought at the local pharmacy.
37. Few individual participants indicated some resistance to the constraints and demands of the male-dominated society in East Champaran. Yet, there is a fear of being discriminated against in the society when girls are favoured. When children are valued equally and equal health care is provided, people fear that this behaviour may be despised and must therefore be hidden so they do not lose respect in society.

Consequence: Gender inequality in the trajectory of a woman's life

38. Gender inequality starts before the birth of a girl and continues during childhood through disadvantages in health care and nutrition. Traditional practices, especially dowry payments, substantially impair the economic conditions of a family that has one or more daughters. The fear of putting the whole family at financial risk means that parents save on health care costs, quality of health care and respond very late in time of illness for girls. As girls have less value in the society, their health care is not a priority that is met by the parents. In addition, the decision-making process of seeking health care when a girl (or any child for that matter) is sick remains the domain of men in the family.

Discussion and conclusions

39. According to Suad Joseph, [34] kinship transports patriarchy into all spheres of social life. In North India a strong patriarchal kinship system still exists. It is characterised by male authority over women. The first step of discrimination in the trajectory of life of women starts before birth with the practice of sex-selective abortion. [35]
40. Socio-cultural factors in society prevent equality in the right to health in the trajectory of life for female children. The devalued status of women in North India determines guardians' behaviour patterns on how the right to health services for children is provided. Although guardians claim to love their children equally, daughters bring a perceived massive economic burden to the family, and therefore deserve only minimal effort to have their health needs fulfilled. Their health care provision is less important. For sons, guardians ensure a timely response; for girls a delay is common. The preference of sons in India's health-care provision was confirmed in earlier studies. [36] Decision making in healthcare, predominantly taken by male family members, is done

according to the sex of the child. A woman does not have a voice in such decisions.[37]

41. Health-care costs are not the only reason for the neglect of girls. This study found that even if money is not an issue, families would favour the boy child in health care provision. This is supported with another study showing that the availability of resources would not automatically support health care for girls.[38] This inequality in the life of women correlates with the internalisation of patriarchal principles.[39] This psychodynamic aspect of patriarchy and how it contributes to the persistence of a strong patriarchal kinship system requires further research.
42. Education and women's knowledge influence how the health needs of children are provided. This study found that only very basic knowledge was known by guardians concerning ways of keeping a child healthy. The knowledge of the community in preventive health care for children is indicated by immunisation coverage.[40] While immunisation coverage of children under five years is only 62 per cent in Bihar state,[41] 11 per cent more boys than girls are fully immunised.[42] Duncan Hospital internal data show that 64 per cent of the vaccinated children are boys and 36 per cent girls. These data reveal not only a paucity of knowledge of preventive health care but the parents' preference for boys over girls to receive these services.
43. Furthermore, growth monitoring is essential to assess the nutritional status of children and to recognise an unhealthy development. This research revealed that guardians are less likely to attend the health check-ups with their daughters; thus, the right to preventive health services is not provided in the same way for girls as for the boys.
44. Discriminatory features and suppression continue to be present in women's lives, especially due to dowry practice and the patrilinear kinship system. Fariyal F. Fikree and Omrana Pasha argue these societal issues make the cost of raising a daughter high resulting in the unwillingness of families to invest scarce resources for their health needs.[43] Furthermore, women in this study perceived that their lack in making a visible economic contribution to the family coffers was a factor that undervalued their value as women in decision-making processes.
45. The positive impact women have in the development of children, families, communities and countries when they are empowered is not applicable in North India due to the region's traditional norms.[44] Persistent gender inequality is a barrier to development in East Champaran society, in Bihar and North India in general. The current traditional practices prevent women and girls from enjoying human rights and child rights.
46. Gender inequality (in whatever guise it is experienced) becomes a central obstacle to human development. While findings of this study confirm that gender inequality (in relation to health care for daughters) is an obstacle to development, gender equality leads, according to Derica Alba Kotzé, to the realisation of development goals.[45] Gender equality can be realised only when children are valued equally in society and male and female children are treated equally like 'gold' by their guardians. This demands a rethinking of tradition and a rethinking of attitudes towards health care for boy and girl children.
47. The complex social and cultural factors override the realisation of equal rights in the trajectory of the life of women. As long as these factors are not addressed and law requirements are not pursued, the tradition of violating human and child rights is likely to continue. Policy makers, health professionals and community-level governance need to realise and understand these rights and be responsive to the detrimental health outcomes for girls. This would raise the value of women, and would be a step towards achieving gender equality in health-care provision for children to secure their survival and healthy development.

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