RESEARCH PAPER | Social Science | Volume : 4 | Issue : 4 | Apr 2014 | ISSN - 2249-555X

Gender Inequity in Child Care- A Special Reference to Rural Coimbatore, Tamil Nadu, India

KEYWORDS: Gender, Disparity, Child care

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ABSTRACT *Gender differences are as old as human culture and arose from the biological differences between early human males and females. Gender inequality and equality is most perceived as pertaining to women and their related issues in which men are seen as a dominating force. The roots of health inequalities are many, interconnected and complex. According to socio-biological theorists, in addition to health inequalities being linked to genetic and biological differences, social variables have been identified as a source of health inequalities (Denton et al., 2004). The present paper is explored the care pattern of children during illness and gender disparity in allocation of health care. The sample was drawn from 335 rural mothers, who have at least a male and a female child are selected from four blocks of Coimbatore district, Tamil Nadu, by systematic random sampling method. The study findings reveal that, 80% of household the husband alone makes decision regarding the treatment of their children and 48% of the respondents said that, their parents only take care of the children when they fall sick. The most preferred place for the mothers (42%) in treating their children was government hospitals. The 60% of mothers were traveling 7.5 k.m to access health care. The Younger mothers showing disparity to female children in duration of medical care. The study further divulges that, as income of the family increases, disparity against the female children decreases. The study concludes that the mother who faces disparity not showing any inequity between the children of the both sex.*

Introduction

The child's health and survival depend upon the degree of care with which the child is brought up. Child care starting from birth to the end of childhood is an important consideration in understanding the determinants of child health. The type of care provided to the child may be divided into two main groups: medical and non-medical care. The medical care comprises immunization, timely and appropriate treatment of illness and medical attention at birth. The non-medical care consists of feeding practices, timing of initiation and duration of breastfeeding and introduction of supplementary feeding.

South Asia is well known as being a region of the World where the normally higher number of females than males in the total population is reversed. The factor which is worrying India is the continuing decline of sex ratio (Census of India, 2001). This deteriorating trend may be due to lack of medical and non-medical support to females. Policy-makers have been aware of this trend and have attempted corrective measures. As Prime Minister Manmohan Singh quoted after inaugurating the National Meeting on "Save the Girl Child", was emphatic about the issue "India was living with the "ignominy" of an adverse gender balance. The last census showed a declining sex ratio. Multiple deprivations all with roots in the oppressive structure of patriarchy has resulted in a bias against girls and women. This is a shame and we must face the challenge squarely" (Daily News & Analysis, 2009).

In India there have been significant improvements in the health, employment, and educational status of women over time. Yet, health indices for girls and women compare much less favourably with those of boys and men. The government has recognized the inequalities in health indices and has implemented many schemes to improve women's health like National Rural Health Mission, providing care for women, especially during pregnancy and delivery and after child birth. But the detailed analysis of national data disaggregated by gender, show far greater improvement for males than for females (The Hindu Editorial, 2009).

Though women are born with an advantage; their healthy life expectancy is two years longer and their life expectancy six years longer than those of men but widespread gender discrimination at each stage of the female life cycle, prevalent in a few societies in South Asia, reduces the life expectancy of girls and women and diminishes their chance of survival. This may be attributed to health disparity, sex selective abortions, and neglect of girl children, reproductive mortality and poor access to health care. The perinatal mortality rate, infant mortality rate and under-5 mortality rate are poorer for girls. It is mostly because they are malnourished and brought to hospital later in their course of illnesses than boys (The Hindu Editorial, 2009). Similarly, the results of a cross-sectional household survey in a poor agrarian region of South India found evidence of "pure gender bias" in non-treatment operating against both non-poor and poor women, and evidence of "rationing bias" in discontinued treatment operating against poor women (Iyer et al, 2007).

Pokhrel (2007) also assessed the role of gender in child health care utilization in Nepal and the findings are consistent with those in India and Pakistan. Gender role not only affects illness but also affects the decision to choose a health care provider and how much to spend on the sick child and it also affects the entire steps of a health seeking action.

Significance of the Study

Women receive less healthcare facilities than men. A primary way that parents discriminate against their girl children is through neglect during illness. As an adult they tend to be less likely to admit that they are sick and may wait until their sickness has progressed far before they seek help or help is sought for them. Many women in rural areas die in childbirth due to easily preventable complications. Women's social training to tolerate suffering and their reluctance to be examined by male personnel are additional constraints in their getting adequate health care. Four critical areas of women's health and physical wellbeing deserve special attention: discrimination against girls resulting in higher female mortality; poor nutrition; poor reproductive health; and lower use of medical services when sick. The primary way in which parents discriminate against girls is through neglect during

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illness (Das Gupta, 1987). The paper primarily focused on the availability and accessibility of health care services and the nature of care received by the children of both sex during illness.

Methods

The study covered North and South divisions of Coimbatore Taluk, Tamil Nadu; each division consists of two Panchayat Blocks. Coimbatore North includes Periyanaickenpalayam and Sarkarsamakulam Blocks, and Coimbatore South consists of Thondamuthur and Maddukkarai Blocks. Each of these Panchayat Blocks consists of varying number of Village Panchayats. The sampling process involved selection of one village panchayat using lottery method from each blocks of Coimbatore. From each village panchayat 20% of the mothers having at least one male and female child below the age of 15 years are selected through a systematic random sampling method. As the study population is rural women who would be with varying levels of literacy, it was decided to use the interview method of data collection.

Findings

The data's related to socio-economic status of the mother's gives valuable lead to any social science study and further it provides detailed and deeper assessment with the main study variables. In the present study 65% of them aged between 26-35 years and in excess of half of them belong to backward community and on an average their family income falls between Rs. 2000 to Rs.4000. The educational status of the respondents was considerably poor, 60% of them learned up to secondary level education and 30% were illiterate. Due to their poor economic conditions and lack of education forced them to work as an agricultural labourer (39%) and 38% remains as house wife. Majority of them (94%) have no savings and 65% of them were non-migrants.

The study areas were the typical Indian village, where the 53% mothers were living in a single room house and 77% of them live in a tiled house. Seven out of ten houses have no toilet facility. With respect to availability of electricity, most of the respondents have such facility through free electricity scheme and 11% of them live in darkness.

Availability and Accessibility of Health Services

The availability and accessibility of health services is the major issue the rural India face since independence. The Government of India tirelessly taking measures to ensure 'Health for All' for every section of citizens through health care network system funded both by the centre and state. In the government initiated health care support, the maternal and child health programme contributing widely to reduce maternal and infant mortality and morbidity by Universal immunization progarmme, child welfare programme, and control of infectious diseases and through mass health awareness initiatives. The study results reveals (Table: 1) that nearly two fifths of the mothers have primary health centers in their village itself; the rest of them have to travel from 0.5 kilometer to 15 kilometers. Three fourth of them visit primary health centers to relieve from minor illnesses; about one fifth of them do not prefer primary health centers for treatment because they feel that treatment is not up to their expectations and also because of non-availability of medicines and other health care facilities. More than two fifths of them have to cover a distance of 0.5 kilometer to reach medical shop while more than one fourth of them have it in their village. Half of the mothers take their children to private clinics to treat minor illnesses and the rest do not prefer private clinics due to lack of affordability and accessibility.

Child care

The child care component (Table: 2) is taken into consideration, the 94.3% of the mothers discuss about their children's health with husband. As for making decision regarding treatment of children, in four fifths of the households the husband alone makes decision. The above finding demarcates the existence of patriarchic dominance though the women contribute their part in the family income. The Yount (2005) also comes out with similar findings his their study conducted in Minya, Egypt that women do not often report having the final say about decisions related to children's health rather someone else has the final say especially the husband.

Table : 1- Availability and Accessibility of Health Services

Variable	Categories	Frequency	Percent
Distance to Primary Health Centre (in km)	.00	125	37.3
	.50 – 1.00	20	6.0
	1.00 – 2.00	95	28.3
	2.00- 3.00	56	16.7
	3.00-4.00	3	.9
	4.00- 5.00	22	6.6
	6.00 & above	14	4.1
Reasons for visiting Primary Health Centers	Not visiting	61	18.2
	Minor Illness	253	75.5
	Emergency	20	6.0
	For free medication	1	.3
Distance to Medical Shop (in km)	.00	92	27.5
	.50	143	42.7
	1.00	18	5.4
	1.50	10	3.0
	2.00	66	19.7
	3.00	6	1.8
Visiting Private Clinic	Not visiting	155	46.3
	Minor Illness	180	53.7

With regard to the care pattern to the children when they fall sick, half of the mothers say that their parents only take care of children. The place of treatment is most crucial and important decision the mother expected to make to save the child from illness and disease. With regard to place of treatment, more than two fifths of the mothers preferred government hospitals and twenty eight percent of them go to the Primary Health Centres, but the contradicting findings of the Saha (2003) is that mothers felt home remedies were sufficient to cure the illness of the children and financial constraints and supernatural beliefs also prevent them from utilizing the allopathic treatment. About three fifths of them have health cards for their children, issued by the Primary Health Centers and government hospitals.

Table:2-Child Care Component

Variable	Categories	Frequency	Percent
Discussion of illness with	Husband	316	94.3
	In laws	5	1.5
	Respondents Parents	11	3.3
	Others	1	.3
	None	2	.6
Decision making on treatment	Husband	269	80.3
	Respondent	14	4.2
	Respondents Parents	18	5.4
	Others	5	1.5
	Respondent and husband	29	8.7

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Care given by when child falls sick	Husband	9	2.7
	Respondent	44	13.1
	Respondents Parents	162	48.4
	Respondent and husband	98	29.3
	In laws	21	6.3
	Others	1	.3
Place of treatment	Government Hospital	142	42.4
	Primary health centre	93	27.8
	Private Clinic	1	.3
	Private Hospital	99	29.6
Health card for the children	Not having	139	41.5
	Having	196	58.5

Gender inequity in Child care

The age and caste status of the mothers do not have any decisive role in the inequity between the male and female children in the duration of treatment in case of illness. Mothers having higher secondary and graduate level education treat both male and female children for the same period. Those who are educated up to primary, secondary as well as the illiterates treat their male children for long duration than female children. It is found that the inequity in duration of treatment does decrease when the educational level of the respondents gets higher. However, the mean difference analysis does not confirm that mothers having different educational levels vary in their level of inequity in duration of treatment.

The study further reveals that as the income of the family increases, inequity against the female children decreases. Here again the mean difference analysis does not confirm the role of family income in inequity in duration of treatment. The family size, birth order of the sexes and migration do not have any significant influence on discrimination in duration of treatment of male and female children.

Conclusion

Allocating resources is not consciously planned any inequality in providing them timely and appropriate care and in the process of promoting their health as well. The nature of work, economic position, educational level and fertility behaviour of the mother, availability of the resources and the family size are the major determining factors of health care allocation and value to their children. When the education level and the family income of mothers raise the gender discrimination shown against female children reduces considerably. The present scenario is totally contrasting with yester years that the parents revolve around their children and not showing any bias in allocating resources to them irrespective of the sex of the child. The parents not seeing their children as an economic advantage like earlier rather observe them as pride and value them equally.

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