



# Addressing Gender Issues in Reproductive and Child Health

In Uttar Pradesh, as in much of northern India, girls are not treated the same as boys by families and within health systems. There is a strong preference towards sons which often results in neglect of girl children. This neglect leads to poor health and nutrition in girls and can increase chances of death. These gender disparities continue into adulthood, resulting in disempowered women suffering from poor reproductive health. Reducing these gender gaps will go a long way towards achieving healthy families and communities that can develop and prosper.

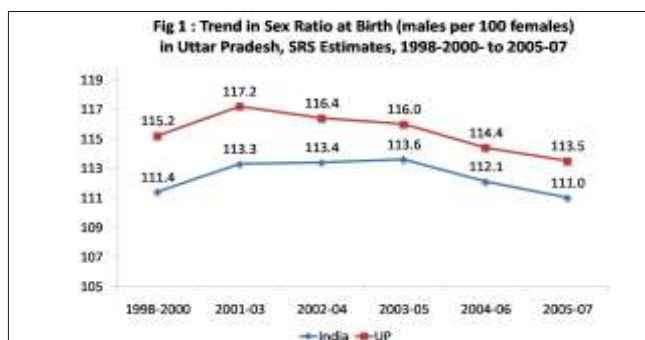
## Evidence of Gender Disparity

### Son Preference

Numerous studies in India cite a strong preference for boys over girls by most couples, particularly in the northern and central belt of the country. The practice of continuing to have children in an effort to have sons is said to have contributed to the slow pace of reducing the number of births per woman, and thus not realizing the economic, health and development benefits of smaller family size.

In Uttar Pradesh, more than one-third of the women (38%) want more sons than daughters (NFHS-3). The desire for more sons as compared to daughters is found to be higher (41.1%) among older women (40-49 years) as compared to younger women (24.4%, 15-19 years). Preference for boys is highest among rural, less educated, and poor women.

An analysis of the Sex Ratio at Birth (SRB), which is conventionally defined as number of male babies born per 100 female babies, indicates that the SRB in Uttar Pradesh is consistently higher than the country as shown in Figure 1. This further suggests how couples attempt to convert their desire for sons into practice. Though there has been slight reversal in the recent years, concerted efforts are still needed to address such gender imbalances.



### Health and Nutrition Status

One can see differences in the health care and nutrition of boys and girls in early childhood. After the neonatal period, significant gender differences are seen in early childhood mortality rates. The findings from NFHS-3 reveal that post neonatal mortality rates are significantly higher for girls (32 per 1000 live births as compared to 25 for boys) as are child mortality rates (43 versus 22) and under five mortality rates (125 versus 101). These data speak volumes about the care practices in the State.

Boys and girls under age five are equally likely to have diarrhea, ARI, fever or any of these illnesses; but boys are more likely to be taken to a health provider and sooner. Many girls are not getting enough of the right food to eat. Though there are no significant gender differentials in the nutritional level of all children below five years of age, this data appears to mask the true picture. When disaggregated by age, we find that girls in the age group of 2-5 years have significantly poorer nutritional status in terms of height-for-age (stunting) and weight-for-age (underweight) as compared to boys. Even when socio-economic and demographic conditions are same for both the sexes, girls are truly at a disadvantage.

### Women's Reproductive Health

Women's reproductive health in UP is poorer than in most other states in India. Social and cultural norms lead to early marriage and childbearing, low use of modern contraceptives, dismal maternal health and high levels of maternal death. Only around a quarter of women (26%) received three or more ANC visits, about two-thirds (65%) received two or more doses of tetanus toxoid (TT), half of the women were given iron and folic acid (IFA), but only 9% took it for at least 90 days (NFHS 3). The majority of deliveries in UP (88%)

are conducted at home and more than two-thirds of these home deliveries are attended by untrained health professionals. Such low level of utilization of Reproductive and Child Health (RCH) services, which are supposed to be available free of cost by the government, may mean that those services are not available or are so poor as to be undesirable, or that the overall low status of women prevents them from accessing these services, or both.

### ***Women's Empowerment, Domestic Violence and RCH***

Women's empowerment can be measured by looking at several aspects, including earning status, decision-making power and autonomy in terms of mobility and need for permission to undertake various tasks. Women were questioned on several of these dimensions in the three rounds of National Family Health Surveys. In the third round, 34 percent of currently married women were employed in the year preceding the survey; however, one-fifth of these women received no payment for their work and a little more than one-third were paid only in-kind.

Over half of the women participated in making decisions about their own health care, making large household purchases, household purchases of daily needs, and visiting their own family or relatives. However, only 34 percent participated in making all four of these decisions and nearly one quarter did not participate in any of the four decisions. Only 23% of women were allowed to go alone to the market, health facility and to their own village or community.

This disempowerment often leads to low self esteem, which can be seen when nearly half of the women reported believing that it is justifiable for a husband to beat his wife under specific circumstances such as showing disrespect to her in-laws and neglect of house or children. The extent of intimate partner violence reported by women in UP indicates the lack of respect

and low value accorded to women.

About two fifths of ever married women reported having experienced physical violence at the hands of intimate partners during the past 12 months preceding the NFHS 3, 9% reported sexual violence and 16% reported emotional violence. Pregnancy or the post-partum period may be a particularly vulnerable period for women, with almost one-third of the women facing violence during this period. Empowered women, who make independent decisions, are more likely to experience violence. Violence also has significant influence on unmet need. Women who face violence are more likely to have unmet need for family planning services. Intimate partner violence, may lead to lower utilization of health care for them and their children.

### ***Male Involvement and RCH***

In Uttar Pradesh, women have to depend on others in the family (husband and in-laws) in almost every domain of decision making, including the sphere of health care. The analysis of NFHS-3 data reveals that while women's autonomy improves the utilization of certain RCH services (ANC and TT), male involvement appears to be a key factor for overall utilization of RCH and ICDS services.

Women whose husband received information from the health provider or health worker about the signs of pregnancy complications (vaginal bleeding or convulsion or prolonged labour) were significantly more likely to use ANC, family planning (both spacing or permanent methods), and had less likelihood of childhood morbidity and under nutrition among their children. Similarly, women whose husband was told by health provider or health worker about importance of delivery in a health facility were significantly more likely to use ANC services, deliver in an institution or by a health professional use family planning (both spacing or permanent methods) and seek immunization, and less likely to have morbid or undernourished children.

## ***Recommendations for Addressing Gender Disparities in the Care of Girls and Women in Uttar Pradesh***

### ***Health and Family Welfare Department***

- Collect and analyze gender disaggregated data from service delivery records.
- Ensure male involvement as an integral strategy of service delivery and communication
  - ▶ Provide information on antenatal care, delivery care, postnatal care, family planning, nutrition, and immunization with men,
- ▶ Make health facilities more friendly to men, and
- ▶ Use personal testimonies of male involvement in RCH to encourage greater male involvement.
- Develop an inter-sectoral strategy to address domestic violence, and use healthcare delivery contacts as opportunities to identify victims of domestic violence.
- Design and implement a communication campaign

to sensitize communities on equitable care, treatment and nutrition for the girl child.

- Sensitize Village Health and Sanitation Committees, Rogi Kalyan Samitis and Panchayati Raj Institutions on gender issues in RCH to serve as agents of change.
- Proactively reach out to the girl child below two years (by peripheral workers).
- Develop and test interventions to reduce gender differences.
- Monitor the implementation of the PCPNDT Act reduce demand for sex selective abortions.
- Ensure that Appropriate Authority is in place and every Ultrasound machine is registered, and, in particular, track the use of mobile ultrasound machines.
- Ensure that data on case load of each machine is available and monitored.

## ICDS

- Collect and analyze gender disaggregated data from service delivery records.
- Reach out to the girl child effectively, particularly those below the age of two years.
- Emphasize on minute follow-up of the nutritional status of children at ICDS, particularly girls, and

ensure their full participation in ICDS.

- Ensure regular monitoring and special care for children who are undernourished, stunted or wasted.
- Use Nutrition and Health Days as entry points for reaching out to the community, sensitizing them on the importance of health care seeking for children, especially for girls.

## Other Departments: Police, Panchayat, School, etc.

- Mobilize the community and sensitize the police so that more cases of domestic violence, physical harassment, rape, prenatal sex determination are brought to the notice of the administration.
- Develop and participate in an inter-sectoral strategy to address domestic violence.
- Organize legal literacy sessions on aspects like domestic violence, rape, dowry, inheritance, PCPNDT, etc for the community, link workers and health providers.
- Sensitize school children on the ills of gender discrimination and how to challenge the same at a societal and household level.

This brief is based on secondary data analysis of NFHS-3 and other data sources for Uttar Pradesh, and has been drawn from the following unpublished papers, through the support of the MCH-STAR Initiative to IndiaCLEN, PFI and ICRW:

1. Kumar, S.K., Levitt-Dayal, M., Dadhwal-Singh, A. (2009). Gender Differentials in Mortality and Nutritional Status Among Children in Uttar Pradesh. *Unpublished manuscript*.
2. Sahu, D., Mishra, R.M., Mondal, S., Kumar, S.K., Levitt-Dayal, M., Dadhwal-Singh, A. (2009). Effects of Women's Autonomy and Male Involvement on RCH Service Utilization in Uttar Pradesh. *Unpublished manuscript*.
3. Achyut, P., Verma, R., Kumar, S.K., Levitt-Dayal, M. (2009). Gender-based Violence and its Effects on RCH Service Utilization in Uttar Pradesh. *Unpublished manuscript*.
4. Dhawan, J., Chellan, R., Deshmukh, V., Kumar, S.K., Levitt-Dayal, M., Dadhwal-Singh, A. (2009). Gender Differentials in Health Care Seeking for Children Under Five in Uttar Pradesh: Evidence from NFHS-3. *Unpublished manuscript*.
5. Kulkarni, P.M., Kumar, S.K., Levitt-Dayal, M. (2009). Sex Ratio at Birth, Son Preference and Use of Ultrasound in Uttar Pradesh. *Unpublished manuscript*.

The Maternal and Child Health Sustainable Technical Assistance and Research (MCH-STAR) Project is an initiative to improve policies, programs and resource allocation in maternal, neonatal, child health and nutrition (MNCHN) in India. The MCH-STAR initiative aims to create a legacy of Indian institutions that provide technical leadership in

research, program evaluation, policy analysis, responsive technical assistance and advocacy of global standards in MNCHN.

The Indian Clinical Epidemiology Network (IndiaCLEN) is a network of trained clinical epidemiologists, social scientists, health economists and biostatisticians engaged in research and training. IndiaCLEN's goal is to improve the health of populations through the application of the principles of clinical epidemiology, to improve the efficacy, effectiveness and efficiency of health care.

The Population Foundation of India (PFI) was established in 1970 by a dedicated group of industrialists and population activists led by Bharat Ratna the late Mr JRD Tata who guided it as the founder Chairman. The Foundation has been at the forefront of the Non Governmental efforts towards a rights-based, gender-sensitive approach for Human development.

The International Center for Research on Women (ICRW) has earned a reputation as the leading international institution on gender and development. ICRW tackles the complexities of the world's most pressing problems poverty, hunger and disease by demonstrating that a focus on women and gender is necessary for lasting social and economic change.

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