

**OBSTACLES TO GENDER EQUALITY IN EAST CHAMPARAN DISTRICT
OF BIHAR, NORTH INDIA:**

**EXPLORATION OF THE RIGHT TO HEALTHCARE FOR CHILDREN
UNDER FIVE**

by

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Declaration

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I declare that **OBSTACLES TO GENDER EQUALITY IN EAST CHAMPARAN DISTRICT OF BIHAR, NORTH INDIA: EXPLORATION OF THE RIGHT TO HEALTHCARE FOR CHILDREN UNDER FIVE** is my own work and the sources I have used or cited have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

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Abstract

Child rights, especially the right to health for children, is a concept of human development. The aim of this qualitative study is to explore the obstacles to gender equality in the right to healthcare for children under five years in East Champaran, Bihar, North India. Ten key informant interviews and nine focus group discussions with mothers, fathers, grandmothers and grandfathers were conducted to research the barriers of guardians to accessing healthcare for their children, including their root beliefs and choices, which causes health inequalities. It was found that a strong patriarchal tradition predominates in these communities in North India, which favour sons and disadvantages daughters in healthcare provision. Despite the existing child rights and human rights policies that have been legislated, in India traditional practices that discriminate against female children remain dominant in the society, and limit development in East Champaran, Bihar, North India.

Key Words: child rights approach, right to healthcare, human development, capability approach, gender equality, North India, children under five

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Abbreviations

AHS	Annual Health Survey
ARI	Acute Respiratory Infections
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
BCG	Tuberculosis
CHC	Community Health Centre
CHW	Community Health Worker
CRC	Convention on the Rights of Children
DTP3	Diphtheria, Tetanus, Pertussis
EHA	Emmanuel Hospital Association
FGD	Focus Group Discussion
GDI	Gender-related Development Index
GEM	Gender Empowerment Measure
GII	Gender Inequality Index
GNI	Gross National Income
GNP	Gross National Product
HDI	Human Development Index
ICDS	Integrated Child Development Scheme
IHDI	Inequality-adjusted Human Development Index
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
LHCP	Local Health Care Provider

MCV	Measles
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MPI	Multi-dimensional Poverty Index
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NHM	National Health Mission
NNMR	Neonatal Mortality Rate
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
PHC	Primary Health Care
POL3	Poliomyelitis
SDG	Sustainable Development Goal
SRB	Sex Ratio at Birth
U5MR	Under five Mortality Rate
UIP	Universal Immunisation Programme
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children`s Fund
WHO	World Health Organisation

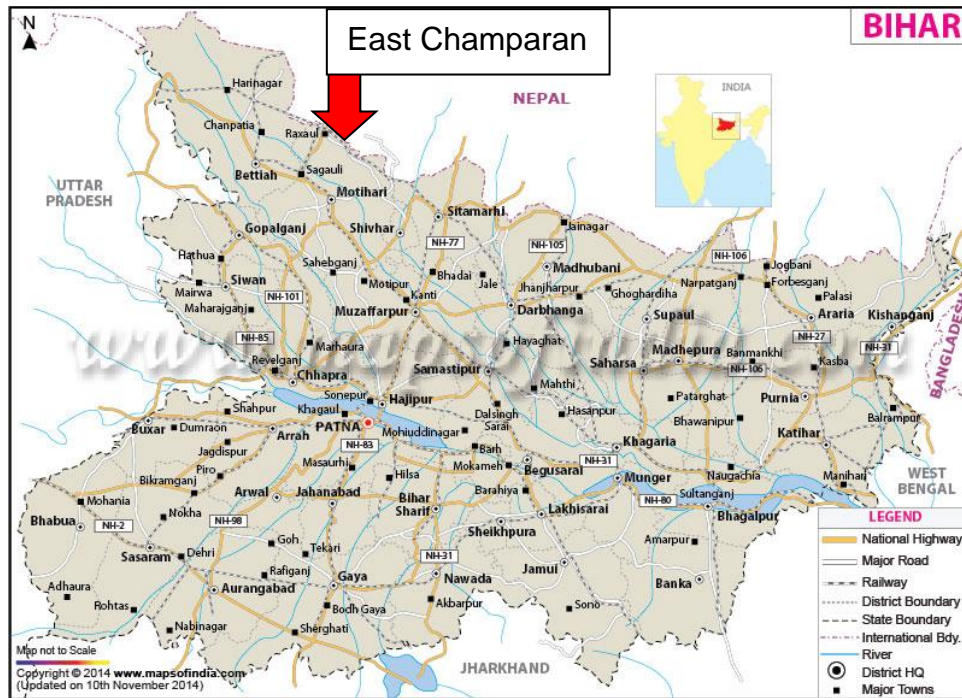
Maps of India, Bihar and East Champaran

India



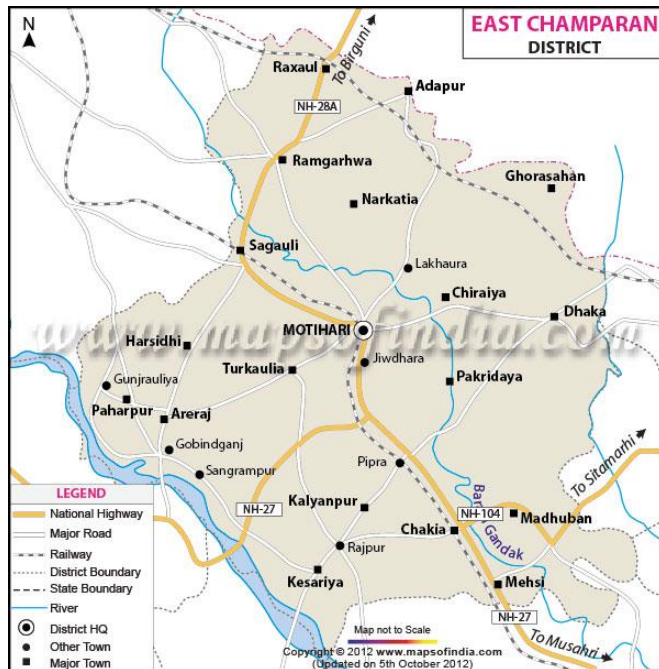
Source: Map of India (www.mapsofindia.com)

Bihar



Source: Map of Bihar (www.mapsofindia.com)

East Champaran



Source: Map of East Champaran (www.mapsofindia.com)

CHAPTER 1 ORIENTATION OF THE STUDY

1.1 INTRODUCTION

In 1989 the United Nations General Assembly introduced the Convention on the Rights of the Child (CRC), which means that countries that signed the CRC, are under an obligation to uphold the rights of children. Worldwide, thousands of children are denied the opportunity to grow up in peaceful healthy surroundings and develop their full potential (UNICEF 2014b:3). In developing countries, the realisation of children rights faces many challenges, poverty being one of the primary issues (UNICEF 2014b:11). Northern India is a complex example, because of dramatic gender disparities in the region. The issue in northern India is not only an overall high mortality rate in children, but the specific higher mortality rate of female children as opposed to male (UNICEF 2014a:19; Census 2011; NFHS-3). This indicates an existing gender inequality in children, which influences their development.

This study highlights the reasons for gender differences in healthcare provision by guardians of girls and boys under five years of age.

1.2 PROBLEM STATEMENT

Every year, in developing countries millions of children die as a result of diseases that would be preventable if basic healthcare were provided. India is one of these countries (UNICEF 2011:4). Although the availability of basic healthcare is the right of every child, this is not the reality. Instead, the life of children in developing countries is marked by poverty, with limited access to basic healthcare and nutrition, and clean drinking water, and limited possibilities to an adequate education. Growing up under such conditions affects lifelong cognitive development and can impair children physically and emotionally (UNICEF 2014b:7).

Evidence suggests that in South Asia female children are discriminated against in the provision of adequate healthcare and nutrition, which is provided to male children (Das Gupta 1987:77; Sen 1990; Klasen & Wink 2003:297; Chen et al 1981:64; Croll 2000:10; Victora et al 2003:235).

Das Gupta argues that the reasons leading to the preference for sons are rooted in the social and cultural structure of the society (Das Gupta et al 2003:182). In 2003, Das Gupta documented the son preference in South, and East Asia, including the countries of China, Republic of Korea and India.

Literature shows that female children are subjected to inferior healthcare and disease prevention compared with their male counterparts (Victora et al 2003:235). Female discrimination and neglect limits individual personal development and deprives girl children of their basic capabilities, which then increases the risk of poverty (Sen 1999:87). The rights of children must be realised. This includes providing adequate healthcare for children of both sexes, thus breaking the cycle of poverty extending from generation to generation (Bradshaw 2007:14).

Duncan Hospital, a private hospital in Raxaul, East Champaran, is run by Emmanuel Hospital Association (EHA), a Christian hospital network in North India. The hospital reported that it was four times more likely for male children under five years old to be brought to the paediatric ward than for girls (unpublished EHA hospital records). The question was then raised by the EHA: Do girls obtain less healthcare? In addition to this question, this thesis explores the ways in which guardians are influenced by their culture and economic resources in seeking medical care for their children.

The aim of the study was to understand the obstacles to gender equality in East Champaran of Bihar, North India, in order to promote gender equality in healthcare provision and the children's welfare.

1.3 RESEARCH AIM AND OBJECTIVES

To answer the research question, secondary research objectives were defined in such a way that they would lead to the achievement of the primary objective.

Primary research objective

To explore the reasons for persistent gender inequality in the right to healthcare for children under five years in East Champaran, Bihar, North India.

Secondary research objectives

To examine the determinants of child development and child survival in terms of child rights policies that are specially defined in India.

To examine the extent of gender inequality in the current health situation for children under five years in North India

To investigate the reasons for persistent gender inequality in health-seeking behaviour of child guardians in East Champaran, Bihar, North India.

1.4 THEORETICAL FOUNDATION OF THE STUDY

This research draws on the concept of the child rights approach to development to explain the research problem as it sets out the standards of healthcare and gender equality for children. In India, the Convention on the Rights of the Child was politically agreed in 1992 (UNICEF 2009:33) (see Chapter 2). Despite the economic growth between 1990 and 2007 that reduced poverty for many people in India, a large number of people remain poor still suffer in the various states. Gender inequality and the lack of implementation of children's rights are major sources of concern as the North Indian region seeks to develop (UNICEF 2009:33). Gender equality is centred on the children's rights approach and is a goal towards which the nation must work to achieve development successfully. The Nobel prize-winning welfare economist Amartya Sen researched gender disparities and discrimination against women (Sen 1990). His concepts of gender equality and human development with the capabilities approach show the crucial role of women in development and the importance of equal care of children. He states that development should mean the expansion of opportunity to every citizen, irrespective of gender, caste, religion and language (Sen 1999 3-4).

1.5 IMPORTANCE OF THE STUDY

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 healthcare for their children. This knowledge gap calls for an exploration of the complex factors that contribute to the decision-making process in seeking healthcare for children under five.

The study provides up-to-date complex explanations about the gender differences that occur in childhood. These factors help to understand the barriers for guardians to access healthcare. They also support the development of strategies to address directly the root beliefs and choices made by guardians that cause health inequalities. It is hoped that these findings would help to reduce these inequalities and promote female child rights. Giving attention to the situation in this location is the first step for improvements to occur. The findings, therefore, have the potential to contribute to the ongoing community health programme in Duncan Hospital Raxaul, East Champaran, Bihar, India. With this, the realisation of the child rights approach concerning child survival and child development would be supported.

1.6 BRIEF DESCRIPTION OF RESEARCH DESIGN AND METHODOLOGY

This study is embedded in qualitative paradigm social science research, because it aims to explore human behaviour. Qualitative research is used to study a phenomenon in depth. It operates inductively and is used to develop and deepen theories (Creswell 2014:16).

The context in this study was explored in depth so that certain behaviours of guardians, in terms of seeking healthcare for their children, were made known. Semi-structured interviews with key informants, and focus group discussions (FGDs) with mothers, fathers, grandmothers and grandfathers were used as methods for the qualitative research (Chapter 5.4). The data analysis was carried out using the method of grounded theory (Corbin & Strauss 2007).

The researcher also used existing statistics to analyse certain aspects: gender-related child mortality rates, nutrition, and vaccination data with respect to sex differences. In addition, literature on gender inequality in healthcare seeking for

common childhood diseases in India and surrounding countries was reviewed, and used to build an overview of the topic and to identify gaps of knowledge in this area.

The qualitative research method is justified to answer the research question in a comprehensive in-depth way. Empirical research was required to explore guardians' decision making in providing healthcare for their dependants. It was not enough to rely on a literature review. The explanatory qualitative research design was used to provide a holistic analysis of the research problem (Creswell 2014:4).

1.7 CHAPTER LAYOUT

This master's thesis includes seven chapters.

The first chapter explains the research background, problem statement, research objective, and the importance of the study, including a brief description of the research design and research methodology.

The second chapter provides the theoretical framework, and explores the components of child survival and child development in relation to child rights and human development concerning gender inequality.

Chapter 3 gives a brief description of India and the country's socio-economic situation and culture with the focus on Bihar and the study area of East Champaran.

Chapter 4 includes the literature review about child survival, child development and gender inequality.

The research design, methodology, and data collection to justify the study findings are outlined in Chapter 5.

Chapter 6 describes the findings and compares them with the theoretical framework of the child rights approach to human development. In the final chapter the study findings are presented, together with recommendations.

1.8 CONCLUSION

The first chapter provides a general introduction to the study 'Obstacles to gender equality in East Champaran of Bihar, North India: Exploration of the right to healthcare for children under five' with the outline of the research problem, research background, research objectives and a brief explanation of the adopted qualitative research design. Chapter 2 outlines the theoretical framework of the study and focuses on the child rights approach to health in relation to gender equality and the benefit to human development by explaining the capability approach.

CHAPTER 2 CHILD RIGHTS APPROACH: A CONCEPTUAL FRAMEWORK OF HUMAN DEVELOPMENT

This chapter provides the conceptual framework, and explores the child rights approach to human development, based on the international standards of the Convention on the Rights of the Child (CRC). Children are entitled to human rights, but at the same time they have special rights because of their vulnerable situation as children. In this chapter, the focus is on the principles of child survival, child development, and the principle of non-discrimination related to gender equality in healthcare, a fundamental human right.

The importance of the close connection between human development by enlarging people's capabilities and the child rights approach to development is explained. The ways in which gender inequality in healthcare provision could influence child development are highlighted.

2.1 INTRODUCTION

'Our children are our most precious resource' (Deb 2016:v). This meaningful statement is often shared in political meetings about child rights. These words demonstrate the awareness of, and importance of children. Today's children will build the next generation and they are the leaders, dreamers, and doers of society in the future (UNICEF 2014b:3-5). However, in low-income countries, 17 000 children under the age of five, die every day. This shows that children are not cared for in the way that they deserve (UNICEF 2104b:3). Anthony Lake, executive director of UNICEF since 2010, states his concern 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' (UNICEF 2014b:2). 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. Elementary deprivations of child rights are concentrated in two regions in the world, namely sub-Saharan Africa and South Asia, to which India belongs (Sen & Dréze 2010:65). Anthony Lake's request for future

development, is that the equity of children's rights has to be at the centre of development actions for all children (UNICEF 2014b:5).

2.2 CHILD RIGHTS APPROACH

The child rights approach is a continuation of the Universal Declaration of Human Rights, which was adopted in 1948 after World War II and the atrocities of the Holocaust, to secure freedom of speech and expression, worship, and freedom from want and fear of every human being. The freedoms became known as the 'Four Freedoms' and summarise the values of democracy. They formed the basis of human rights (Regan 2012:73). Human rights are indivisible and establish the basic civil, political, economic, social and cultural entitlements and freedoms. They are universal to all human beings anywhere in the world and inalienable at all times (Regan 2012:71).

In 1989 child rights were adopted by many governments, with exceptions being Somalia, South Sudan and the United States. Child rights are human rights for children, defined as human beings below the age of 18, and recognising their special needs. The CRC contains 54 articles, of which 41 (UNICEF 2016) (Appendix 1) define the minimum entitlement given to children to protect their right to live, develop, and achieve their potential (UNICEF 2014b:9). Recently there has been discussion about whether CRC could also include children before birth. There was no consensus. Until now, child rights account to children from the moment of birth (Faix et al 2016:291). This leaves out the unborn as holders of the CRC. They are protected through abortion law.

Children's rights focus on four core principles of non-discrimination: the rights to life, to reaching the best interests of the child, to survival, and to development (UNICEF 2014b:6). This means that every child is entitled to equal access to healthcare, regardless of gender. Every child should be able to enjoy a happy and healthy childhood and develop in a healthy manner.

The rights of the CRC that are most relevant to this study, namely Article 2, Article 6 and Article 24, are highlighted here.

Article 2: Non-discrimination

‘The Convention applies to all children, whatever their race, religion or abilities; whatever they think or say, whatever type of family they come from. It doesn’t matter where children live, what language they speak, what their parents do, whether they are boys or girls, what their culture is, whether they have a disability or whether they are rich or poor. No child should be treated unfairly on any basis’ (UNICEF 2016).

This article incorporates the principle of equality for boys and girls, irrespective of social background, and opposes any discrimination or disadvantage due to race. This is a challenge in developing countries such as India, where the development opportunities of girls might be limited because of gender (Faix et al 2016:283). However, even in industrial countries, the transfer of this right faces problems in terms of educational opportunities, which should not depend on the social background of families (Faix et al 2016:283).

Article 6: Survival and Development

‘Children have the right to live. Governments should ensure that children survive and develop healthy’ (UNICEF 2016).

Governments are under the obligation to fulfil the right of survival and healthy development, including the provision of healthcare for children.

Article 24: Health and Health services

‘Children have the rights to quality healthcare – the best healthcare possible – to safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy. Rich countries should help poorer countries achieve this’ (UNICEF 2016).

This article incorporates the idea that every child has the right to a certain quality of healthcare and to grow up in healthy surroundings. It is the responsibility of rich countries to support poor countries in this matter.

The child rights-based approach to development inspired changes in laws and policies within countries to improve the current circumstances to which children

are exposed. It is a framework for holistic development with the aim of supporting programmes to realise child rights. For the first time, countries have committed to doing everything possible to promote child rights and offer children a healthy start in life for moral, economic, and humanitarian reasons and to promote peace and opportunity for every child. Fulfilling the rights set in the CRC also advances the internationally applied Sustainable Development Goals (SDGs). In 2015, the 17 SDGs were adopted by world leaders as a new development agenda for the next 15 years to end poverty, fight inequalities and protect the environment. The SDGs are human and child rights designed to secure the poorest people in the world (UN 2016).

The child rights approach contains three groups of rights called the three 'Ps' (Chopra 2015:18). These Ps are guidelines to structuring programmes and development work for children (UNICEF 2015).

Participation Rights: Children have the rights to take part in matters that affect them directly and have their voices heard.

Protection Rights: Children have the right to be protected against violence, abuse and neglect.

Provision Rights: Children have the right to enjoy the provision of nutrition, healthcare, a family and a safe home.

These three obligations place children and their circumstances in the centre and encompass all areas considered in the child rights that are relevant to child development.

In low-income countries in particular, capacity to fulfil child rights may be severely limited. The main obstacles to realising these rights are poverty, lack of access to healthcare and schools, use of child labour, child sexual abuse and the status of the girl child in the society (Bajpai 2012:450-457).

A familiar life story that demonstrates that child rights are not taken into action is that of Malala Yousafzai. She was denied education because she was female. Malala Yousafzai, who is a children's rights activist and the youngest Nobel prize winner ever, speaks for millions of children and advocates gender

equality for children and the right of education for girls. She stated that 'one child, one teacher, one pen and one book can change the world' (Yousafzai 2014:230). With this phrase she pointed out that equal education that includes girls is the most important principle in transforming a society and is central to development.

In the promotion of child rights through governments, courts play a central role in making child rights a reality. The rights need to be represented in the courts to create justice for children (Bajpai 2012:470).

Other important agents in making child rights a reality are non-governmental organisations (NGOs). With their child rights policies, they concentrate on effective implementation and monitor child development projects at community level. They deliver resources and services to meet the basic needs of children. NGOs also support governments to ensure the implementation of child rights (Bajpai 2012:472).

2.2.1 Child rights approach in India

The government of India submitted its first country report on the CRC in 1997. With this, the rights approach to child development was gaining importance and had shifted from a welfare approach towards a development approach (Bajpai 2012:477). Various policies have been developed in India to implement child rights and promote child survival and child development (Chopra 2015:36). These are four important policies:

1974 National Policy for Children: The National Policy for Children is a commitment by the state to provide services to children to ensure their full physical, mental and social development. The main factor is the provision of a comprehensive health and nutrition programme, covering all children, and equality of opportunity will be ensured (Chopra 2015:38).

1975 Integrated Child Development Services Scheme: The Integrated Child Development Scheme (ICDS) is a national programme that aims to improve the health and nutrition for children to improve the health of mothers and children under six years of age (Chopra 2015:56) (see Chapter 4.2.4).

2005 National Commission for Protection of Child Rights: The National Commission for Protection of Child Rights ensures that all laws, policies and programmes conform with the child rights perspective in the constitution of India and with the UN Convention on the Rights of the Child (Chopra 2015:40).

2006 Integrated Child Protection Scheme: This is a national plan of action for children. Twelve key areas were identified to achieve necessary targets and ensure that the rights and entitlements of children could be reached. The main goals are the reduction of infant and maternal mortality rates and of malnutrition in children. Female foeticide, female infanticide and child marriage would be abolished and the survival, development and protection of the girl child would be ensured (Chopra 2015:39).

The child rights approach is an advantage in India's development. It should enable children to take part and demand their rights. Success can be seen only when the duty-bearers are ready for transformation to reach effective changes (Bajpai 2012:478).

2.2.2 Right to non-discrimination

In this study the forms of gender discrimination against females in childhood are highlighted. The term 'gender discrimination' is used to describe the systematic unfavourable treatment of individuals because of gender, which denies rights, opportunities and resources (Reeves 2000:2). However, basic healthcare services that are essential for overall development should not depend on caste, gender, place of birth and the circumstances of guardians (Singh 2011:861). In India, the opportunity of access to healthcare depends on whether the child was born in a rural or an urban area, because of access to and availability of health services (Singh 2011:862). The strong desire of parents to have a son discriminates against the female sex (Das Gupta et al 2003:156). This in turn may be influenced by the status of women in society (see Chapter 3.2) Discrimination against females can begin before birth, when parents decide to stop having children, when they have the number of sons they want (Das Gupta et al 2003:156). Another form of gender discrimination is sex-selective abortion during pregnancy and at birth through infanticide (but probably not reported) (Das Gupta et al 2003:156). What is also common in

India is the neglect of females in early childhood, which is demonstrated by higher under five mortality rates (U5MR) of girls than boys (Das Gupta et al 2003:157).

The CRC prohibits discrimination of children according to gender. Article 2 highlighted that wellbeing should not depend on culture or the status of the family, and should include children in poverty and with disabilities (Bajpai 2012:19).

2.2.3 Right to child survival and child development

For more than 30 years, international organisations such as the United Nations Children`s Fund (UNICEF), World Health Organisation (WHO), national governments and NGOs have worked to implement child survival and child development programmes. In this programmes child rights are promoted and child mortality and its causes are addressed. It is realised that early childhood is the most important stage for development of a person`s life (UNICEF 2014b:11). That is why investment in early childhood health and wellbeing should be central to their development.

One of the important achievements in child health was the initiative of James P. Grant as, UNICEF`s executive director from 1980 to 1995. He tried to tackle global health issues and focused on highly effective low-cost interventions in developing countries, for example the availability of vaccination serum, oral rehydration salt to treat diarrhoeal disease, monitoring the growth of children, and educating mothers about the benefits of breast feeding in combating child death. These efforts are known as the `child survival and development revolution`. This intervention showed a significant achievement in the nationwide average numbers in the reduction of child morbidity and mortality (Bellagio 2003:323) and motivated future focus on these basic health practices to promote child health.

In the SDGs, the promotion of child survival and health is relevant. Goal 3 is to `ensure healthy lives and promote wellbeing for all at all ages` (UN 2016). It focuses on the eradication of diseases and the reduction of the wide range of health issues associated with child mortality. Among others, the primary goal related to child survival and child health is to end preventable deaths of children

under five and newborns before 2030. In detail, the aim is to reduce the U5MR to 25 per 1,000 live births worldwide. The secondary goal is universal health coverage with access to quality essential healthcare services, vaccines and affordable effective good-quality and essential medicines for all people (UN 2016).

If child mortality were the only indicator for child survival, its definition would simply mean avoiding death. However, child survival does not mean preventing death alone; it is the quality of life that makes an important difference. To achieve a healthy state has various levels, and involves mental, physical and social wellbeing (Chopra 2015:45). Therefore, child survival needs to be addressed through comprehensive child development programmes, covering human needs of mental, physical and social wellbeing.

2.2.4 Right to health

To enjoy the highest standard of health is a fundamental right of every human being without distinction of race, religion, political belief, and economic or social condition (UN 2015). This applies to children too, as defined in CRC Article 24 (Bajpai 2006:2).

In 1946 WHO defined 'health' as 'a state of complete physical, mental, and social wellbeing and not merely the absence of diseases or infirmity' (Bajpai 2012:374). Not only do diseases play a role, but also the social conditions in which an individual is born, grows, lives, works and grows older are important determinants of health status (Deb 2016:120).

In 1978, the Declaration of Alma Ata formulated 'Health for All by the Year 2000' as a slogan. It was defined as a minimum level of health service through primary healthcare. All people in all countries should have access to health service to live productive lives and participate in social activities. However, slow socio-economic development in many countries, lack of resources, promotion of gender inequality and maintenance of the low status of women have left this plan unfulfilled (Bajpai 2012:375). The importance of this dream was renewed for the twenty-first century through WHO calling again for 'Health for All' (Bajpai 2012:375). Significant indicators for the realisation of the right of health for all

include the child mortality rate, coverage of routine immunisation, and nutritional status (UNICEF 2014b:16).

Meeting health needs is crucial for child development and sets the course for development capacities in their future (UNICEF 2014b:21). In the first three years of life, the development of the brain is taking place. When a child experiences malnutrition, associated with iron deficiency anaemia during these early years, this may damage the development of the brain and lead to detrimental irreversible effects on physical, cognitive and social development. It puts children into low education levels and reduced productivity (UNICEF 2014b:22). It risks their future development because children that fall behind in the first years of life are never able to catch up (Nussbaum 2015:188).

The realisation of the right to health is influenced by healthcare itself and by underlying determinants such as water, sanitation, food, nutrition, housing, healthy occupational and environmental conditions, education, information.

Figure 4 represents this connection.



Figure 2.1: The right to health: Underlying determinants of child healthcare (Deb 2016:118)

The availability, accessibility, acceptability and quality of healthcare influence healthcare itself and the underlying determinants. The meanings of the terms are explained below.

‘Availability: A sufficient quantity of functioning healthcare facilities, goods and services is available’ (Deb 2016:118).

Accessibility: Everyone has access to health facilities, goods and services. There are four main overlapping aspects of accessibility: economical accessibility (affordability); non-discrimination; information accessibility; and physical accessibility (Deb 2016:118).

Acceptability: Health facilities, goods and services must be culturally appropriate and medical ethics must be respected in the society. Social, cultural and economic factors influence how health facilities are utilised (Deb 2016:119).

Quality: The health facilities, goods and services must be scientifically and medically appropriate and of good quality (Deb 2016:119).

The right to health is more difficult to realise in poor socio-economic circumstances, when underlying determinants such as the availability of clean water, sanitation, food and education are limited. The availability, accessibility, acceptability and quality of healthcare in such situations are provided inadequately (Deb 2016:119). This leads to neglect of the health needs in a population. Health and wellbeing have great value in economic reform because they increase simultaneously the quality of life and productivity (Deb 2016:123; UNICEF 2014b:22).

A life in poverty places children at higher risk of morbidity and mortality. They have lower resistance to diseases and are more exposed to infections (UNICEF 2014b). Ill health perpetuates poverty and forces people to live in environments that make them sick (Regan 2012:215). In the end this can harm the society and the development of a whole country when a generation is limited by their capabilities. Therefore, health can be seen central to sustainable development. If child health, child survival and child development are promoted in a country, a generation is growing with capabilities of raising the quality of life and wellbeing, a goal of national development. The human development approach is explained in Section 2.3.

2.3 GENDER AND DEVELOPMENT

In developing countries worldwide, women are highly disadvantaged in various areas of life and experience greater poverty than men (Chant 2008:166). The

contribution women could bring to development if they did not stay in this disadvantaged position has been realised internationally (Regan 2007:162). Over the last years, various approaches in development have emphasised the role of women. The women in development approach (WID) approach supported women's participation in development programmes by giving them access to resources. The disadvantage of this approach is that changes in the overall social, cultural, legal and economic structure were not emphasised. The women and development (WAD) approach recognised that both men and women were disadvantaged in the global economic structure, but the patriarchal social systems that exist in many developing countries were not given enough attention (Regan 2007:162)

The gender and development (GAD) approach was introduced in 1980. It focused on social gender relations between women and men in society, and aimed to empower those that are disadvantaged (Regan 2007:162). Unlike GAD, the gender, law and development approach (GLAD) includes the rights-based approach, and supports the aspect of more equal access to resources and to equal rights. In many societies the legal system has historically supported men. The GLAD approach highlights the importance of ensuring equal rights for men and women, for example that women are permitted to inherit land (Regan 2007:162-163).

2.4 GENDER EQUALITY

While gender refers to 'socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women', sex refers to 'biological and physiological characteristics that define men and women' (WHO 2016a). Therefore, the aspects of sex do not differ much among human societies, while aspects of gender in different places show great variation (Momsen 2010:3). Gender norms and relations can influence health outcomes and wellbeing.

Gender equality means that women have the same opportunities in life as men. It is achieved when women and men have the same rights politically, socially, economically and on cultural levels (Mayoux 2006:16; Momsen 2010:8). It reflects that men and women have different needs and priorities. The idea of

gender equality focuses on social expectations and norms that influence opportunities for individual development. The absence of gender equality means a loss for development through limited opportunity to develop the individual human potential (Momsen 2010:8).

Gender equality in health means that, across their life course and in all their diversity, women and men have the same conditions and opportunities to realise their full rights and potential to be healthy, to contribute to healthy development and to benefit from the results (WHO 2016a). In many countries girls have fewer opportunities than boys, and are often more vulnerable to violence and exploitation and have fewer opportunities to participate in quality education and receive appropriate healthcare (Regan 2012:96).

Gender equality is centred on the children's rights approach, and is the goal of human development of all nations. Kotzé argues that when gender equality is achieved, this automatically leads to the realisation of development goals (Kotzé 2009:15).

How does gender inequality influence the achievement of the development goals? If there is a connection, it would be important to combat gender inequality to improve the outcome of development goals.

In the SDGs, the fifth goal, namely 'gender equality', is crucial to sustainable development, and affects various goals of development. SDG 5 is applied to gender equality and aims to empower all women and girls. Two main targets of goal should be named here: first, to end all forms of discrimination against girls and women; and second, to give women equal rights to economic resources, access to property, financial services, inheritance and natural resources in accordance with national laws (UN 2015). This corresponds with GLAD, as explained earlier.

To understand the causes of gender inequality, contributes to minimise it. Sen analysed worldwide gender bias and discrimination against women, together with the mortality impact because of gender-related unequal rights in developing countries. Gender disparities mean the denial of equal rights and opportunities based on gender (Aparna & Thakur 2012:359). Causes of gender disparities are located in religious beliefs, family situations, society, caste,

culture and state of underdevelopment (Aparna & Thakur 2012:359-363; Momsen 2010:39). Therefore, gender inequality can be related to economic resources such as the provision of healthcare, but can also be totally unrelated to economic resources, for instance violence, rape and neglect of women, which are taking place in Asia (Aparna & Thakur 2012:360).

Sen observed seven inequalities that exist worldwide, but are predominant phenomena in India (Aparna & Thakur 2012:360):

- Mortality inequality: higher mortality rates of women compared with men
- Natal inequality: parents want newborns to be boys rather than girls – a statistical phenomenon in India
- Basic facility inequality: no encouragement to support the natural talents of women for fair participation in social functions and career opportunities
- Special opportunity inequality: higher education for far more men than for women. This is true even of rich countries in Europe and North America
- Professional inequality: employment and promotion in work and occupation: women face greater handicaps than men
- Ownership inequality: ownership of property can be very unequal. For example, traditional property rights that favour men. In India in 2000, out of 120 million landholders, only 12 million were women
- Household inequality: men are allowed to work outside the home: women can do it if they can combine work with household duties

2.5 HUMAN DEVELOPMENT

Since 1980, human development has gained importance in the development process (Regan 2012:80). The human development approach is based on human rights and has been shaped by the basic needs approach. Human development was defined by economists Mahbub ul Haq and Amartya Sen as. 'People are the real wealth of a nation', which means people are agents of

development and transformation (Regan 2012:42). Human development focuses on enlarging people's choices (UNDP 2015; Regan 2012:26). The purpose of development is seen as creating an environment in which people enjoy long, healthy, and creative lives (Regan 2012:27). This statement presupposes that the primary goals of development and reduction of poverty are not only material wealth in the form of economic growth and increase in gross national product (GNP). Human development is a process of enlarging people's capabilities, freedoms and choices to live a healthy life, acquire knowledge and access a decent standard of living (Regan 2012:43). Conditions that human development requires are the opportunity to participate in political and community life, environmental sustainability, realisation of human rights and gender equality. To give an example of gender equality, if justice for women were ensured, they would be more likely to receive education to enhance their abilities and benefit the individual development knowledge (D The dimensions of human development are pictured in Figure 2.2.

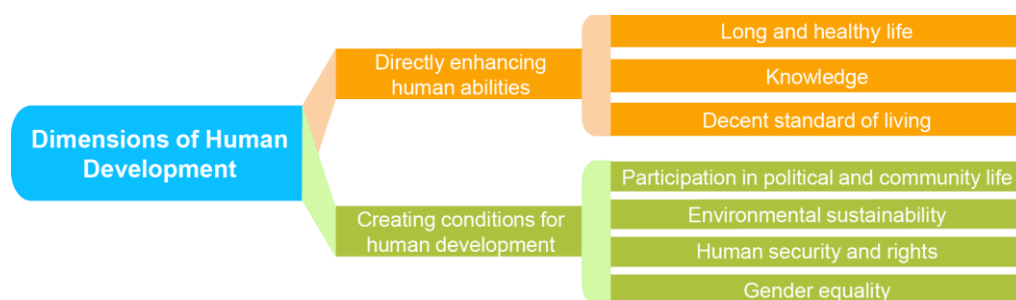


Figure 2.2: Dimensions of human development (UNDP 2015:viii)

In the past it was assumed that through economic growth and an increase in GNP this would automatically improve the quality of living when benefits trickled down to the society. This assumption has failed to be realised. Economic growth does not necessarily mean an improvement in living conditions and quality of life (Nussbaum 2015:53-57). Before the human development approach the basic needs approach has guided development since the 1970s. The objective was to meet the basic needs, based on Maslow's hierarchy of needs (Regan 2012:157). The fulfilment of basic needs, such as the availability of nutrition, healthcare, education and possibilities of participation, would allow the society to rise above poverty, but would not help in developing individual opportunities and in enlarging the opportunities of a country (Nuscheler

2012:176). Therefore, the basic needs approach was like human development a people-centred approach and a shift from investment in economically productive activities to an investment to cover basic human needs (Regan 2012:156). Both human development and human rights seek to ensure freedom, wellbeing and dignity for all people. Rights have a core position because they are universal and can be demanded by everyone that is entitled to them, therefore they are stronger than needs. A 'rights framework' is more respectful of human dignity and human agency than a 'needs framework' (Regan 2012:73). Human rights and children's rights in the broader sense 'secure these capabilities and freedoms' (Regan 2012:35) and provide conditions for human development. This means that the protection of children's rights are the foundation for human development to create an atmosphere of freedom, dignity and justice' to develop the individual potential (Bajpai 2012:437).

2.5.1 Human development approach

The people-centred human development approach, also known as the capabilities approach, is grounded in the views of Sen and Nussbaum (Nussbaum 2015:26). Essential to this approach is the conviction that the quality of life would improve if people were able to develop their capabilities. This approach sees development as a process, 'expanding people's human capabilities' (Regan 2012:108). These capabilities enable human beings to have opportunities and to act, to enjoy individual freedoms in being and doing (Regan 2012:108). It is a task of all nations to improve the quality of life for all human beings by enlarging their capabilities. While Sen does not define specific capabilities, Nussbaum identified ten core capabilities that are important for people's development (Nussbaum 2015:41-42). These ten core capabilities are life, health, integrity, senses of imagination and thoughts, emotions, practical reason, affiliation, play, ability to live in relation to animals, plants and the world of nature, and control over one's political and material environment (Nussbaum 2015:41-42, Regan 2012:108-109).

The capability approach is closely combined with human rights, particularly child rights. The communality is that humans have basic entitlements and society is responsible for supporting these requirements. The core capabilities

correspond almost exactly with human rights (Nussbaum 2015:72-73). The promotion of these capabilities is essential from as early as the beginning of life. The physical and mental development of children is very important in the early years. If children receive a good start in the first years of life, they are more likely to live productive lives and develop learning capacities up to their full potential (Chopra 2015:46). Furthermore, investment in health in the first years is a boost to every aspect of child development (UNICEF 2014b:5). As a result, children are more likely in the future to earn their own incomes and take responsibility for their own lives. On the other hand, if children are growing up in poverty, without encouragement and without play and welfare, they may be limited to dreaming of a better future and live a better future (UNICEF 2014b:5).

2.5.2 Human development index

In 1990 the human development index (HDI) was developed based on the capability approach. The HDI includes the three dimensions of income, health and education (Regan 2012:26). Health is reflected in the HDI through life expectancy, education through the years of schooling, expected years of schooling and standard of living through the gross national income (GNI) (Regan 2012:26).

The main critique of the HDI was that it did not consider gender inequalities (Regan 2012:26). In 2010, three new measures of human development were introduced, namely the inequality adjusted human development index (IHDI); the gender inequality index (GII); and the multi-dimensional poverty index (MPI), which capture important aspects of human development (Regan 2012:28).

2.5.3 Indicators of gender inequality

To measure the various forms of women's disadvantages and gender inequality, the United Nations Development Programme (UNDP) developed two indexes. The gender-related development index (GDI) is an extension of the (HDI). It has three indicators: life expectancy, education and income. In addition to the HDI, a comparison of gender is made (Klasen 2004:10). To measure the inequality of gender participation in economic and political matters, the gender empowerment measure (GEM) is used. This index considers female

and male shares of parliamentary seats, of positions as legislators, managers and senior officials, of professional and technical workers, and of estimated earned income to reflect political participation, decision-making power and economic participation. The best value is 1.000 and the worst 0.000. In 2006 the GEM score in India was 0.497 (Bihar 0.378), which demonstrates strong disparities in gender empowerment (UNDP 2011).

2.5.4 Gender inequality in India

The social ramifications of gender inequality in India are extensive. Causes, among others, have their roots in culture and the kinship system (see Chapter 3.2). Comprehensive research into the phenomenon of gender inequality has been carried out. Dréze and Sen realised that this would be only the beginning of knowledge about the wide range of this phenomenon of gender inequality (Dréze & Sen 2010:271).

Five crucial points were captured by Dréze and Sen that apply to gender inequality in India in connection with development. First, gender inequality and deprivation of women are among the social failures in India. India has achieved little in promoting gender justice (Dréze & Sen 2010:273). Second, gender inequality does not decline automatically with economic growth. When economic growth had a positive influence by raising the literacy rate or employment rate of women, the reduction of gender inequality happened very slowly or only indirectly. Third, because of the link with child mortality and related demographic achievements, gender inequality is not only a social failure, but contributes to other social failures, for example child mortality, sex-selective abortion and violence. Fourth, women need to receive more social justice, but social justice can be achieved only through women. There has been growing awareness of the disadvantages of women in the Indian society, but ways in which to achieve change have been neglected. Fifth, the empowerment of women does not necessarily reduce the preference for sons. When traditional discrimination of women remains and women are not really free, the barriers of inequality persist. Sen argues there is a need for freedom to question and doubt values and traditions up to rejection of female discrimination in order move towards development in this area (Dréze & Sen 2010:274).

2.5.5 Rights of women in India

The status of women in Indian society and the promotion of their equal rights have been priorities of the government over the last decades (Kakar 2015:94). The rights are upheld to back up social and economic equality. They are secured in Indian supreme law, the Constitution of India, Articles 14: Equality before the law; and 16: Equality of opportunity in matters of public employment reference. Other acts that support the rights of women as pointed out by Kakar (2015:94) include this legislation:

1956: Hindu Succession Act. The law calls for equal right for women to inherit parental property.

1961: The Dowry Prohibition Act. The law makes payment of dowry a punishable offence.

1986: The Indecent Representation of Women (Prohibition) Act. The law prohibits indecent representation of women through advertisements or in publications, writings, paintings, figures or in any other manner.

1987: The Commission of Sati (Prevention) Act. The laws seek to prevent Sati practices – that is immolation of widows shortly after their husbands' deaths or the forced burning of widows.

2005: The Protection of Women from Domestic Violence Act. The law seeks to protect women from domestic violence, including physical, emotional, verbal, economic and sexual abuse.

However, the implementation of these rights has been extremely insufficient and the lives of women in India are marked by violence, suppression and disadvantages. In fact, it is common for offenders to be protected by the police, and women are not conceded their rights. Despite an excellent rights foundation, legal protection is not happening. Only when women are networked in social groups and empowered, are they are more likely to enjoy protection from the legal system (Kakar 2015:94; 114). Despite the laws on protection of women, dowry deaths are still a widespread phenomenon (Kakar 2015:94). The Human Rights World Report of 2015 stated that the Indian government had introduced guidelines for medical treatment and examination for women who

had been raped, but only two states adopted these guidelines, and the allocation for resources for implementation failed (Human Rights World Report 2015:281).

2.5.6 Contribution of women in development

Studies have shown that the social roles of women have extremely positive effects on development (Nuscheler 2012:100). Because of the central role of women, their empowerment has a positive effect, not only on women but on their children, families, communities and countries (Kotzé 2009:7) and would benefit development and poverty reduction. When women are representatives in Indian village parliaments (*panchayat*), they are less corrupt and act for the good of the community (Kakar 2015:115, 156). Political and economic participation of Indian women in public is seen as an efficient practice to limit violence and reach sustainable empowerment (Kakar 2015:115). Another benefit of women in development is that they have a greater influence on the progress of their children than men do. They take care of children's nourishment and health, and would rather stay hungry themselves and feed the children (Nuscheler 2012:100).

The achievement of gender equality is important for economic development. Evidence suggests that in societies that discriminate based on gender, there is greater poverty, slower growth and poorer quality of life (Momsen 2010:9). In areas where women had more equal rights there was less malnutrition (Nuscheler 2011:101) and female farmers raised yields by one fifth (Momsen 2010:9).

The promotion of gender equality is seen as a means to achieve poverty reduction (Chant 2008:183; Nuscheler 2012:101). Addressing these gender inequalities is a fundamental principle underpinning the achievement of the SDGs. Poverty reduction without considering gender equality and empowerment of women would be a very ineffective approach. Women could have a huge impact on economic growth and reduce other development problems if they were empowered and had a chance to act (Momsen 2010:15).

2.6 CONCLUSION

The realisation of the child rights approach and human rights approach is essential to overcoming gender-related barriers and improving the wellbeing of children. In a review 25 years after the CRC was introduced, it is stated that in general the world today is a better place for children. But this is not experienced by every child so far (UNICEF 2014b:7). The implementation and realisation of the rights that support gender equality face certain challenges and limit development when women and girls are not treated equally. Development cannot take place without adherence to women's human rights (Kotzé 2009:6) and girl child rights.

Human rights and child rights secure the capabilities and freedom for human development to enable people to live the lives they value. 'Human development is essential for realising human rights and human rights are essential for full human development' (Regan 2012:80). Going further, the same may be applied to child rights: 'Child development is essential for realising child rights, and child rights are essential for full child development'. Although these rights attract policymakers to include them in countries' action plans, their full realisation is pending so far. Gender disparities in healthcare for girls and differences in child mortality are contrary to the agreed child rights. Gender equality is a condition to human development (UNDP 2015:viii) and also fundamental for the achievement to the currently applied SDG's.

CHAPTER 3 INDIA: BRIEF OVERVIEW OF SOCIO-ECONOMIC STATUS AND CULTURE

3.1 INDIA: BRIEF SOCIO-ECONOMIC STATUS

India became independent from the British Empire in 1947 during the worldwide decolonisation after World War II (Dréze & Sen 2013:15). This was an important step for the country after almost 200 years under British rule. Since the mid thirteenth century, various regional powers have dominated North and South India, which might be a reason for the enormous socio-economic and cultural differences within states until now.

India is the fastest growing population worldwide, with 1.21 billion people. It is the country in which the largest number of children live. As many as 351 million children (29% of the population) are under five years old (Pujan 2015:5). Approximately 100 million children are in the poorest wealth quintile, which means that a high percentage of children live far below the standard that the child rights charter requests (Krishnan et al 2013:419; Bajpai 2012:449). They struggle to survive, face poverty, and suffer the mishandling and omissions of their own guardians (Bajpai 2012:449).

India has the largest democracy in the world. Twenty-nine states are governed by its constitution. The social structure is still characterised by undemocratic practices from the past, such as the caste system, poverty and widespread corruption. The booming economy in India that was initiated by market liberalisation in 1991 (Dréze & Sen 2010:62; Sachs 2005:170) led to rapid growth of the middle class in Indian society. They were able to generate growth in consumption, while the consumption opportunities of the poorest stayed stable, and poverty was still rampant (Dréze & Sen 2010:2). The caste system is a strong aspect in Indian society, especially in rural areas, which is slowing development and seen as one of the biggest obstacles to getting out of poverty (Karkar 2015:152).

According to the latest estimate, 39% of India's population live below the poverty line (Nuscheler 2012:90). The poverty line refers to the proportion of population that live below a specified per capita income and are considered to

be living in poverty (Regan 2012:17). It can be misleading because it limits poverty by income and does not consider other important areas such as social opportunities, quality of life, education and health. In the past, the poverty line was US\$1.25 income/day but was raised to US\$1.90 income/day in 2015 by the World Bank (Ferreira 2015:37).

India is a country in which several hundred languages and dialects are spoken. The language used for official purposes such as parliamentary proceedings is English. However, Hindi is the most widely spoken language and the primary tongue of 41% of the population (World Fact Book 2015). The huge variety of languages and the high percentage of illiterate population have severely limited economic growth in the society (Dréze & Sen 2010:78). Figure 3.1 shows the literacy rate of adults aged 15–24 in the various states in India (Census 2011).

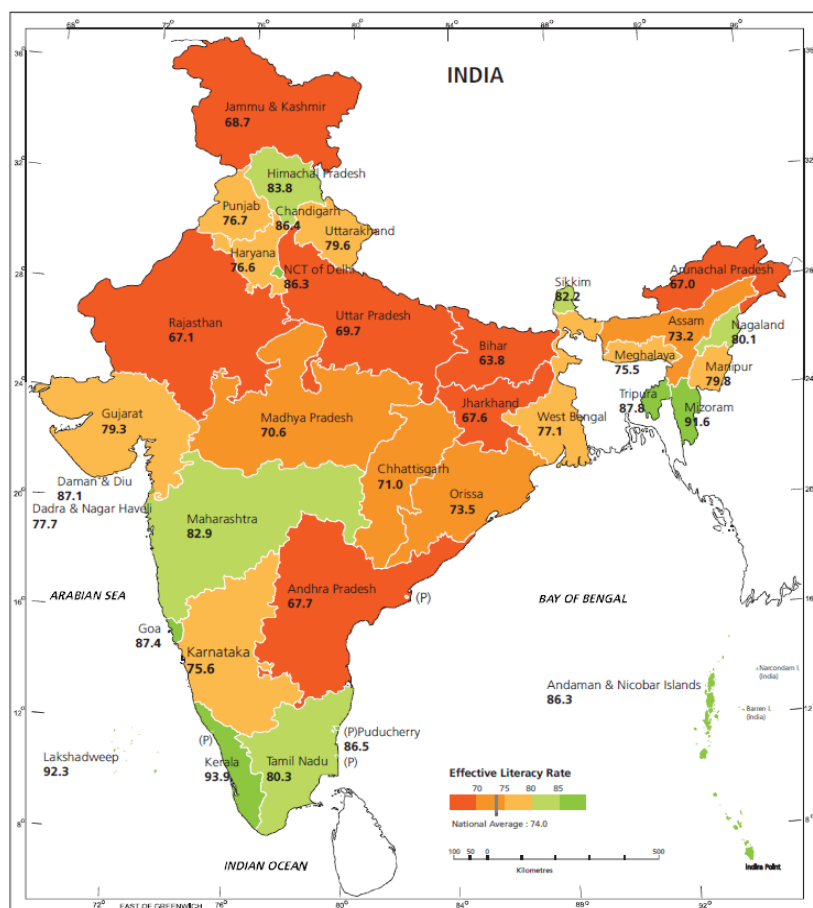


Figure 3.1: Literacy rate map India (Census 2011)

The national average of India's adult literacy rate is 74% (Census 2011), which is 12% lower than the worldwide average (86%) (World Fact Book 2015). The states with the highest adult literacy rates are Kerala (94%) in the south and Mizoram (92%) in the north east. Bihar is one of the states with the lowest adult literate rate of 64%, an indicator of Bihar's underdevelopment. Lack of education for women, who were more likely to be illiterate, is reflected in the gender differences in literacy rates, with much lower figures for female literacy in Bihar shown in Table 3.1.

Table 3.1: LITERACY RATE BY SEX

	male	female	total
Bihar 2001	60%	33%	47%
India 2001	75%	54%	65%
Bihar 2011	73%	53%	64%
India 2011	82%	65%	74%

Source: Census 2011

The data show high rates of lack of education for the of women. The illiteracy rates are higher among women in North India. Girls are consistently denied equal opportunities to attend and complete primary schooling (Chakrabarti 2012:28; UNICEF 2015). In Bihar, 56.9% of girls over six years attended school (NFHS-4).

India counts as a medium human development country according to the HDI. In the human development report of 2015 India had an HDI rank of 130 from a total of 188 countries. Table 3.2 below compares the HDI of India in the years 1998 and 2014 with the data for South Asia and the world.

Table 3.2: HUMAN DEVELOPMENT INDEX INDIA; SOUTH ASIA, WORLD

	India 1998 ¹	India 2014	South Asia 2014	World 2014
HDI	0.563	0.609	0.607	0.711
Life expectancy at birth (years)	62.9	68	68.4	71.5
Expected years in school	n/a	11.7	11.2	12.2
Mean years of school	n/a	5.4	5.5	7.9
GNI ² PPP ³ /\$	2 077	5 497	5 505	14 301

Source: Human Development Report 2015:210-211

The HDI in India has risen from 1998 to 2014. The data from South Asia and the national average of India are quite similar. Compared with the world, both India and South Asia are below the world average.

India is marked by huge socio-economic differences between states. While some of the 29 Indian states have human development indicators that are almost close to those of the Western World, others have failed to improve their socio-economic opportunities. Table 3.3 below shows the Human Development Index from 23 Indian states in 1999–2000 and 2007–2008 and their ranking.


There is a major gap between the HDIs of the lowest and highest states. Each HDI measurement of Bihar (North India) ranks among the last four, and always demonstrates a low human development level far below the Indian national average.

¹ Human Development Report 2010. In the report the indication of school enrolment has a combined primary, secondary and tertiary gross school enrolment ratio and is not equivalent to expected and mean years in school.

² GNI- 'Gross national income measures the value of the gross domestic product, together with the income received from other countries, less payments made to other countries' (Regan 2012:15).

³ PPP- 'Purchasing power party is a measure that indicates what this income will buy locally; it equalises local currencies against the cost of a given basket of goods in terms of US dollars' (Regan 2012:15).

Table 3.3: INDIAN STATES: HUMAN DEVELOPMENT INDEX AND RANKS

State	HDI 1999-2000	HDI 2007-8	Rank 1999-2000	Rank 2007-8
Kerala	0.677	0.790	2	1
Delhi	0.783	0.750	1	2
Himachal Pradesh	0.581	0.652	4	3
Goa	0.595	0.617	3	4
Punjab	0.543	0.605	5	5
NE (excluding Assam)	0.473	0.573	9	6
Maharashtra	0.501	0.572	6	7
Tamil Nadu	0.480	0.570	8	8
Haryana	0.501	0.552	7	9
Jammu and Kashmir	0.465	0.529	11	10
Gujarat	0.466	0.527	10	11
Karnataka	0.432	0.519	12	12
West Bengal	0.422	0.492	13	13
Uttaranchal	0.339	0.490	16	14
Andhra Pradesh	0.368	0.473	15	15
Assam	0.336	0.444	17	16
Rajasthan	0.387	0.434	14	17
Uttar Pradesh	0.316	0.380	18	18
Jharkhand	0.268	0.376	23	19
Madhya Pradesh	0.285	0.375	20	20
Bihar 	0.292	0.367	19	21
Orissa	0.275	0.362	22	22
Chhattisgarh	0.278	0.358	21	23

Source: India Human Development Report 2011: 2

3.2 INDIA'S SOCIO-CULTURAL CONTEXT IN RELATION TO GENDER INEQUALITY

3.2.1 Kinship system in India and reasons of son preference

India is dominated by a patriarchal kinship system, meaning a son brings wealth, strength, blessing and is highly valued in a family (Arnold et al 1996:7; Chakrabarti 2012:28; Krishnan et al 2013:424; Dyson & Moore 1983:35; Pande & Astone 2007:4; Das Gupta et al 2003:153).

While several Asian countries are dominated by patriarchal systems, such as China and South Korea, in India the situation is rigid (Das Gupta et al 2003:161). This common Indian saying reflects the desire to give birth to a son: 'May he elsewhere afford the birth of a female, but here he shall bestow a man!' (Pande & Astone 2007:2). Traditionally families benefit economically from sons. They will earn a salary in the future and stay with their parents after marriage.

Therefore, by raising a son, simultaneously a family will be blessed with wealth and a daughter-in-law (Arnold et al 1996:2; Das Gupta et al 2003:166). Sons will care for their parents as they age and are therefore seen as security.

A daughter is seen as an 'object' that will be married and sent away (Aparna & Thakur 2012:360) like a burden to the family (Chakrabarti 2012:28). Another reason for the devaluation of women is the payment of dowries, which is still common practice in North India (Das Gupta et al 2003:166-168). In many communities, female babies are killed immediately after birth to relieve them of suffering and dowry demands later in life (Aparna & Thakur 2012:385). To illustrate the value of the life of a girl, Sen used the metaphor of a 'candle in the wind'. It can flicker and be extinguished at any time (Aparna & Thakur 2012:364)

3.2.2 Differences in the kinship systems between northern and southern India

Dyson and Moore (1983) found differences in kinship systems between the northern and southern Indian states (1983:44-48). The kinship system in the northern states is generally characterised by exogamic marriage. An exogamic marriage allows marriage only outside a social group. This means that a daughter leaves her parents' home when she gets married. This Indian saying states that investment in a daughter will benefit someone else. 'Bringing up a daughter is like watering a neighbour's plant' (Anjanamma & Nagarajy 2015:657). This means the family loses the daughter, wealth and property in the future when she gets married. Daughters later care for their own families by doing the household work and are less likely to earn a salary. Any earnings would automatically benefit the husband's family and not her own (Das Gupta et al 2003:161).

The kinship system in the north gives parents enormous future advantages when raising sons, and disadvantages when raising daughters (Das Gupta et al 2003:158). This phenomenon creates neglect of and discrimination against women, which is manifested in denial of education, and lack of adequate healthcare and basic skills, which would equip them to earn a living or to fight for their rights (Bajpai 2012:456).

In the south, the ideal marriage is endogamous. This means that a woman will marry within a known social group, and thus will be somewhat familiar with the man she marries. In the south the payment of dowry is not important (Dyson & Moore 1983:44; Pande & Astone 2007:4). Women can also receive property rights, which boosts their level of autonomy (Dyson & Moore:1983:45).

3.2.3 Status of women

To bear a son gives the woman standing in her husband's family as the mother of the future men of the family. Having a son in the family is part of tradition in Indian culture (Kakar 2015:70) as he carries the role of the ancestor, which is central to prestige during his lifetime and even after death for funerary rituals (Kakar 2015:166; Pande & Astone 2007:4). If a wife does not bear a son, she carries the risk that the husband will take a second wife, and she will be relegated merely to domestic help (Das Gupta et al 2003:175).

The status of widows in Indian society has a close connection with female disadvantages (Dréze & Sen 2013:263). Widows suffer from reduced quality of life and social marginalisation, and are particularly vulnerable to poverty (Dréze & Sen 2013:263). When the husband has died, the widow experiences the violation of property rights. Although legally she has the right to a share of her husband's property, this is not the case in reality. Therefore, widows are not able to be owners of land to make a daily living. It is common that a widow depends on her adult son while being separated from her daughters when they were married (Dréze & Sen 2013:263).

3.3 BIHAR AREA OF STUDY

This study took place in the North Indian state of Bihar, East Champaran, which borders the country of Nepal in the north, and the Indian states of West Bengal (east), Jharkland (south), and Uttar Pradesh (west) (Map of India). The capital city of Bihar is Patna and the administrative capital of East Champaran is Motihari. Bihar is divided into nine divisions and 38 districts, split into 101 sub-divisions, 534 blocks and 44,874 villages (GOB 2006; Kumar & Ray 2013:416). The language that is spoken in East Champaran is Bhojpuri, but the official language in Bihar is Hindi.

Bihar is one of the most underdeveloped regions in India and worldwide (Kumar & Ray 2013:416). With a population of more than 103.8 million (54,185,347 men and 49,619,290 women), Bihar is the most populous state in India and contains more than 10% of India's population (Census 2011). Nearly half of the population in Bihar live below the poverty line (Kumar & Ray 2013:417). This reflects poor socio-economic development (Kumar & Ray 2013:415), which is also shown by the low HDI (see Table 3.3). In Bihar, few improvements in living conditions can be recognised over the last decades. The state is marked by its active corruption, enormous size and breakdown of welfare in society (Dréze & Sen 2013:111).

The low development affects accessibility to and availability of healthcare and the health status of the population, as shown by the high rate of infant mortality rate (IMR), U5MR and low immunisation coverage (Kumar & Ray 2013:415) (see Section 4.4). Bihar's routine immunisation coverage rates have been consistently lower than the national average (Kumar & Ray 2013:420). The children of Bihar are dying of common preventable childhood diseases, such as acute respiratory infections, diarrhoea, measles and tetanus (Thind 2004:137). In the communities there are many superstitious beliefs about diseases, which misrepresent the seriousness of these diseases, caused by lack of knowledge. To give an example, when anyone is suffering from measles there is the thinking that a female god has given mercy to this person, and therefore the female god has visited the house. The house becomes a holy one and people usually start to worship the god there (EHA internal report).

Bihar has one of the poorest medical records in India with regard to providing adequate healthcare for mothers and children. The public healthcare system fails to provide essential services, and the population is forced to buy medicine in the local shops or at the market out of their own pockets. The limited availability, accessibility, acceptability and quality of the public health system are responsible for the population's poor health status (Kumar & Ray 2013:418-427). Health facilities that have been constructed are not functioning or lack medication, adequate equipment and qualified staff (Kumar & Ray 2013:427).

Eighty-nine per cent of the rural population in Bihar are farmers. Resources are available to contribute to agriculture in Indian state economics (Kumar & Ray 2013:417). Even large land resources in Bihar are not used effectively. The reasons for this ineffectiveness might be the large quantity of unskilled human resources, in addition to poverty, and because the land is constantly hit by floods during the monsoon season (Kumar & Ray 2013:417).

3.4 EMMANUEL HOSPITAL ASSOCIATION

This study was accomplished in partnership with the community health project of a large faith-based NGO, namely Emmanuel Hospital Association (EHA), which has its head office in New Delhi. EHA is a network of 20 hospitals and 42 development projects in various states in North India. The health services integrate essential clinical services in hospitals, primary healthcare and community development to address the health priorities of poor and marginalised people, and to facilitate the development of healthy communities, regardless of caste, race, creed and religion (EHA internal report). EHA is a Christian institution, which sees poverty not as economic deprivation, but as a state in which people cannot reach their God-given potential. This understanding of poverty guides development work in EHA projects to transform communities.

One of these health projects is located in Raxaul, East Champaran, Bihar. Health provision includes a hospital, named after the founder missionary, Dr Cecil Duncan, a Scottish surgeon, which was founded in 1930, and several community health programmes.

Duncan hospital provides 200 bed hospital services in general medicine, obstetrics and gynaecology, surgery, paediatrics, orthopaedic and intensive care to serve the population of northern Bihar and Nepal. In addition, an outpatient department provides essential health services to more than one million people per year (EHA Annual Report 2014-15).

A comprehensive community health department supports communities with various projects, focusing on empowerment of women, people with disabilities and mental disorders, people living with HIV, protection of vulnerable families from slavery and sustainable freedom; capacity building of the government

health delivery system; and primary healthcare through peripheral health centres and mobile clinics (EHA Annual Report 2014-15).

3.5 CONCLUSION

Over the past years, India has witnessed economic growth. Despite this, there are massive development deprivations, giving India the status of low human development. The development of India has been strongly influenced by the culture and traditions of Indian society. Bihar represents one of the most underdeveloped states in the north of India. Half of its population live below the poverty line and suffer poor health status caused by a dysfunctional public healthcare system.

How guardians treat their children in North India is influenced by traditional norms. The strong patrilineal kinship system leads to a preference for sons and the disadvantaged status of female in the society. As a result, daughters are seen as a burden. So far, the positive impact female could have in a society through educational development has not been considered and illiteracy rates of women are much higher.

CHAPTER 4

LITERATURE REVIEW ON CHILD DEVELOPMENT AND GENDER INEQUALITY IN INDIA

4.1 INTRODUCTION

Basic healthcare is the right of every child according to the CRC 1989 (Appendix 1). In most developing countries, children lack basic healthcare and nutrition (Bajpai 2012; Chopra 2015). Chapter 4 provides an overview of the current state of research in the area of child survival and child development in North India. Emphasis is on the evidence of gender inequalities in healthcare provision for children under the age of five years in the study area. The causes of gender inequalities in children's healthcare are highlighted and the approaches that have been successful in eradicating them in order to boost the development of children.

4.2 CHILD SURVIVAL AND DEVELOPMENT

Child survival and child development are huge concerns of development worldwide. According to the World Health Organisation (WHO), six million children did not reach their fifth birthday in 2014 (WHO 2016b; UNICEF 2014b:11). Often child survival is measured by the child mortality rate, also known as the U5MR, and is used as indicator to evaluate child survival programmes (UNICEF 2012:1). The child mortality rate or U5MR refers to the death of infants and children below the age of five. This is different from the infant mortality rate (IMR), which refers to the death of a child within the first year of life (WHO 2016b). U5MR and IMR are correlated with socio-economic status and educational background of guardians (Black 2003:2226; Krishnan et al 2013:419; Victora et al 2003:233).

4.2.1 Data on child survival and deliveries

4.2.1.1 Under-five mortality rate

In 2015 the global average of U5MR was 43 per 1,000 live births (WHO 2016b). There is a huge difference in child mortality between high-income countries and low-income countries. The average U5MR in low-income countries was 76 per 1,000 live births in 2015, whereas the U5MR in high-income countries was 7 per 1,000 live births (WHO 2016b). Over the last few decades there has been

huge emphasis on promoting child survival by reducing the U5MR worldwide. Globally, the U5MR has more than halved, decreasing by 53% from 1990, but it did not reach the Millennium Development Goal (MDG) 4, which aimed at a 66% reduction (UNICEF 2014a:24).

The largest number of children in the world live in India and 20% of under-five deaths worldwide occur in India (UNICEF 2011:4). This means 1.83 million children in India die before they reach their fifth birthday. The national U5MR average is 53 per 1,000 live births (UNICEF 2014a:18). However, numbers vary enormously among states in India, and can be much higher than the national average. Causes that account for this under-five death are mainly preventable diseases, such as respiratory infections (pneumonia) and diarrhoeal diseases, (Black 2003:2279, Bhan 2013:172). The progress that is being made in the reduction of the U5MR in India since 1990 is shown in Figure 4.1 below.

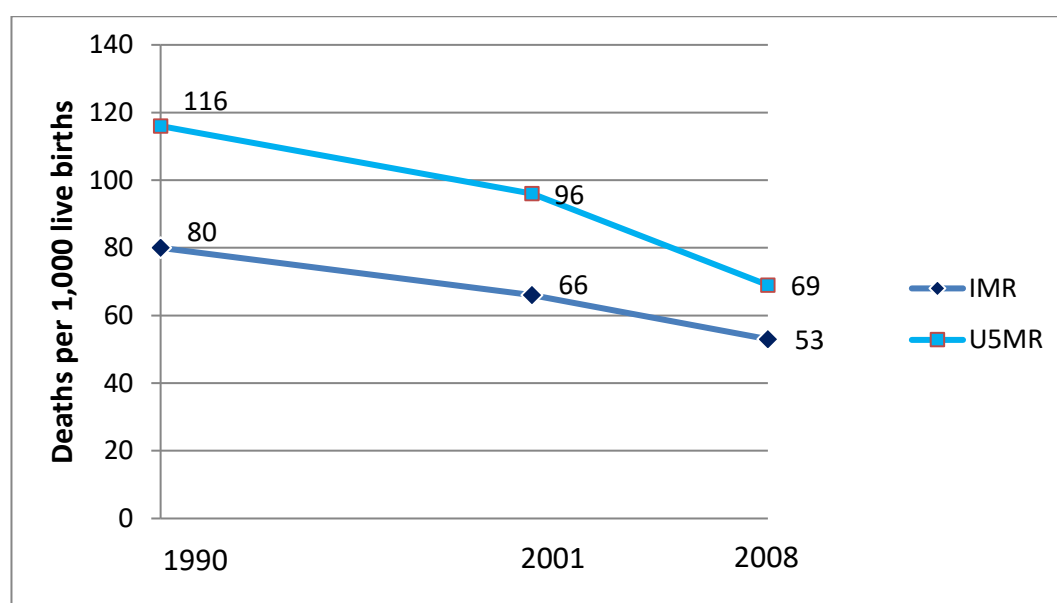


Figure 4.1: Child mortality in India (UNICEF 2011:4)

The U5MR declined between 1990 and 2008 by 34% and reached 53 mortalities per 1,000 live birth in 2013, as stated above (UNICEF 2014a:18). The progress India is making in improving child survival and reducing the morbidity of these diseases will have a significant impact on the SDGs as India makes up a large part of these numbers (UNICEF 2011:3).

When interpreting the data, it has to be kept in mind that there are high numbers of unreported cases, since many poor families do not register their newborns

in the government registry. The national birth registration rate in India is 41% for children under the age of five. In Bihar only 5.9% of male and 5.7% of female children under the age of five were registered after birth (NFHS-3). There is no significant difference in the registration percentages between male and female children. Children with educated mothers and fathers and those from the higher wealth quintiles are more likely to be registered (NFHS-3). Even so, it is the right of every child to be legally registered and officially recognised by the government, according to CRC Article 7 (Appendix 1).

4.2.1.2 Infant mortality rate

The IMR is the most sensitive indicator of children's health (UNCEF 2012:1). The IMR worldwide in 2015 was 4.5 million children (WHO 2016b), which makes up the major part (75%) of all U5MR deaths. Globally, the IMR has decreased from 63 per 1,000 live births in 1990 to 32 per 1,000 live births in 2015 (WHO 2016b).

Death during the first year of life is often caused by common childhood diseases such as pneumonia, diarrhoea, infectious diseases, and malnutrition. In 1990 the IMR in India was 80 per 1,000 live births. It declined to 53 per 1,000 live births in 2008 (UNICEF 2011:4), and reached 41 per 1,000 live births in 2013 (UNICEF 2014a:19). This is still considerably higher than the worldwide average.

Child survival at birth is greatly influenced if the mother attended antenatal care during pregnancy and had the opportunity of a clean delivery by a skilled birth attendant (Deb 2016:132). If the delivery takes place in a health facility with a skilled midwife or trained health worker, this improves the survival chances of the child and decreases morbidity and the risk of child stillbirth during labour and medical complications of the mother.

In India, 47% (2007–2008) of all deliveries take place in an institution with a skilled birth attendant (UNICEF 2011:9). However, in Bihar only 12–20% of the total deliveries take place at a medical institution (NFHS-3). In addition, according to NFHS-3 two thirds of women in Bihar do not receive antenatal care, which puts the mother and child's survival during pregnancy and at birth at risk.

4.2.1.3 The situation in East Champaran

A baseline survey was done between June 2014 and August 2014 in East Champaran (Blocks Raxaul, Adapur, Ramgarhwa) through Duncan Hospital. Raxaul Community Health Programme determined the IMR and sex ratio at birth (SRB) (chapter 4.3.1). The survey included interviews of 23,158 households and showed an IMR of 82 mortalities per 1,000 live births. This was almost double the IMR of 48 mortalities per 1,000 live births compared with the recorded number in the National Family Health Survey (NFHS-4) Bihar in 2015–16. This is a huge difference between the measured data of IMR in East Champaran and Bihar's average IMR. A possible reason could be that the situation of child healthcare in East Champaran is much worse than in other districts of Bihar. Another reason could be unreliable NFHS data. However, the question arises of how representative this study is, and calls for further research.

4.2.2 Health programmes in India

The standards of the Indian government's healthcare system were established by the Ministry of Health and Family Welfare in the National Health Mission (NHM), which was launched in 2013 with two submissions, namely the National Rural Health System (NRHM) and National Urban Health System (NUHM) (NHM 2016).

The structure of the health care system comprised these aspects (Kumar & Ray 2013:422–423):

- Community health centres (CHCs):

Four medical specialists with postgraduate degrees, first referral unit for primary healthcare (PHC) for a population of 80,000–120,000 people
Primary healthcare centres (PHCs): Act as referral unit for six sub-centres for a population of 30,000 people

- Health sub-centres (SCs):

Provide healthcare for the needs of the rural population for 5,000 people

Other important health norms have been established in the NHM:

- Free drugs and free diagnostic services:

Provision of free drugs service and free diagnostic service to lower the out-of-pocket expenditure on health

- National ambulance service:

Free service is provided everywhere in the country, which arrives within 30 minutes of call

- National mobile medical units (NMMUs):

Cover medically unserved areas

- Janani Shishu Suraksha Karyakram (JSSK):

Provides free transport, free drugs, free diagnostic, free blood, free diet at delivery in a public health institutions and for sick children up to one year

- Mother and child health wings (MCH wings):

Provide a capacity of 100/50/30 beds in high-case-load district hospitals for mothers to reduce the maternal mortality rate (MMR) (NHM 2016)

The health programme for children, namely the Integrated Child Development Scheme (ICDS), will be explained in more detail. It is a national programme to improve the health of mothers and children under six years of age and has been implemented since 1975 by the Indian Government (Chopra 2015:56). ICDS is seen as the world's largest community-child development programme, aiming at holistic development for children below the age of six by supporting their survival, growth and development (Chopra 2015:57). The Government of India

is committed to making the programme available nationally in order to attain equal opportunities for all Indian children and to achieve progress in the SDGs. The aim is to reach the most vulnerable children and pregnant mothers in rural areas, and urban slums (Chopra 2015:56–59; Bajpai 2012:47).

The programme focuses on improving health and nutrition to reduce the mortality, morbidity and malnutrition of children. Furthermore, it boosts the psychological, physical and social development of the child. The education of mothers in health and nutrition aims to improve the knowledge and practice of keeping the child healthy and nourishing it well (Nandini & Naresh 2006:80). The scheme is linked to primary healthcare services, including health check-ups, immunisation, vitamin A supplements, growth monitoring and supplementary feeding. These are all essential components in the development of a healthy child. The full range of services that are provided through the ICDS is illustrated in Figure 4.2 below.

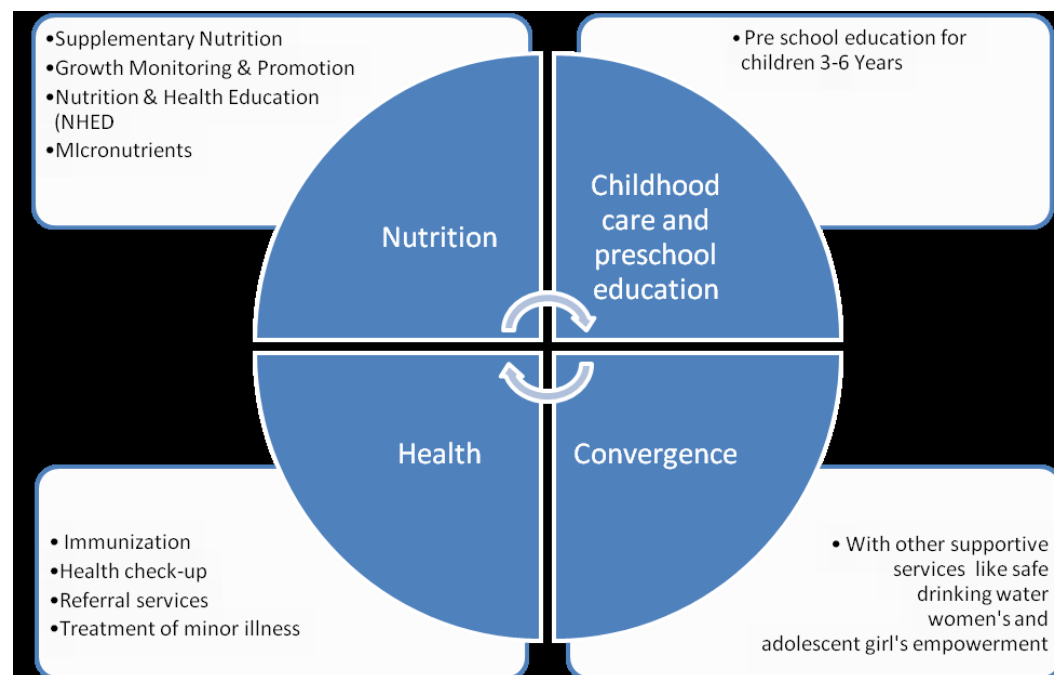


Figure 4.2: Integrated child development service (Republic of India 2013:2)

Currently, the programme covers 75 million children under the age of six in India. More than half participate in early learning activities such as preschool education for children aged between three and six. The services at village level are integrated in childcare centres called Anganwadi Centres (AWCs). The title of the responsible person is 'Anganwadi'. The costs of the ICDS per child per

year are about US\$10–22. However, more than 40 years after the development of the ICDS, quantitative coverage is disastrously inadequate (Bajpai 2012:48). In most parts of the country the Anganwadi does not work the whole day and earns wages below those of an unskilled labourer. Qualitatively the programme is oriented towards formal education rather than playing to promote the personal development of children (Bajpai 2012:48).

The ICDS in Bihar reaches 6.5 million children below six years, that is, 34% of all Bihar's children below six (Census 2011) with their activities (Republic of India 2013). However, the implementation of the ICDS in Bihar faces many challenges, and problems can be found at various levels. Of 394 ICDS projects that were sanctioned in Bihar, only 183 are operational, because funds provided through central government hardly reach the state level for usage. The quality of care children receive is not always what the standards require. The staff lack training on how to run the AWCs. In the AWCs themselves, lack of materials, can be observed, including cooking utensils. The conditions for children are worse; they hardly have space to sit. The budget to rent an AWC is limited. Health checks such as growth monitoring are seldom done because trained staff are not available (Nandini & Naresh 2006:83). They receive their salary only twice a year, which does not encourage them to fulfil their work duties well (Nandini & Naresh 2006: 82). The idea of the ICDS is good, but the implementation, especially in Bihar, is a challenge.

In Bihar the infrastructure and human resources to provide healthcare according to the standards have many gaps (Kumar & Ray 2013:424). So far it has not been not possible for the state government in Bihar to build a health infrastructure that is adequate to provide health services according to the national norms (Kumar & Ray 2013:425).

This leaves Bihar and many other parts of India without a functioning government healthcare service, and therefore the population have to pay for services of private providers out of their own pocket. In 2000 in India about 33 million people fell below the poverty line because they had to pay healthcare themselves. Therefore, out-of-pocket expenditure is seen as an inefficient way

of financing healthcare in developing countries as it pushes households into poverty (Garg & Karan 2009:116–117; Shahrawat & Rao 2012:213).

4.3 GENDER INEQUALITY

Gender inequality of children raises the question of the guardians' involvement and responsibility in caring for and protecting their children's health and survival. The observed gender inequalities in sex ratio at nativity, in child survival and in child health (nutritional status and immunisation status) and the effects of the education of mothers on gender inequality are reviewed in Chapter 4.3.1 – 4.3.6.

4.3.1 Gender inequality in sex ratio

Sex ratio is an important indicator of aspects of gender relations, sex discrimination and a link to the cultural behaviour in a society, and correlates with the socio-cultural position of women (Dréze & Sen 2010:272). The sex ratio demonstrates the number of females per 1,000 males (Dréze & Sen 2010:229; World Fact Book 2015). Worldwide, the human sex ratio is approximately 952/1,000 males (Dréze & Sen 2010:230). In India the sex ratio is 940/1,000 males and in Bihar it is 916/1,000 males (Census 2011). India has the lowest sex ratio of its surrounding countries (World Fact Book 2015).

A low sex ratio could reflect an excess of female mortality for various reasons, which might be related to gender discrimination (Dréze & Sen 2010:69, Das Gupta et al 2003:154). Over the last years there has been a shift from mortality inequality to nativity inequality owing to sex-selective abortion (Krishnan et al 2013:419; Sahni 2008:1; Dréze & Sen 2010:258). Therefore, the low sex ratio in India reflects a lower female birth rate, and not a higher rise in female child mortality.

The sex ratio is very different in the various regions of India shown in Table 4.1. There is a predominantly low sex ratio in North India. This makes it clear that the low sex ratio is not a natural effect in India. Otherwise, it would on average be the same nationally.

Table 4.1: SEX RATIO / SEX RATIO AT BIRTH IN NORTH AND SOUTH
INDIAN STATES

	Sex ratio 2001	Sex ratio at birth 2001	Sex ratio 2011	Sex ratio at birth 2011
India	933	927	943	919
Bihar (NI)	919	942	918	935
Haryana(NI)	861	819	879	834
Uttar Pradesh (NI)	898	916	912	902
Punjab (NI)	876	798	895	846
Tamil Nadu (SI)	987	942	996	943
Kerala (SI)	1058	960	1084	964

Source: Female/1,000 male; NI: North India; SI: South India (Census 2001/Census 2011)

Factors that are regarded as helping to reach and improve an equal sex ratio are a high literacy rate of women, participation of women in social and professional activities, and fewer patrilineal traditions (Dréze & Sen 2010:232). A positive example with a high sex ratio is Kerala (SI), where women in the society have a more liberated position than in North India.

The explanations for the parental preferences for sons and the way in which it influences the sex ratio are complex. Dréze and Sen focused on aspects such as a low rate of labour participation by women, gaps in literacy rates, restricted female property rights, and girls being separated from the biological family when they marry (Dréze & Sen 2010:231). These are cultural aspects because of the strong patrilineal kinship system in India (Chapter 3.2.1).

Krishnan et al found that the more wealthy and the more educated groups are, the lower the sex ratio at birth (Krishnan et al 2013:421). The use of ultrasound during pregnancy (for sex determination) was strongly related to parental education and wealth index (Krishnan et al 2013:424). Moreover, an increase in income levels and education in the context of patrilineal social and cultural

structures results in misuse of resources, for example for sex-selective abortion. Caution should be taken in this case that the lower socio-economic imitate the more advantaged wealthier groups and more gender discrimination would be observed when their socio-economic status raises (Krishnan et al 2013:424).

From South Korea and China, it appears that even when women receive education, the sex ratio is persistently low. This shows that sex-selective abortion does not depend on the empowerment on women. Instead, it has its roots in the culture and calls for a review of cultural norms and values (Dréze & Sen 2010:258).

The sex ratio is higher among the 'lower' castes: Assuming that lower caste means less household wealth, this justifies that the gender inequality is less pronounced in the poorer households. Poverty reduction may add to female disadvantages and economic progress alone does not reduce gender inequalities (Dréze & Sen 2010:244–245). For example, Haryana (879/1,000) and Punjab (895/1,000) (Census 2011) both experienced rapid economic growth, with an increase in per-capita income. However, they still have the lowest sex ratios in India (Dréze & Sen 2010:245).

In terms of gender inequality and religion, research of Muslim influences in sex ratio found no evidence that discrimination against women is greater among Muslim-dominated areas (Dréze & Sen 2010:234). Survival of girls under five does not vary much between Muslims and Hindu in North India (Dréze & Sen 2010:272).

The sex ratio at birth in East Champaran was measured in the baseline survey conducted by the community health department at Duncan Hospital. The overall calculated sex ratio at birth was 922/1,000. This reflects a slight difference compared with NFHS-4 East Champaran 2015–16, which was 934/1,000. A much higher difference exists in NFHS-3, where the sex ratio number was 893/1,000 in East Champaran. The results of sex ratio blocks Raxaul, Adapur, Ramgarhwa are shown in the Table 4.2 below.

Table 4.2: SEX RATIO AT BIRTH RAXAUL, ADAPUR AND RAMGARHWA

Block	Sex ratio at birth (number of girls per 1,000 boys)
Raxaul	801
Adapur	883
Ramgarhwa	1,082
Total (average)	922

Source: Baseline survey 2014

The sex ratio showed a wide variation in the three blocks in which the sex ratio at birth was measured, with a much higher sex ratio in Ramgarhwa than in Adapur and Raxaul. The reason might be that Ramgarhwa is a rural area. The lowest sex ratio was found in Raxaul. The differences in the proportion of women that underwent abortion are shown in Table 4.3.

Table 4.3: WOMEN THAT HAD AN ABORTION

Block	women that had an abortion
Raxaul	5%
Adapur	5%
Ramgarhwa	1%

Source: Baseline survey 2014

The reason for these differences might be that in Raxaul and Adapur there are more opportunities to access private clinics and diagnostic centres than in Ramgarhwa. This area is more rural and people have less opportunity to undergo abortion owing to decreased access to clinics. Combining the results of Tables 4.2 and 4.3, it may be concluded that sex-selective abortion could be one of the main reasons for the adverse female sex ratios in Raxaul and Adapur blocks.

4.3.2 Gender inequality in nativity

The availability of modern technology for sex determination has made it common in some parts of Asia, including India, China and South Korea, for parents to decide the sex of their children through sex-selective abortion with a preference for boys. This results in gender inequality in the sex ratio at birth, with a lower number of females in society (Jha et al 2006:211; Borooah 2004:1791; Arnold et al 1996). A low sex ratio at birth is one cause of the 'missing girl' phenomenon, which was analysed by Das Gupta (Das Gupta 2009:8). Over the last decades, the 'missing girl' phenomenon has increased in many countries of South and East Asia, including India, China and South Korea (Das Gupta 2009:2; Sen 1990; Sen 1992:587-588).

Gender inequality therefore starts before birth with gender-selective abortion. According to Karkar, 12% (180 000) of Indian foetuses are aborted every year because of sex determination (Karkar 2015:104). The UN estimated that a much higher number, namely 780,000 girls per year, are aborted illegally in India (Anjanamma & Nagaraja 2015:657). As stated, the Indian Parliament prohibited sex determination, but it appears that enforcement of the law has been neglected (Krishnan et al 2013:425). It is widely known that sex-selective abortions and other methods of female infanticide take place all over India (Dréze & Sen 2010:257–258; Jha et al 2006:211, Kurtz & Kurtz 2015:222-225). Even the police do not enforce the law to stop sex determination and sex-selective abortion. Instead, it was mentioned that the police collect bribes to earn extra money from doctors that are violating the law (Jha et al 2006:211; Kurtz & Kurtz 2015:225).

In a male-dominated society such as India, gender inequality is already promoted before the birth of a child (Dréze & Sen 2010:257; Jha et al 2006:211; Dyson & Moore 1983:43). Men and women have strong desires for sons rather than daughters (Das Gupta et al 2003:156). In practice it is even reported that in areas such as Punjab and Haryana in north west India mobile ultrasound units visit rural areas to determine the sex of unborn children. In Indian states where sex-selective technology was available, these showed the highest differences in sex ratios (Aparna & Thakur 2012:379). Studies have shown that parents would rather take out a loan for sex determination, followed by an

abortion, as it saves them money for dowries later (Krishnan et al 2013:424). A saying advertises sex determination thus: 'Pay 500 rupees now and save 5 lakh (500 000) of rupees later' (Kurtz & Kurtz 2015:222).

In Duncan Hospital there are about 6,000 deliveries per year. In the period April 2014–March 2015 there were 5,463 deliveries, 13 maternal deaths and 245 stillbirths. In total, 2,900 male and 2,563 female children were born. This accounts for a sex ratio at birth of 884 per 1,000 males. In the previous year from April 2013 to March 2014 the sex ratio at birth was 834 per 1,000 live births (2,424 female births and 2,904 male births). This reflects a clear difference between the sex ratio at birth in the hospital and that in the baseline survey (922/1,000). More boys are being delivered in the hospital compared with the general sex ratio at birth in East Champaran (922/1,000) and Bihar (935/1,000) (Census 2011). It may be assumed that parents prefer delivery in hospital when they give birth to a boy child. This would presuppose that they know the sex of the child before they give birth, even though this practice is prohibited in the country.

4.3.3 Gender inequality influencing child survival

Gender differences in child survival are reported in many developing countries (Klasen 2004:3). South Asia has extremely poor health provision for female children. They are 30–50% more likely to die before the age of five years than their male counterparts (Cleason et al 2000:1194, Dréze & Sen 2013:248; Victora et al 2003 et al:235; Klasen 2004:10). One reason may be the failure of guardians to provide adequate healthcare for equally their girls and boys. It has been observed that female children who are sick are brought to less qualified doctors, and only in a very advanced stage of illness (Victora et al 2003:235). Parents would spend less money on a daughter than a son. Several researchers found that the expenditure on healthcare for a male was 2.3 times higher than that of a female in the same family (Das Gupta 1987:77; Victora et al 2003:235; Arnold et al 1996:15; Najnin 2011:530). Guardians with female children used cheaper healthcare providers than for male children. They preferred private providers for sons, which are more expensive, but are expected to deliver more satisfactory care (Willis et al 2009:62). The social structure causes disadvantages for girls in receiving medical care, disease

prevention (immunisation) and nutrition (Dyson & Moore 1983:51), which leads to differences in child mortality, and confirms discrimination against females (Das Gupta 1987:77; Klasen & Wink 2003:297; Chen et al 1981:64; Croll 2000:10; Sen 1990). The inequalities from which children suffer are reflected in gender differences in the child survival data (U5MR) and (IMR).

4.3.3.1 Gender inequality child survival data in India

A comprehensive representation of child survival data in India would be incomplete without attention to the numerous differences between states and differences related to sex.

Biological differences between males and females account for some of the gender gaps. The literature suggests that males have biologically more survival difficulties in infancy compared with females (Klasen 2004:6). This means that an equal IMR in relation to gender would be an indication of gender bias favouring males (Klasen 2004:6).

Normally, boys have a higher mortality rate than girls at any period of life, but in South Asia girls have higher mortality rates during childhood (UNICEF 2012:62). In 2013, India's national average U5MR for gender was 51 males per 1,000 live births to 55 females per 1,000 live births (UNICEF 2014a:19), showing only a slight difference of four deaths, which may not be statistically significant. .

To explain the numerical differences in U5MRs in India, the U5MR of two North Indian states (Bihar; Uttar Pradesh) and two South Indian states (Kerala; Tamil Nadu) are presented in Table 4.4 (NFHS-3 1999–2005) and Table 4.5 (Census 2011).

Table 4.4: CHILD MORTALITY RATES IN INDIA NORTH INDIA, SOUTH INDIA 1999-2005

U5MR 1999– 2005	India	North India		South India	
		Bihar	Uttar Pradesh	Kerala	Tamil Nadu
Male	73	75	87	14	32
Female	80	97	111	19	45
Total	76	85	99	17	39

Source: NFHS-3 1999-2005 ⁴

Table 4.5: CHILD MORTALITY RATES IN INDIA, NORTH INDIA, SOUTH INDIA 2011

U5MR 2011	India	North India		South India	
		Bihar	Uttar Pradesh	Kerala	Tamil Nadu
Male	55	60	71	14	28
Female	64	68	87	16	26
Total	59	64	79	15	27

Source: Census 2011

The states in northern India show much higher U5MRs than the southern Indian states. Therefore, despite the progress of the U5MRs of the national averages, they hide disparities between states and many children continue to suffer (UNICEF 2014b:2; Dréze et al 2007:377).

To explain the sex numerical differences, the IMR of two North Indian states (Bihar; Uttar Pradesh) and two South Indian states (Kerala; Tamil Nadu) are presented in Table 4.6 (NFHS-3 1999–2005).

⁴ A NFHS was done in India in 2015/16. Currently the data have not been released.

Table 4.6: INFANT MORTALITY RATES IN INDIA, NORTH INDIA, SOUTH INDIA 1999-2005

IMR	India	North India		South India	
		Bihar	Uttar Pradesh	Kerala	Tamil Nadu
Male	59	56	69	19	28
Female	59	65	77	13	36
Total	59	61	73	16	32

Source: NFHS-3 1999–2005

Evidence suggests that increased female child mortality occurs mainly after the age of one year (Dréze & Sen 2010:233). The gender pattern in the first year is less unequal, meaning that the IMR and the neo-natal rate show less difference between male and female ratios compared with the U5MR of the same year (Dréze & Sen 2010:233; Table 4.6). The effect of preferential treatment of boys and the neglect of girls in nutrition and healthcare provision appears later in childhood (Dréze & Sen 2010:233).

In some states in India, the reduction of child mortality rates simultaneously increased the sex ratio, which demonstrates improved survival chances of girls for example in the state of Kerala (Dréze & Sen 2010:237). If the lower sex ratio did not disappear with the decline in child mortality rate, this suggests that gender inequality caused by girl discrimination does not automatically disappear with the decline of child mortality rates (Dréze & Sen 2010:238). In northern India the improvement of child survival has not been simultaneously successful in removing discrimination of girls (Table 4.4; Dréze & Sen 2010:238).

4.3.3.2 Gender inequality in healthcare provision in Duncan Hospital

Admission numbers of children under five years according to sex at EHA Duncan Hospital Raxaul have been monitored in the period from April 2014 - March 2015 in the paediatric ward. 75% of the total admissions were male and 25% were female children (hospital internal data). Assuming that boys do not

get sick more often than girls, the data could be explained by the behaviour of parents seeking healthcare. With sons, there is an increased likelihood of seeking treatment in a private hospital than when a daughter is sick (Bhan et al 2005:723).

A similar feature shows the admission numbers of newborns according to sex in the nursery of Duncan Hospital directly after birth. In the period April 2014–March 2015, 82% admitted newborns were male and only 18 % were female (hospital internal data). This shows a significantly higher number of male admissions in the private hospital after birth for medical check-ups. Again, this may indicate that parents are more likely take a son to a private hospital than a daughter. This may cause higher risks of morbidity and mortality among female children when they are denied medical care directly after birth.

4.3.4 Gender inequality and nutritional status

The nutritional status in childhood is directly linked with child survival and child development. Globally, about half of child mortality under the age of five is caused by malnutrition. Children suffer from malnutrition when they are not able to receive an adequate amount of food in quality or quantity (Regan 2012:214). This can lead to life-threatening conditions. Severe acute forms of hunger and malnutrition include marasmus (wasting) and kwashiorkor (oedema because of protein-energy malnutrition) (UNICEF 2015). Worldwide, in 2014 an estimated 16 million children under the age of five were severely undernourished (WHO 2016b). If children sink into malnutrition during the first five years of life, and especially the first two, they develop ill health and poor learning abilities (Dréze et al 2007:378). These limitations are difficult to overcome in later years and affect children's development and wellbeing (Dréze et al 2007:378).

A chronic form of malnutrition occurs over time, and is a growth failure that is measured by the height-for-age score. The child is normal in proportion, but shorter than normal for his or her age. This is called stunting (UNICEF 2015). Worldwide there are 159 million stunted children (WHO 2016b), two thirds of them living in Asia (UNICEF 2014b).

India accounts for one third of the world's children who suffer from malnutrition and more than half of Indian children are undernourished, as calculated by the

weight-for-age criteria (Dréze & Sen 2010:67). Malnutrition is one of the main reasons for children under five not fulfil their potential and contributes to child mortality and morbidity and mortality (WHO 2016a). A healthy nourishment in the first years of life is important for adult health, wellbeing and productivity (WHO 2016a).

In Bihar more than half of the children are underweight, according to the weight-for-age criterion. In the Bihar NFHS-3 of children between the ages of six months and six years, 22% of male children and 27% of female children were severely malnourished, showing a gender difference. In moderate malnutrition there was also a slightly higher percentage of malnourished females, namely 58% compared with 54% malnourished male children (NFHS-3 Bihar).

In South Asia, including India, various studies have researched gender inequality of nutrition in childhood (Chen et al 1981; Griffiths et al 2002; Sen & Sengupta 1983; Miller 1981; Khan et al 1989; Bajpai 2012:13). A significant gender difference in the nourishment of children was first found in studies from Bangladesh Chen et al (1981) and Miller (1981), showing that females aged between 0 and 5 years were given less food than males. Sen and Sengupta (1983) found that villages in India with better overall nutritional records showed higher sex discrimination in the nourishment of the children.

Griffiths compared the nutritional status of three Indian states, namely Tamil Nadu (South India), Uttar Pradesh (North India), and Maharashtra (Middle India). The results did not give evidence of sex-selective discrimination against the female children in terms of nutritional status (Griffiths et al 2002:779). This supports the argument that sex differences in nutritional status are a biological feature rather than a socially related occurrence (Griffiths et al 2002:785). For future research, it would be more meaningful to measure weight for height, as it is regarded as more appropriate in gender differences compared with weight-for-age score (WHO 2016b).

However, an indirect form of discrimination against females is early weaning of breastfeeding. If the child is a daughter, there is a strong desire to become pregnant again soon, and the mother stops breastfeeding as soon as she has

conceived (Griffiths et al 2002:779; Bajpai 2012:13). This may explain the neglect of females in nutrition (breastfeeding).

If women are discriminated against in a family, this can lead to undernourishment. Under this condition there is a high risk of women bearing children with low birth weights, which increases the risk of the child suffering from malnutrition from the start of life and affects the child's development in early childhood. (Dréze & Sen 2010:70).

4.3.5 Gender inequality and immunisation

Immunisation in childhood protects against illness and supports physical, emotional and cognitive development (Singh 2012:6). Therefore, immunisation is seen as a cost-effective intervention in public health to prevent disease and disability caused by vaccine-preventable diseases in childhood. About 20% of the annual under-five deaths are caused by vaccine-preventable diseases (Singh 2012:6). It is obvious that when children have the chance to grow up healthy, they do better at school and are more productive adults (Singh 2012:6). Mainly in developing countries, the poorest proportion of the society are not fully covered by immunisation (Pande & Yazbeck 2003:2075; UNICEF 2011:5)

A notable achievement in child health through immunisation is the worldwide reduction of measles deaths by 80% between 2000 and 2013. In 1990 worldwide immunisation coverage was 73% and rose to 84% in 2013 (UNICEF 2014b:17).

In 1985–86 India implemented the universal immunisation programme (UIP) to vaccinate all children against the six childhood diseases, namely diphtheria, tetanus, pertussis (DTP3) poliomyelitis (Pol3), tuberculosis (BCG) and measles (MCV). If a child receives all these vaccines, it is fully immunised. In NFHS-3, it was estimated that 44% of 12–23-month-old children in India were fully immunised (NFHS-3; Chopra 2015:30), most were partially immunised, and only 5% had not received any vaccination at all (NFHS-3) (actual data of the NFHS-4 not yet available). However, in South Asia, India has the highest percentages of children that are not immunised in (Dréze et al 2007:380), as shown from year 2006 in Table 4.7 and year 2014 in Table 4.8.

Table 4.7: VACCINATION DATA INDIA AND SOUTH ASIA 2006

Vaccination	Bangladesh	Bhutan	Nepal	Pakistan	Sri Lanka	India
BCG	5	8	15	20	1	<u>27</u>
DTP3	15	11	20	35	3	<u>36</u>
MCV	23	13	27	33	4	<u>44</u>
Pol3	15	10	20	<u>35</u>	3	30

Source: UNICEF (2006) State of the World's Children (Immunisation percentage of children under three years who have not received the stated vaccine. The underlined data are the highest percentages)

Table 4.8: VACCINATION DATA INDIA AND SOUTH ASIA 2014

Vaccination	Bangladesh	Bhutan	Nepal	Pakistan	Sri Lanka	India
BCG	5	5	4	<u>13</u>	1	<u>13</u>
DTP3	4	3	10	19	1	<u>28</u>
MCV	4	5	14	1	1	<u>26</u>
Pol3	4	3	10	25	1	<u>30</u>

Source: UNICEF (2014) State of the World's Children (Immunisation percentage of children under three years who have not received the stated vaccine. The underlined data are the highest percentages)

The northern states of India had poorer immunisation levels than the southern states (Singh 2011:872). Additionally, gender inequality in immunisation rates was higher in the northern states (Singh 2011:872). In Bihar the immunisation coverage of the children that were fully immunised was 12% in NFHS year 1998–99, 33% in NFHS year 2005–06, and 62% in NFHS year 2015–16. This shows enormous improvement in the coverage rates with an increase of 29%, but is still below the national average in immunisation coverage (Kumar & Ray 2013:420).

The NFHS-3 of Bihar reports data of fully vaccinated children according to gender, showing a significant gender difference with 38% male fully vaccinated children and 27% female fully vaccinated children (NFHS-3). Other studies in

various areas of India found a gender difference in immunisations, with the evidence that girls are less covered than boys (Pande & Yazbeck 2003:2076; Borooah 2004:1719; NFHS-3). This feature is found throughout the country (Pande & Yazbeck 2003:2084) with worst performances in the northern states, for example Rajasthan, Uttar Pradesh and Bihar. Generally, Pande found that immunisation levels among poor female children in rural areas were the worst (Pande & Yazbeck 2003:2084, Kumar & Ray 2013:418). Even though parents do not have to pay for the vaccines, because they are provided by government, other costs may be involved, for example travel fares, and time for travelling and waiting, which may mean time taken off work. The gender difference in vaccination rates with a lower coverage of girls reflects the persistent discrimination against women in Indian society, and is not a result of the dysfunctional health system (Pande & Yazbeck 2003:2086).

This discrimination could be observed at Duncan Hospital outpatient centre. Between April and June 2014, 2018 children received basic immunisation: 1284 (64%) were male and 734 (36%) female children (hospital internal data). The much higher number of males that were vaccinated leads to the assumption that parents prefer to bring their boys for preventive immunisation rather than girls. The difference also might be influenced by the general gender inequality in sex ratio in northern Indian states, including Bihar.

In the government hospital of Raxaul, vaccination services are provided and an outreach programme delivers immunisation service directly to the surrounding villages. Over a three-month period from April to June 2014, a total of 11 048 children received one of the basic vaccinations: 5944 (54%) were boys and 5104 (46%) were girls (internal data PHC Raxaul Hospital). In these data a clear numeral gender difference is present, but less obvious compared with the differences in Duncan Hospital. This may be explained through reasoning that when a team comes directly to the village through the outreach service, more guardians are likely to vaccinate boys than girls.

4.3.6 The effect of the education of mothers on gender inequality

The education of women has had many positive effects on women, including children's healthcare. The ability of women to earn an income enhances their

social status, making them less dependent on their husbands and parents-in-law (Dréze & Sen 2010:245–246). The educational development of women is a relevant aspect in gender inequality. In India it is the women's role to fulfil the household duties (Dréze & Sen 2010:251). Men are less likely to do domestic chores. When women are employed, they have less time to care for children, which is seen as a disadvantage (Dréze & Sen 2010:252). However, the labour force of women could raise their value and therefore improve their survival chances when the benefits of women educational development are considered (Dréze & Sen 2010:252). Beside this, an advantage of educated women is that they are likely to be less dependent on sons as a source of social status and old age security (Murthi et al 1995:748).

Dréze and Sen researched the connection between human deprivation in lack of education, high illiteracy rates, malnourishment and social inequality. Educational underdevelopment, for example high rates of illiterate women, and social inequality are correlated with the high rate of malnutrition of their children (Dréze & Sen 2010:70). The education of women is found to be the most relevant factor in child health, including good nutrition. Research into nourishment among literate and illiterate mothers found no gender discrimination among literate mothers (Borooah 2004:1728). This would mean fewer gender differences in educated mothers in the nourishment of their children.

Another interesting observation is the connection between the education of women and child health. It seems obvious that with the education of women, child mortality rates would decline, and gender differences in child mortality rates would disappear (Bhan et al 2005:722). That this is not true of India has been proved in several studies.

A study in west India revealed that gender differences in U5MR are found in literate and illiterate groups, making it clear that education alone would not combat gender inequality (Pandey et al 2002:308).

The gender inequality in the utilisation of hospitals increased when mothers were more educated (Bhan et al 2005:723). Educated mothers are 33% more

likely to bring their sons to the hospital. Educated women probably favour sons, which reflects the prevailing cultural norms in gender (Bhan et al 2005:723).

In rural North India improved education of women and a higher household income did not automatically commit these resources to female children in a male-preference society (Krishnan et al 2013:424). Therefore, guardians would still invest more in their sons than daughters, even when money is not an issue.

In a study by Bhan, it was found that maternal education and rising economic status reduced the general U5MR and IMR, but not the gender differences in mortality rates (Bhan et al 2005:722; Murthi et al 1995:748). Besides, in the extremely patrilineal regions in India, there is more discrimination against daughters by educated women than uneducated women (Karkar 2015:105).

The underlying causes of female discrimination such as urbanisation, a high level of male literacy, non-existent medical services, and a low level of poverty were found to be associated with an increase in female disadvantage in child survival. The poorest children of the population experience less gender inequality in mortality rates than slightly richer groups (Murthi et al 1995:752). It seems female disadvantage decreases in poorer communities, possibly owing to less emphasis on cultural values. Through this pattern a danger can be seen when the socio-economic status improves through education and work of women. When the capacity of resources increases, and the society has an opportunity to focus on cultural values, this could translate to a strengthening the son preference in a patrilineal society. According to these conditions, the improvement of socio-economic factors and economic growth do not automatically lead to a reduction in gender inequality (Dréze & Sen 2010:246).

It is not clear which variables in India work effectively to reduce gender inequality. Sen considers social and cultural aspects, women's property rights and aspects of the kinship system (exogamy and endogamy) as the most important influencing conditions (Dréze & Sen 2010:247). However, he argued in his findings that variables that are related directly to women's agency such as education and labour-force participation would reduce gender bias in child survival (Dréze & Sen 2010:248). This positive connection conflicts with what was found by Krishnan et al (2013) Karkar (2015) and Pandey et al (2002),

namely that the gender difference would not decline through education and literacy (above).

4.4 CONCLUSION

The implementation of child rights in India regarding child survival and child development are below standard. This is reflected in the indicators of U5MR, IMR and numerous differences related to gender.

The neglect of female children in healthcare provision is an obvious feature in North India. Female children are less likely to receive immunisation coverage and health check-ups after birth. Guardians are less likely to bring female children to qualified doctors in a private hospital. This reflects decreased willingness to spend money on healthcare for female children.

The underlying factors that lead to female discrimination in children are vague. Correlations with cultural traditions seem to be pertinent in this matter. Gender differentials did not have not the tendency to disappear over time with the educational development of women and increase in their income. On the contrary, it was found that when the northern states were compared with those of the south, the underlying feudal social structures and attitudes worsened gender inequality (Krishnan et al 2013). Various studies have shown that gender bias is not correlated with socio-economic conditions such as poverty and income level. Instead, it is determined by social norms. Because of the strong son preference, parents are not ready to commit resources to girls and tend to deny curative healthcare (Pandey et al 2002; Willis et al 2009; Krishnan et al 2013:424).

The education and empowerment of women alone might not serve to remove gender inequality in sex ratios and child mortality rates. The study will help to gain knowledge in the reasons for discrimination against females in North India.

CHAPTER 5 RESEARCH DESIGN AND METHODOLOGY

5.1 INTRODUCTION

This chapter describes the research design of the study and explains how the researcher collected and analysed empirical data to draw up findings and conclusions to ensure validity and reliability. The primary research data were collected through the qualitative research method. Secondary research data, in the form of a literature review, were presented mainly in the third and fourth chapters and complement the primary research. The research information was then compared with what children are entitled to according to the child rights approach. To answer the research question, secondary research objectives were defined in such a way that they led to the achievement of the primary objective.

5.2 RESEARCH DESIGN AND METHODOLOGY

Depending on the research question and research objective, quantitative or qualitative methods, or both, namely 'mixed methods', may be appropriate. This study is embedded in a qualitative paradigm of social science research as it aims to explore human behaviour. Qualitative research is used to study a phenomenon in depth. It operates inductively and has the advantage of developing and deepening theories, while finding new meanings (Creswell 2014:16).

The epistemology formulated by Kuhn forms the background of the methodology. Epistemology means the theory of knowledge aimed at discovering the meaning of knowledge. According to Kuhn, research is based on certain assumptions or paradigms. Science is grounded in academic achievements in the past, from which cumulatively other scientific findings are derived (Kuhn 1976:25). One important aspect of Kuhn's epistemology, as opposed to quantitative research, is that the researcher is part of the research process, and is not a neutral observer (Kuhn 1976:19). In social science, a neutral approach is not possible since a human being lives and acts in a certain context and is not understandable outside this context (Lamnek 1995:13).

The research process may be explained by 'Mouton three worlds' framework (Mouton 2004:137–143). The first world is that of 'everyday life'. Problems that are recognised here are the beginning of the research process itself. In the present case, these are obstacles to gender equality in North India. In the second world, namely the 'world of science', the methodological approach is defined and the procedure in the field of research is described with the use of interviews, questionnaires, obtained data and data analysis. The third world is called 'meta science', and consists of reflections on the nature of science.

Various methods can be used for qualitative research, namely different forms of interviews, group discussions, ethnographical approaches and content analytical procedures (Hug 2001:22). Semi-structured interviews and FGDs were used as methods for this qualitative research (Chapter 5.4).

The researcher used secondary data of specific aspects: gender-related child mortality rates, nutrition and vaccination data according to sex differences. In addition, literature on gender inequality and healthcare in India and surrounding countries was reviewed and used to build an understanding of the topic and to identify gaps of knowledge in this area. The literature review included journals, books and articles searched by the keywords 'gender inequality', 'son preference', 'healthcare', 'health-seeking behaviour', and 'South Asia'. The main access for the literature search was the central library of Zurich, Switzerland.⁵ These articles led to other references on the topic for a comprehensive overview of the literature review.

5.3 JUSTIFICATION FOR THE RESEARCH METHOD

The research question requires a comprehensive in-depth method of empirical research to explore guardians' involvement in providing healthcare for their dependants. It is not enough to rely on a literature review. The explanatory qualitative research design was used to provide a holistic analysis of the research problem (Creswell 2014:4).

⁵ All types of literature can be searched with URL http://www.recherche-portal.ch/primo_library/libweb/action/search

The qualitative approach enabled research of the subjective reality of the participants, and the results were inductive, which means that single conditions led to generalised norms or theories (Faix 2007:69; Creswell 2014:14). To reflect on the behaviour of the guardians in seeking healthcare for their children, in-depth interviews are appropriate to gain qualitative data, as potential obstacles to gender equality were studied.

A qualitative research method is appropriate to answer the research questions and explore the obstacles to gender equality in East Champaran of Bihar, North India, in relation to the right to healthcare for children under five. Exploring these obstacles calls for asking for the reasons with the question word 'why' through a qualitative approach.

In qualitative research, one phenomenon is studied in depth. Various perspectives and explanations of people's behaviour patterns, and their contexts and cultural background are explored. This is called 'thick description' and adds to the validity of the study (Creswell 2014:202; Rice & Ezzy 2001:13–14). Thick description was further developed by Geertz in 1973. Since then, thick description has gained recognition in social science (Rice & Ezzy 2001:13).

Validity of the study is provided by various types of triangulation. With triangulation a phenomenon is studied in its complexity and achieved accuracy of the findings (Rice & Ezzy 2001:38). Through the literature review and qualitative research approach, FGDs and semi-structured interviews, data triangulation was applied, which means that various methods and data sources were used to strengthen validity (Creswell 2014:201; Rice & Ezzy 2001:38). Different perspectives of the research were explored through the involvement of a joint researcher living in the study area. This is called researcher triangulation, which raises the validity of the study (Rice & Ezzy 2001:38).

Empirical work in the intercultural field, particularly in the management of open interviews, is subject to numerous confounding factors, such as the influence of different languages. In this study, the researcher did not speak the local Bhojpuri language. That is why she was not able to conduct the interviews

herself. This also made it impossible to interpret facial expressions and gestures during the interview process. The researcher lived for eight weeks in the study area, which gave some inside into the cultural context but limited interpretation of the interview answers. However, qualitative research is influenced by the researcher and the ways in which he or she notices, explains and interprets information (Helfferich 2009:22). The accuracy of the findings was supported through researcher triangulation. The greater the experience one has with the participants in the study setting, the more valid the findings (Creswell 2014: 202). That is why the interpretation and analysis of the qualitative data in this study were discussed and cross-checked with a joint researcher, who worked for more than two years in the study area, and had greater insight into North Indian culture.

5.4 RESEARCH TECHNIQUES OF QUALITATIVE RESEARCH

Qualitative research intends to collect data directly from people by talking to them and observing their behaviour and actions (Creswell 2014:185). Usually multiple sources of data are used and the research does not rely on a single source (Creswell 2014:186).

There are various ways in which interviews can be conducted to collect qualitative data, such as narrative interviews, structured and semi-structured interviews, key informant interviews, FGDs and biography interviews (Creswell 2014:190). The techniques used in this study were FGDs and semi-structured interviews with key informants. The reasons that these forms of interviews were seen as appropriate for this research are explained below.

5.4.1 Semi-structured interviews

A semi-structured interview is a useful method, as participants can reflect on their opinions and feelings while answering open-ended questions and therefore are able to clarify what they mean and can provide additional information (Rice & Ezzy 2001:85–59). The advantage of semi-structured interviews is that there is no fixed order of the questions. New topics and issues that may arise in the interview process that the researcher did not anticipate can be included (Meuser & Nagel 1997:487; Biggam 2011:146). The views of the participants are recorded in a comprehensive way. Through the interview

guide, data can be recorded systematically, which is an advantage for the analysis of the data compared with a narrative interview (Vogel 1995:76).

The interview guide contains relevant themes, and should include all important topics related to the research question. The interview guide was pretested, and the interview lasted for about half an hour (interview guide key informant interview Appendix 5).

5.4.2 Focus group discussions

The aim of an FGD is that the participants should describe the perceptions and beliefs of a certain population (Rice & Ezzy 2001:72). A specific issue is discussed and guided by a moderator, a person that is living in the study area, and is able to speak the local Bhojpuri language. FGDs are seen as the most appropriate method to make the opinions of people known (Rice & Ezzy 2001:74). It is culturally common in this context to meet and discuss in groups. In an FGD the interaction among the participants when they start to talk about a topic in more detail is significant. Group discussions facilitate participants to give and clarify their opinions and speak about a topic without having to talk about their own situation, which they may be reluctant to do (Kitzinger 1995:300). Focus groups are considered to encourage people to open up and present their views because people are more relaxed talking about something when they feel that others have similar experiences. This is especially useful in studying sensitive topics such as this subject of research (Rice & Ezzy 2001:73).

5.5 STUDY POPULATION

The study population is the proportion of people from which the samples (participants) are selected. The study population in this research was part of the population in East Champaran, including the three blocks of Raxaul, Ramgarhwa and Adapur. These blocks were selected because they are addressed through the community mother and child health programme of Duncan Hospital (EHA) and include 8.8% of the total population in East Champaran.

5.6 SAMPLING AND RECRUITMENT PROCEDURE

A sample is a smaller set of the study population from which data are collected. Sampling can be determined by convenience sampling and purposive sampling (Biggam 2011:132).

5.6.1 Sampling and recruitment for key informant interviews

The informants for the interviews were selected purposively to obtain insights into issues of importance (Rice & Ezzy 2001:43). The researcher expects the purposefully selected participants to understand the phenomena under study. Since it is a qualitative study, it does not need a huge number of participants (Creswell 2014:189).

Ten participants for semi-structured interviews were recruited as key informants. Certain criteria were applied, such as having first-hand knowledge of the community and having lived in the study area for at least one year. These key informants could be people over 18 years old that worked in the community health programme, health practitioners from the area or health staff from any health facility in the study area. Participation in the interview too half an hour and was voluntary.

TABLE 5.1: CODING KEY INFORMANTS

Code	Occupation	Sex	Age
A-d-f	doctor	f	34
B-d-f	doctor	f	41
C-chw-m	chw	m	38
D-chw-f	chw	f	68
E-n-m	nurse	m	28
F-n-f	nurse	f	22
G-chw-f	chw	f	50
H-chw-m	chw	m	46
I-chw-f	chw	f	42
J-lhcp-m	lhcp	m	40

Code abbreviations: chw: community health worker n: nurse
lhcp: local healthcare provider d: doctor

5.6.2 Sampling and recruitment for focus group discussions

The groups involved five to eight people who had a similar socio-economic background. Pre-existing networks and snowball sampling were used for FGDs with mothers, fathers, grandmothers, grandfathers and community health workers in separate groups. The specific issues were discussed and guided by a moderator. A list of topics had been developed previously (Appendix 4). The FGDs were planned to last about one hour.

TABLE 5.2: CODING FOCUS GROUP DISCUSSIONS

Code	Sex	Partici- pants	Location (block); village	Relationship to the child
FGD-1-m	m	6	Adapur	father
FGD-2-f	f	5	Adapur	grandmother
FGD-3-m	m	7	Adapur; Sirisuya Kala	grandfather
FGD-4-f	f	6	Adapur; Kauraiya	grandmother
FGD-5-f	f	6	Ramgarhwa; Ahrwaliya	mother
FGD-6-m	m	6	Ramgarhwa; Ahrwaliya	grandfather
FGD-7-f	f	7	Raxaul; Behlahi	mother
FGD-8-f	f	6	Raxaul; Harnahi	mother
FGD-9-m	m	6	Raxaul; Harnahi	father

The participants in the mothers and fathers groups were between 18 and 45 years old. The participants in the grandmothers and grandfathers groups were between 45 and 65 years old.

5.6.3 Inclusion and exclusion criteria

Inclusion criteria

The people that participated in the interviews had to have lived at least one year in the study area in the blocks of Raxaul, Ramgarhwa and Adapur, in East Champaran. They had to be 18 years or older, with children or grandchildren between the ages of six months and five years. The participants could be parents or grandparents, depending on who was most involved in raising the child.

Exclusion criteria

People in households without children aged six months to five years and people that had not lived in the study area for more one year were excluded.

5.7 DATA COLLECTION AND ANALYSIS QUALITATIVE METHOD

The data collection for the qualitative method was done with interviews and FGDs. The people who conducted the interviews spoke the native language as their mother tongue. Training was conducted beforehand, in which the purpose of the questions was explained to the interviewers to avoid misinterpretation of answers and circumstances. The trained people were not associated with the interviewees to prevent bias and promote openness. They were employed through the community health programme of EHA, and were briefed on the consent form by having the contents read to them. They signed or fingerprinted the consent form.

5.7.1 Interviewing process

The selection of the places where FGDs should be conducted and of key informants was done in discussion with the joint researcher. A plan was developed for the dates on which the participants could be visited to conduct the interviews. According to this plan, the participants were contacted to make an appointment for the interview. For the FGDs, a village contact person was informed at least one day beforehand to arrange a group according to the requirements for this research.

FGDs were conducted in the villages in which the participants lived. The moderator was requested to search for a quiet private area to conduct the discussions, so that people around could not hear what was discussed. The interviews were audio recorded and transcribed from Bhojpuri into English, because Bhojpuri is not a written language. Two people that worked in Duncan community health projects were chosen to transcribe the interviews because of their proven language skills in the local Bhojpuri language and English.

The key informant interviews were carried out by the researcher if the participant felt confident in speaking fluent English. The interview process was audio recorded and transcribed accordingly. The transcriptions of the English interviews were done by the researcher herself. The interviews in Bhojpuri were transcribed into English. The transcribed interviews were recorded on a CD, and are attached in Appendix 6.

The data analysis process started as soon as the first data were collected. Interviews were transcribed into English (Creswell 2014:195). The computer software Maxqda was used to analyse the qualitative data.

5.7.2 Research process by grounded theory

The procedure was carried out with grounded theory, which is appropriate for qualitative explorative data analysis (Corbin & Strauss; 2007 Creswell 2014:196; Faix 2007:78–79). The researcher develops an abstract theory that is grounded in the data that have been collected. The process of data analysis involves multiple stages of data collection and the interrelation of categories and subcategories with the aim of generating core categories (Creswell 2014:14). The theory includes inductive and deductive procedures of analysing data that will be repeated several times (Rice & Ezzy 2001:191; Strübing 2008:48). In 1967 grounded theory began with the publication of the book the discovery of grounded theory by Glaser and Strauss. Today it is one of the most prominent research approaches of social science research (Strauss & Cobin 1996:112; Equit & Christoph 2016:9). The researcher gained experience with this method during her course work.

In grounded theory, data are extracted from the collected material as central process. It is a theory-generating process, but pre-existing theories are used to find new meanings through deductive and inductive work (Rice & Ezzy 2001:194). 'Deductive' means that the collected data are analysed according to a category that is derived theoretically. Statements of a specific topic are allocated to this category (Rice & Ezzy 2001:194; Faix 2007:161). Inductive means that the collected data are analysed without specifying a category and important data material is coded. The categories are derived from codes that appear similar. The advantage of inductive coding is that new topics are considered that were not used in the interview guide, but were mentioned in the interview process (Rice & Ezzy 2001:194). This is done through open, axial and selective coding (Rice & Ezzy 2001:195).

During the process of open coding, key phrase 'chunks' in the interviews are marked and coded by 'noting patterns and themes' (Rice & Ezzy 2001:196). This process is done twice. When coding is being done, categories are

extracted and a larger more inclusive concept is developed (Corbin & Strauss 2007:75). This central method continues throughout the grounded theory process up to the development of theories (Corbin & Strauss 2007:69). The development of the theories does not happen automatically. It involves a lot of mental work and coding. In the process of axial coding, the codes are rearranged by using a coding paradigm in which the context, cause, intervening condition, strategy and consequences of a phenomenon are derived. Through this process it can be recognised that categories are repeated and can be put together in connection. This is called axial coding (Rice & Ezzy 2001:196). Selective coding is the process by which all categories are unified around one 'core' category (Rice & Ezzy 2001:197; Corbin & Strauss 2007:14). This process is similar to axial coding, but involves a higher level of generality (Rice & Ezzy 2001:197). Grounded theory also allows abductive coding in which individual statements are taken seriously. A category is built without other statements on this topic (Faix 2007:162).

The present study was conducted according to a circular process of data analysis. This included repeating interviews, adaption and analysis. This process can be stopped only when no new findings emerge and a saturation of data has been achieved (Ezzy & Rice 2001:48).

The methodological research process is illustrated in Figure 5.1 (below).

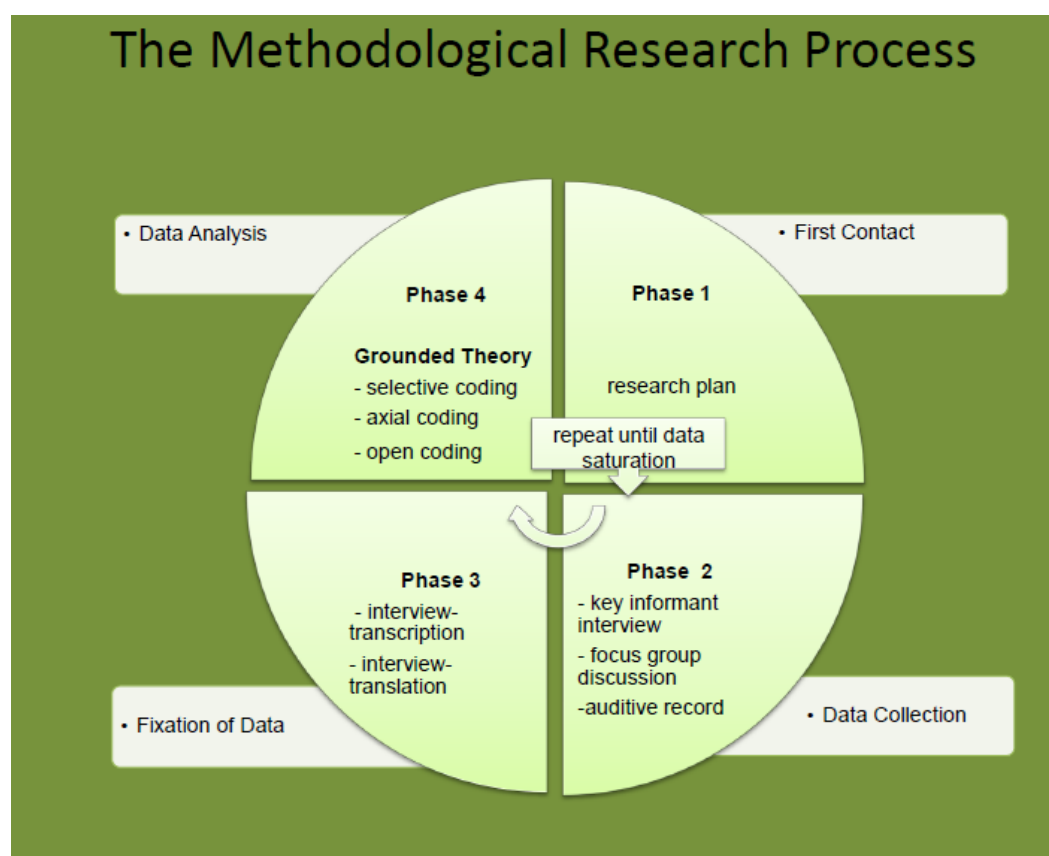


Figure 5.1: Methodological research process (Source: own representation)

5.8 ETHICAL CONSIDERATION

The ethical clearance application form for the research was submitted to UNISA Research Ethics Committee. The Emmanuel Hospital Association Institutional Review Board, India, approved the study.

The research took into account the ethical principles of: autonomy, respect, dignity of person, and justice. The interviewees were informed of their rights, and were required to agree. Before starting the interviews, they signed or fingerprinted the informed consent. Interview participants would remain anonymous during the research period and in the event of publication.

5.9 LIMITATIONS OF THE STUDY

The study was conducted in East Champaran in three villages in the blocks of Raxaul, Ramgarhwa and Adapur in a certain cultural background and socio-economic settings. Therefore, the study results may not be representative of different conditions, settings and circumstances. In the study, attention was

given to preventing bias as far as possible (see Chapter 5.3: Justification of research methods). However, in every qualitative study, the subjectivity of the researcher affects the ways in which information is perceived and interpreted (Helffferich 2009:22). A range of limitations of the research design can be identified, which include several forms of bias.

Interviewer bias: The interviewer had limited experience in the area of research and conducting interviews, but was trained before the study to avoid misinterpretation. The advantage of the interviewer is that the person speaks Bhojpuri, the native language, and is culturally adapted.

Translation bias: In intercultural work there are many opportunities for misinterpretation of the data through the influence of language translation.

Interpretation bias: A highly culturally related context may lead to inaccurate conclusions being drawn from the data. The responders may be more likely to say what the researcher wanted to hear than tell the real story. To reduce potential misinterpretation and incorrect analysis, the researcher lived for eight weeks in the research area. To acquire familiarity with the culture within this time was only partially possible. Therefore parts of the interviews that were difficult to comprehend were discussed with a native Indian joint researcher.

There were visible signs that interview candidates did not want to offer their views and gave only social appropriate answers. Sharing an opinion openly would not be culturally appropriate.

5.10 REFLECTION ON AND CHALLENGES OF THE RESEARCH

At the time of the field research in April 2015 an earthquake of magnitude 7.8 in Nepal claimed almost 8000 deaths. The tremors also affected North India, Bihar and shocked the population. Some of the staff that had been appointed to support this study were busy with emergency response work in Nepal and North India, which delayed the transcription of the interviews.

5.10.1 Key informant interview

The purposive selection of the key informants was done with the project leaders of the EHA community health programme. Through their recommendations,

participants were selected and the suitability of their backgrounds was explained. An adequate number of key informants were found easily.

It was not always possible to generate open narratives during the interview. Through further questioning, probing questions were introduced. Partly leading questions were used, even though it was explained that only open questions could be asked. However, the interviews were used because certain parts of leading questions were not interpreted as having a decisive influence in the outcome of the study. The use of leading questions could be criticised because it restricts freedom of narrative.

5.10.2 Focus group discussion

Two moderators would be employed to guide the FGDs. These moderators should be able to speak English and the local Bhojpuri language fluently. This could not be realised because suitable people could be found in the area with these language capabilities. Therefore, the chosen moderator could speak only the local Bhojpuri language fluently. The moderators were trained on conducting FGDs before the process of data collection started. A training session was conducted on two days and these important topics were included:

- Collection of participants (group size, over 18 years, children/grandchildren boy/girl between 0 and 5 years)
- Role of the moderator
- Handling the consent form
- Topic of the research and research questions discussed
- Practical workshop for conducting FGD and giving feedback afterwards

This was done through communication with a translator who was available for the training sessions. The moderators' understanding of the topic was checked. Information might have been lost because of language issues. This could have reduced the quality of the interviews, as the researcher was not able to clarify questions by probing.

In East Champaran it is difficult to find highly qualified people for certain jobs. The moderators had done FGDs before. They had a certain amount of experience and were therefore seen as the most appropriate people. Still, the

skills of leading the discussion were not always optimal, and probing according to the questions showed certain limitations.

After the first FDGs had been conducted and the audio records were transcribed, the researcher realised that questions were not being asked as explained in training. The moderator used guiding questions to obtain answers from the participants and not much probing was done on interesting answers. To improve the quality of data, a second training session was conducted to alert the moderator and give feedback to improve the interview process.

5.10.3 Audio recording

It was recommended that interviews should be conducted in silent places to prevent the recording of surrounding noise. However, at times it was difficult to find silent places in the community. Therefore, some parts of the records were difficult to understand and could only partly be transcribed. Another difficulty in the transcription was that several people spoke at the same time during the discussion.

As planned, the process of transcription started as soon as the first interviews had been conducted. The whole process of transcription lasted longer than expected. To accelerate this process, transcription was shared among several translators. To ensure correctness of transcription, some transcriptions were crosschecked.

5.11 CONCLUSION

In this chapter the research design and methodology of the study were explained. A qualitative research approach was appropriate to generate data explaining the behaviour of healthcare provision for children under the age of five. For the qualitative research, semi-structured interviews with ten key informants and nine FDGs with mothers, fathers, grandmothers and grandfathers were conducted for data collection. The research process was planned according to grounded theory. After the collection of data and transcription of the interviews, the data were analysed by computer software Maxqda. Despite detailed planning of field research, unexpected difficulties arose because of the earthquake in Nepal during the field research. The

findings of the research are discussed in the next chapter through the application of the research process phase 4 (Figure 5.1).

CHAPTER 6 EMPIRICAL RESEARCH FINDINGS AND DISCUSSION

6.1 INTRODUCTION

This chapter discusses the empirical research findings in line with the research objectives with the aim of exploring the obstacles to gender equality in the right to healthcare for children under five years. These findings include the views of key informants that were expected to have a broad knowledge of healthcare in the study area. Additionally, the views of mothers, fathers, grandmothers and grandfathers of children under the age of five and their behaviour in providing healthcare for their children was explored by conducting FGDs. The findings are discussed in the context of gender equality in the right to healthcare for children under five years in North India. In the discussion, reference is made to the theoretical background (Chapter 2), that is, India: Brief overview of socio-economic status and culture (Chapter 3) and literature review (Chapter 4).

6.2 RESEARCH FINDINGS OF OPEN CODING

In total 626 codes were identified and assigned to corresponding categories. After the full process of open coding (inductive, deductive, abductive) (see Chapter 5.7.2) of the 19 interviews, including ten key informant interviews and nine FGDs, a code system with main themes, categories, sub-categories and emerged. They are illustrated in Figure 6.1.

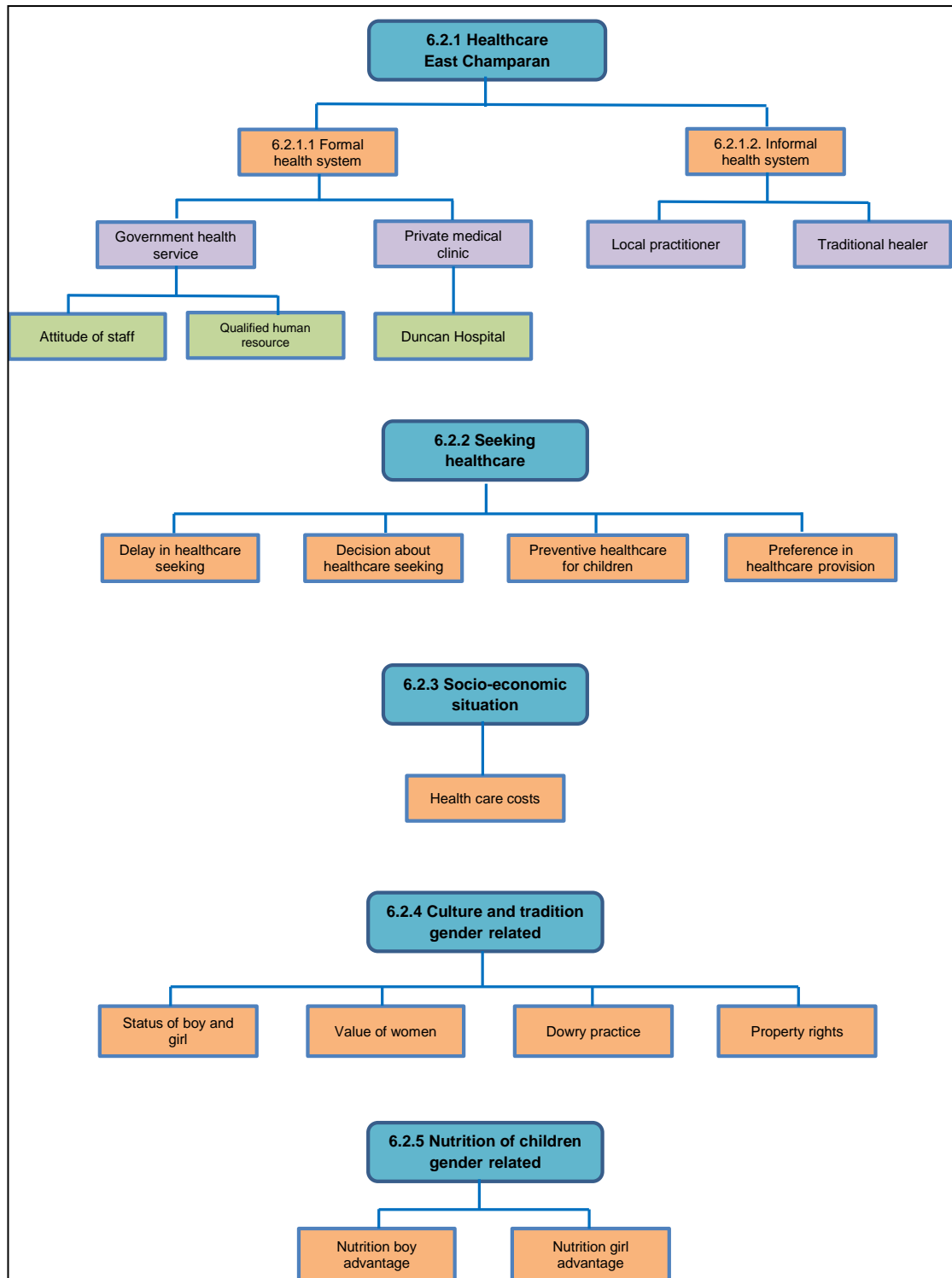


Figure 6.1: Findings code system (Source: own representation)

6.2.1 Healthcare, East Champaran

Healthcare in East Champaran is provided through a formal healthcare system, including the government health service, and registered healthcare providers, such as EHA Duncan Hospital. There is also an informal health system, which

offers a range of services such as local practitioners, who provide healthcare in unregistered small private clinics, and traditional healers.

6.2.1.1 Formal health system

Government health service

The capacity of the government's healthcare provision in East Champaran is extremely limited. A doctor at Duncan Hospital stated that there is no functioning government hospital in Raxaul (B-d-f), although according to the NHM there should be a hospital for every 100,000 people and PHC for every 30 000 people (A-d-f) (Chapter 4.2.4). This is a requirement in India's health policy. However, like so many laws in India, it has not been realised and is not yet available (B-d-f). The doctor stated in the interview: 'There is no CHC here for now, while the PHC covers eight times what it is supposed to cover' (A-d-f).

The same doctor added that apparently there is a budget for building and running a hospital, but people in responsible positions are not qualified to fulfil the requirements and use this budget (A-d-f). There are insufficient qualified people to construct and run a hospital according to the requirements of the NHM. Therefore, building a functioning government hospital or healthcare centre has not taken place and the money has not been used, 'so the money remains unspent' (A-d-f).

The government provides medical care through PHCs (sub-centres). However, these sub-centres are dysfunctional or exist only on paper (A-d-f). Reasons for the community not using the government health services are non-functioning facilities, lack of qualified human resources, the attitudes of the healthcare staff, and non-availability of medication. This is reflected in a statement by a local healthcare provider:

Lack of money, non-availability of government nurses and doctors, behaviour of the government healthcare staff, even though the government is supposed to have all the facilities and the health services; these are not available in any government health centres in the whole Bihar (J-lhcp-m).

The availability of medication in the government health facilities in entire East Champaran has been a challenge. A CHW stated that drugs are not available in any of the government health facilities there (C-chw-m). Therefore, medication has to be bought at private expense (A-d-f). Payment for medication and healthcare forces people to take out loans or sell their property when the child is sick (FGD-1-m).

Qualified human resource

East Champaran is an unattractive place to work because it is a remote area, it is underdeveloped and living conditions are difficult. There are no restaurants or opportunities for leisure activities (A-d-f). The limited educational opportunities for children mean that doctors with families avoid working and living in the area. Furthermore, the area is difficult to access compared with other places in India. In India doctors have many opportunities to work where living conditions are much better, so specialised doctors in particular are rare in East Champaran (C-chw-m; A-d-f). Only if someone sees it as a vocation, would he or she work in the area and accept these difficult living conditions.

Attitude of staff

The attitudes of healthcare staff and the ways in which they deal with patients influence the utilisation of health services. A CHW of Duncan Hospital said that in government health facilities, the staff are not always present and committed to work. It was observed that at 10 am patients were told that it was not time for service. The staff are perceived as being unfriendly and impolite. Therefore, the community are not always keen to use the government's health system because of negative experiences (C-chw-m).

Another example of negative experience is injustice in the treatment of patients. Those who are known to the healthcare staff have preference in treatment. They do not have to wait like everyone else (C-chw-m). Families who can pay extra money for the consultation are preferred and treated first, while others have to wait or come back the next day (C-chw-m). In Adapur PHC it was observed in the past that an auxiliary nurse midwife (ANM) would cut the cord after a delivery only if the relatives paid. The requirement at the time was 200–

300 rupees, although such a service should be free of charge in a government health facility.

The injustice in the healthcare system is reinforced by private practising doctors. A local health provider said that in some situations private doctors pay the government health staff extra money if they refer patients to them (J-lhcp-m). This makes it attractive to sent patients to private health facilities and earn extra money, instead to treating patients in the government health facility. It raises the costs of those requiring treatment.

Private medical clinic – Duncan Hospital

One of the main healthcare providers in East Champaran is EHA Duncan Hospital. Guardians use Duncan Hospital to seek healthcare for their children, even though it is assumed to be very expensive (D-chw-f; A-d-f). This is merely an assumption, based on the size and cleanliness of the building, but even though they do not know the actual costs (A-d-f).

The vision of Duncan Hospital is to serve the most vulnerable of society and people living in poverty (B-d-f). In practice, it is a challenge to identify who deserves charity. People say they have no money, but it may not be true (E-n-m). 'To really help the most needy is a challenge in this place' (B-d-f).

Therefore, a charity assessment form (Appendix 3) was introduced in 2015 to identify the most vulnerable patients and those most deserving support. This is a time-consuming process and is difficult in emergency cases.

In an FGD with fathers it was stated:

We don't like Duncan Hospital; they do not see our condition. They do not see to provide us free treatment. See we do not have money. They don't help us with process in the hospital. They ask us to have registration done. After that they ask to go out and get the medicine, which costs us 1,000 to 1,500 rupees. We don't have any benefit from Duncan Hospital (FGD-1-m).

Duncan Hospital is seen as being too expensive and is perceived as not being available for poor people. Some experienced that attention was not paid to

patients who did not have money. The registration process requires money and so does the medication (FDG-1-m).

6.2.1.2 Informal health system

The gaps in the government health service are being filled by an informal health system. As well as local practitioners, guardians consider the use of traditional healers.

Local practitioner

All the guardians interviewed said that the first choice in accessing healthcare was to consult a local health practitioner (C-chw-m), and not a government health facility. A doctor at Duncan Hospital explained this practice: 'The first point they would go are the local practitioners. These are people who practise in their homes in the village. They are men who have learned some basic practices' (A-d-f).

There are various reasons that guardians seek healthcare from local practitioners. As the name illustrates, local practitioners are 'local'. They are available in the community, which makes it easy to access them. Health practitioners are untrained and informal. Usually they have no formal medical training or a licence to work as healthcare providers (C-chw-m). They might have learned some basic skills by working with a doctor in the past or from their own experiences over the years (A-d-f:1; B-d-f). Without fundamental education, there is high risk that medications would be misused, and children mistreated or are given medication that is unnecessary. 'For example, I visited one clinic; where there was Amikacin (an antibiotic). It is usually kept for resistant cases, but he (local practitioner) was giving it to a five- to six-month old baby for diarrhoea' (A-d-f).

This explains a case in which an infant received a broad-spectrum antibiotic for a disease which, according to WHO standards, would be treated with oral rehydration solution and zinc. Misuse of broad-spectrum antibiotics promotes the development of resistance.

Traditional healers

Traditional healers are the last option in seeking healthcare. One woman in an FGD stated that if a patient did not get well after consulting a doctor, people would visit a traditional healer, as they thought the disease was due to black magic (FGD-2-f). Accordingly, in an FGD with men, the same sentiment was expressed. A traditional healer would be visited when the child did not improve through medical treatment after consulting a doctor (FGD-3-m).

6.2.2 Seeking healthcare

The way in which guardians make decisions about healthcare has a strong influence on child survival and development. A delay in seeking healthcare worsens disease and increases the risk of child mortality. Generally, there is great desire of guardians to have the children cured by using healthcare provision. They use the healthcare providers available: 'Now the community are aware of the need of healthcare and they know the need as well as the wealth of the health, so they know it now, so they go to the health centres' (D-chw-f).

Delay in seeking healthcare

A nurse from the paediatric ward in Duncan Hospital said that a delay had been observed in seeking healthcare. Guardians arrive at the clinic with their children at a late stage of sickness (E-n-m). This runs the risk of a prolonged course of the disease, which would probably increase treatment costs.

In the initial stage people tend to go to the pharmacy, then they will go to a small clinic, reaching here [Duncan Hospital] they come in a very late stage. They will reach here, almost 'out of the house', meaning in very bad condition. So at the end it costs more (E-n-m).

Another reason for a delay was stated by a doctor from Duncan Hospital that guardians are not able to recognise the symptoms of diseases and realise that the child might be sick (A-d-f)

Whether healthcare seeking is timely depends on the sex of the child. When it is a son, they 'run in any kind of sickness' (FGD-2-f). This shows that if a son was sick, guardians immediately make sure that he receives healthcare. On the other hand, for a girl, a CHW stated that they would wait about one day and see whether the child recovered automatically (D-chw-f; I-chw-f). In a male

FGD, it was revealed that there was no need for girls to receive healthcare treatment immediately (FGD-1-m). A local healthcare provider explained that when a girl is sick, she would be left without any healthcare for about five days. When the child has survived these five days, only then will she receive healthcare.

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 (J-lhcp-m).

Decisions about seeking healthcare

The decisions about where to go to seek healthcare are often made by the elders, as they know where to go when someone is sick, stated a grandmother (FGD-2-f). In the same FGD it emerged that if the father has migrated for work, the in-laws make the decision about what to do when the child is sick (FGD-2-f; FGD-3-m). It was explained that mothers cannot decide, because they need money for treatment for which they depend on their husbands (FGD-4-f). When a mother recognises that the child is sick she would normally talk about this with her husband, but if she is the mother of daughters, her statement will not have any consequences. 'When the mother recognises that the child is sick, she will tell about this to her husband but if it is a mother of four or five girls children, then her concern doesn't have any value' (J-lhcp-m).

Preference in healthcare provision

Statements in FGDs show that guardians in the community care for children in the same way, no matter the gender, because they love them both. This was stated in an FGD of mothers, who stressed that because of their love for and mercy for the children, they care for both sexes equally. 'We treat our children equal, we have mercy for them both, how can we leave our daughter behind?' (FGD-4-f; FGD-1-m).

However, in all of the key informant interviews and in some of the FGDs, it was stated that children receive different healthcare according to their sex. There

were clear statements that a son is given preferential healthcare treatment and much more is invested so that a son is cured of a disease.

No, for boys when they get sick, the parents usually don't want to take the risk of home remedies or the local grocery shop medicine. In this case they will straight away go with 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. Compared to this, girls are taken to the hospital only at the fifth or sixth days (J-lhcp-m).

This is right that both have to be taken for treatment, whether it is girl or boy, but I give importance to boy because I have three daughters and one boy, how will I give my daughters to marriage unless he works and earns money (FGD-1-m-).

In FGDs, a large number of statements were made that guardians would treat their children equally, but they would do slightly more for sons. A nurse at Duncan Hospital said that if it is a male newborn, they *will* bring it to Duncan Hospital, if it is a female newborn, they *might* decide to bring the child to Duncan Hospital (E-n-m). In a male FGD it was observed that all children would receive healthcare, but the priority is the son.

If all four children are sick, then the guardian will not think whom to take for treatment and whom not to take. They will take all of them for treatment. The boy they will take first for treatment. They will have love for all of them. Girls can be treated later also (FGD-1-m).

In addition, with a boy, they would go to a place where good quality of healthcare is provided. With the girl, they would go the local doctor. Therefore, they would care for both children, but put in more effort to have the boy treated (FGD-1-m) and the preference for sons could be strongly testified (FGD-1-m; FGD-3-m).

For a boy, parents usually do not want to risk home remedies or the local grocery shop medicine. They go straight away with the child to the local health practitioner at the beginning of the illness. If there is no improvement on the second or third day, they take the boy to the hospital. Girls are taken to hospital

only on the fifth or sixth day (J-lhcp-m). 'If all are seriously ill, then I would take my boy child first, and tell the doctor to start the treatment immediately. This is the context of our society here' (J-lhcp-m).

If the boy and the girl in the family are both sick, they would give the male the advantage for treatment (D-chw-f). The result is inequality in healthcare provision with the advantage in favour of the male child.

An example of this inequality was observed by a doctor at Duncan Hospital. On 21 May 2015 a boy died on the way to Duncan Hospital due to of measles. His sister had measles as well, and could have been admitted to the intensive care unit. However, the parents decided not to admit the girl child into the hospital. The reason they gave was that they had to prepare to bury the son. They decided to take the girl home, with a high risk of losing the second child. A doctor even explained to the parents that there was a good chance of the daughter surviving if they kept her in the hospital. However, the family decided to go home and left the hospital without their daughter being treated.

Preventive healthcare for children

Guardians' knowledge of disease treatment and disease prevention influences child survival. Health education and basic education of guardians in prevention could reduce morbidity and mortality of children. According to information given in the FGDs of mothers and fathers, only basic hygienic, which could be used to prevent diseases in early childhood are known in the community (FDG-4-f; FDG-6-m, FGD-5-f). The prevention of childhood disease through immunisation was rarely mentioned (FGD-5-f).

In terms of disease prevention, it was observed in an FGD that grandmothers do not know how to prevent children getting sick (FGD-4-f). Guardians wish to be taught this and know it is important. 'We don't know how to prevent. We do not have the knowledge in how to prevent our children from getting sick' (FGD-3-m; FGD-7-f).

Routine health check-ups (growth monitoring, vaccination) help to raise a healthy child by monitoring growth and giving advice to mothers. In an FGD

with mothers it was commented that girls would not be taken to these checks (FGD-8 f).

6.2.3 Socio-economic situation: healthcare costs

The payment of healthcare costs is a common reason for families in North India falling into poverty. More than half of Indian households have experienced this. A total of 90% of all healthcare costs in India are paid out of peoples own pocket.

The payment of healthcare costs can lead to lifelong debt (FGD-1-m), especially when people do not have savings. Daily salaries are small. A family in East Champaran earns less than 200 rupees a day if the father works as an unskilled daily labourer. From this small amount, they have no extra money to pay for healthcare in the event of their children's sickness (FGD-4-f). If they become sick, suddenly 5,000 rupees or more is needed urgently. Then they do not know where to take the money from. To be placed in such a situation disheartens people living in poverty (FGD-9-m).

People take out a loan or sell property to pay the healthcare costs to afford the treatment (FGD-1-m). The situation of the government healthcare system described above requires that guardians use private healthcare providers, pay for the treatment, and buy medication by private expense (A-d-f).

According to the question regarding how the availability of money in a family influences children's healthcare provision, a CHW stated that the wealth of a family has no influence on whether children receive healthcare. They favour the boy child, no matter whether they are rich or poor (C-chw-m). In contrast, a local healthcare provider stated that the rich would give equal treatment to boys and girls, but poorer people, where money was an issue, would prioritise and save the boy child (J-jhcp-m). A nurse stated that they pay money for both children, boy and girl, but if the costs rise, the girl would not be treated. Even if charity was offered, they would say that this is not needed. For the boy, they would welcome charity and stay for treatment (F-n-f).

Duncan Hospital has been criticised because the condition of the most vulnerable has not been considered. There was no help with transport, and the

treatment involved a protracted waiting time (FGD-1-m). The findings indicate that the option to receive financial support is either not known or does not reach those who deserve it. However, some guardians manage to use the funds provided. A nurse at Duncan Hospital mentioned that guardians accept those funds for the son (F-n-f). This means that daughters do not receive healthcare, even if guardians do not have to pay the treatment costs.

6.2.4 Culture and tradition as gender related

Status of boy and girl

Society in North India is driven by a patriarchal culture, which means that sons are preferred as they bring wealth, strength, and blessings to the family (D-chw-f). A son is seen in the society as someone that saves the generation, and therefore is much valued (FGD-9-m). A family is recognised only when they have a son (B-d-f). He has the status to being responsible for the generation of the family to continue.

People will remember us through our sons. Even when we die, people would still remember us (FGD-6-m).

First we will take care of the son, because we have to save the son, he will put the fire for the cremation and will take care of us, the daughter will take away the entire household and go (FGD-7-f).

The importance of the son is explained in that only he can start the fire for the cremation, which is called 'Aagi' (H-chw-m). The family benefits economically from a son. He will take care of the family when they are old. He will work and earn a salary (FGD-6-m). Therefore, the birth of a boy means acquiring wealth and a daughter-in-law (A-d-f).

A daughter traditionally leaves the home when she is married. She belongs to her husband's house (I-chw-f). The girl leaves home and lives with the name of the in-laws (FGD-6-m).

The general thinking in the communities is that girls are less valued. If the girl dies, no one would care much (FGD-9-m). It often happens that when a woman is asked how many children she has, her answer is only the number of boys

(D-chw-f). So she counts the number of boy children and does not mention the girls.

The neglect of girls starts at birth. If a boy is born, relatives book a private room and stay to celebrate. Instead, if a girl is born, relatives do not come or look at the baby (E-n-m). 'See if a boy is born, then the family is so happy, but if a girl is born the family is not so happy. It seems like a burden to them. This happens in the society' (FGD-5-f).

If a family has two daughters, there will not be any financial support from the parents. This is seen by a grandfather in an FGD as the 'biggest disease in Bihar'. This would be different when a boy were in the family.

Yes, it's true. In case I have two daughters my own family would not support me. This is one of the biggest diseases in Bihar. If you or me, anyone has more than two daughters, then our own family would not help or support and would push us aside. That would mean lots of expenses (FGD-6-m).

Suppose there is a house with two or three girls and one boy. The mother will try by all means to do everything to save the boy because he is the save keeper of the family's wealth. She may do this even at the cost of giving slightly less care to the daughter, because the daughters are going to belong to another house (FGD-3-m).

Value of women

The value of a woman in North Indian culture is influenced by the sex of the children she bears. If a woman gives birth to a girl, she is not given respect and space in her husband's household (H-chw-m). The responsibility for the sex of the child is given to women. The assumption is that if a woman has three girls, then her uterus is made to bear only female children (A-d-f). That the sex of the child is specified by the genetic material of men is not known in the community (D-chw-f). If a woman bears girls only, this is a risk to her life. Directly after birth when a woman has given birth to a girl, she would be thrown out of the household for six days and not receive any food. She would be given only

leftover food. 'She is going on producing only girl children. Such women are not given any food after delivery' (J-lhcp-m).

Women are discriminated against and in the worst cases are killed when they give birth to a girl. 'Her husband might kill her because they need to have a boy and she is only producing girls' (A-d-f).

It is different if a woman gives birth to a boy. Then she is much valued in the household (D-chw-f). She would be celebrated like a queen, and members of the family would bring special food to her (J-lhcp-m). There would be a huge celebration and tasty food (FGD-9-m; J-lhcp-m).

One statement in an FGD of fathers shows why it does make sense that a daughter should be raised well. In this situation the father would be honoured when his daughter is married. This statement by one father is contrary to what was found the responses so far. For this man, it is worth investing in healthcare and even selling property or land to provide for her healthcare.

If I have to take my daughter for treatment, I would do it with all my heart. I would have to get her married one day and she would go to another house and she would go there through my family. She is like goodness in the family. So even if we have to sell house or land for her treatment and even if we have to beg for the money, we should not stand back. Because as a human, when a person gets his daughter married, he is one of the greatest (FGD-6-m).

A doctor stated that in rich families too, there is a desire to have sons and if a woman delivers a daughter she is discriminated against. 'Also women from well to do families face humiliation when they bear girls' (A-d-f).

Dowry practice

Payment of a dowry when a daughter is married is still prevalent in society in East Champaran (FGD-4-f; G-chw-f). This is the main reason that people do not like to have daughters, as was said in an FGD with fathers (FGD-9-m). The practice of dowry means that girls are a burden to the family (FGD-7-f; D-chw-f; B-d-f). If daily survival and provision of food is a struggle for parents who are

earning only 200 rupees a day, they are unable to save money for dowry expenses.

If a father has three or four daughters, then he will be under high pressure from the dowry tradition. This is the main reason that people are disappointed when girls are born. A father in an FGD mentioned that a girl is same as a boy, they are equal, but the main problem is the dowry. The birth of a girl is not celebrated because families often save this money in a long-term fund or buy land, which they use later to pay the dowry of the daughter (J-lhcp-m; FGD-9-m). The amount that is paid for a girl's dowry is much less (devalued by four times) than what a son receives when he inherits the family's property (H-chw-m).

Property rights

It is common practice in North India that ownership of land can only be given to males. If a family has no sons, the relatives of the family get the land (FGD-2-f). When a family leaves property to the daughter in their will this is her right by law (FGD-2-f). It is only a practice in the society that women do not inherit land (H-chw-m). There is fear in the communities that if females inherit land they would sell it to an outsider (H-chw-m). Most women are uneducated and do not know how to claim their rights (H-chw-m). However, if women demanded their legal rights, village leaders would make it especially difficult and would discriminate against them (H-chw-m). 'By law the wife has the authority over the husband's property, but the society does not allow this' (H-chw-m).

6.2.5 Nutrition of children as gender related

The nutrition of children influences child survival and child development. In some interviews it was reported that mothers feed their children equally and give the same amount and quality of food to boy and girl children (FGD-4-f; FGD-1-m).

There are many who throw away the girl child, but there are also people who get compassion on her they feed her, grow her, take care of her (FGD-4-f).

In some situations, guardians find it important to nourish the girl well so that she can grow properly. However, in an FGD of fathers it was clearly said that boys

deserve more food. It was demonstrated that guardians have no reason or desire for the girl child to develop well, and do not care about their daughters' food. 'We have to give more food to the boys. So that they grow stronger. What is the point of feeding girls?' (FGD-7-f).

A local healthcare provider stated that there is no difference in the food that is given. However, the difference is how the children are motivated to eat the food.

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 (J-lhcp-m).

6.3 RESEARCH FINDINGS: AXIAL CODING

After the development of the code system through open coding, axial coding had been done (see Chapter 5.7.2) to bring the various codes into substantive connection using a coding paradigm in which the context, consequence, cause, strategy, intervening conditions of a phenomenon were derived. The analytical focus is on the phenomenon of healthcare provision for children. This is most relevant to answering the research question.

The various themes and categories were explained in detail in the findings of open coding. Therefore, in the analysis of axial coding the topics already outlined in detail in the section open coding are mentioned briefly and connected.

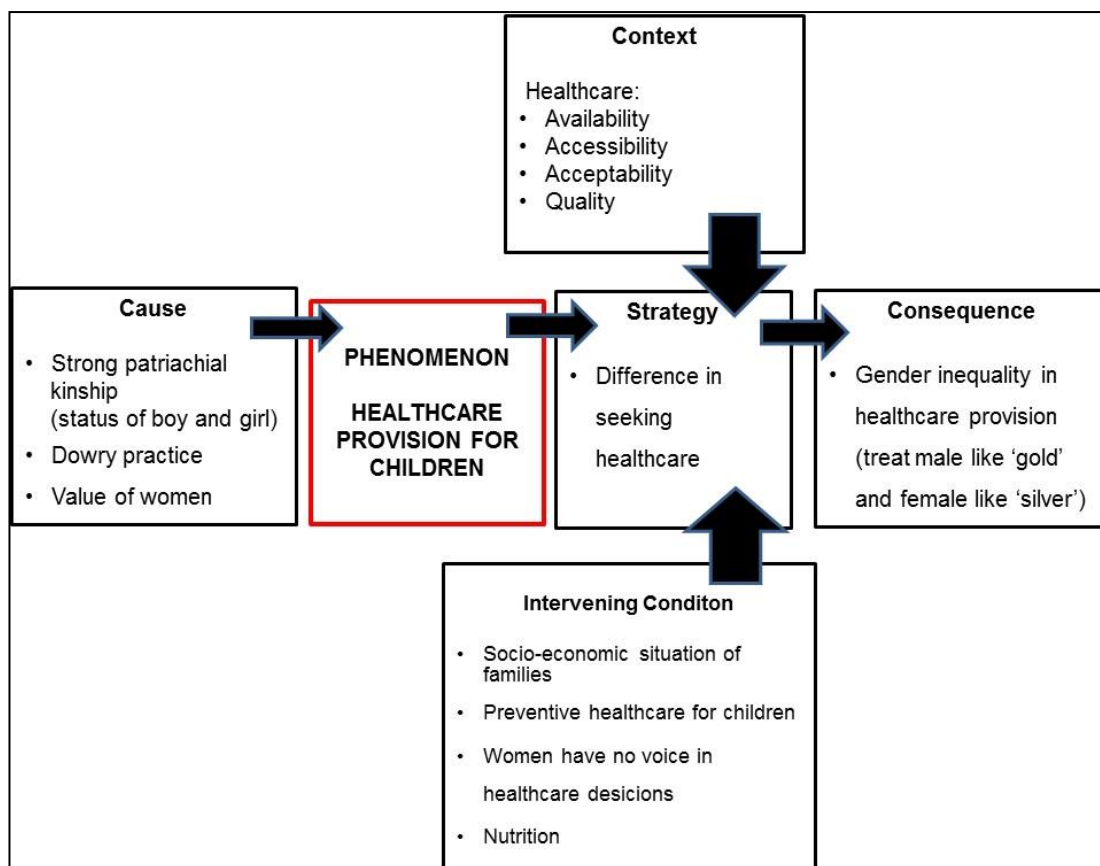


Figure: 6.2: Phenomenon of healthcare provision for (Source: own representation)

Phenomenon: Healthcare provision for children

The tendency that the male sex is preferred in healthcare provision and the reasons behind this are explored. Gender equality in healthcare means that girls and boys have the same conditions and opportunities to be healthy.

- Cause

Patriarchal kinship system

The tradition of the strong patriarchal kinship system in North India hinders equal healthcare provision for children. An important obstacle to equal health care is the value given to boys in the society. Guardians claim that they have love, mercy and compassion for their children, female and male equally (FGD-4-f:12; FGD-1-m). None of the key informants made such a statement that children would be equally treated by their guardians. Therefore, it is questionable what exactly is meant by ‘we love’ our children equally, no matter which gender. However, all key informants revealed that guardians’ actions would be different from what they are saying (B-d-f).

Gender discrimination might be so deeply ingrained and regularly reinforced by social norms and traditions that the parents do not realise that their practices are discriminatory. Discrimination by neglecting females is happening subconsciously. The attitudes to discriminatory practices can be different from thoughts and words (B-d-f). What is done over generations without rethinking and reflecting is assumed to be right and equal.

The son is the descendant of the family and is highly valued (FGD-9-m). He is compared with 'gold' and should therefore be cared for more. The metaphor of 'silver' was used for girls, reflecting being less valued, and therefore deserving less care. 'These days everybody is caring more about gold and not silver, by gold I mean boy' (FGD-6-m). Parents have traditionally more benefits from a son. Therefore, they support his education more, so that he can work later and will earn a salary (FGD-6-m). The money a son earns is necessary to provide for parents in old age (FGD-6-m), important in the absence of providing a pension by the state. The strong desire to have a son is also demanded because of the traditional cremation practices (H-chw-m).

Dowry practice

Having a daughter bears disadvantages for a family that are rooted in the traditional norms. The reason girls are a burden is because of the dowry practice and payment of high amounts of money can limit families' living conditions (FGD-7-f; D-chw-f; B-d-f; FGD-5-f). 'There is reason behind people getting disappointed at the birth of a girl child. The reason is dowry' (FGD-9-m).

Parents' fear of having to pay a dowry places daughters in a disadvantaged status in the family, and affects the way in which the health needs of girls are provided.

Value of women

The value of a woman depends on giving birth to a son (H-chw-m). This means in a broader sense that her personality, character, education and developed skills are not seen as important. If she only gives birth to girls, she would experience disadvantages and discrimination.

Participants revealed that women are considered responsible for the sex of the child. As a woman is not seen as having value, a husband might kill his wife because he is disappointed that his desire to have a son was again not fulfilled (A-d-f). There is hope that a new wife would give birth to the desired son. This demonstrates discrimination against women in the society, which influences the ways in which girls are cared for. If a woman has no value, a girl child will be seen from the same perspective. Later she will be a woman whose value depends on bearing a son. People will care less, if a girl dies (FGD-7-f).

The only reason that females are valued is if a father raises his daughter well and has her married, he will be honoured (FGD-1-m). In North Indian tradition, getting the daughter married is the most important responsibility of parents towards their daughters. The girl child is an important commodity that is presented to another family. An unmarried daughter is a shame and a burden. So, if the 'commodity' is flawed by disease or disability, it is preferable for it to disappear in the early years of life than to reach the age of marriage with the risk of remaining in the family's household as a lifelong burden. Therefore, raising a daughter well does not necessarily mean she will be given the best healthcare possible in the first years of life.

The traditional handling of property rights discriminates against women. Women are not allowed to inherit land (FGD-2-f). If a woman wants to own land, this is made extra difficult by village leaders, who are all men. When women claim their right to ownership of land, they are discriminated against (H-chw-m). Therefore, the empowerment of women through land ownership is blocked by village officials. Men might feel threatened by the success of women. A successful woman who voices her rights could become a positive example for many to follow. Men might fear to lose their position when women have a say in society and start to have power by owning property.

- Context

Availability, accessibility, acceptability and quality of healthcare

Availability, accessibility, acceptability and quality of healthcare affect the healthcare provision and the health status of children.

Availability

In the absence of sufficient functioning public healthcare facilities (A-d-f), guardians are forced to use other formal or informal healthcare options. Local practitioners are often the only healthcare option guardians can afford for their children (C-chw-m).

Accessibility

The timing in seeking healthcare and the required payment of healthcare costs influence health-seeking behaviour. A reason for delay is to save healthcare costs and hope that the child would recover without treatment. There is fear that the costs can rise to lifelong debt, which places families in poverty and deprivation (FGD-4-f). The close accessibility of health practitioners in rural areas is a huge advantage because it saves money and time for transport.

However, lack of money in a family is not a definite reason that the girl child's healthcare provision is neglected. It was stated from a CHW that the boy would be favoured no matter if they were rich or poor (C-chw-m). This means that the decision is made according to the sex of the child. For the son, the best quality of healthcare is provided, and guardians choose to go directly to the hospital, whereas for daughters medicine is bought in the pharmacies (J-lhcp-m).

Acceptability

The importance of healthcare provision is known in the community. Efforts would be made to try to save the child, even if it takes money and time (FGD-1-m). The utilisation of a healthcare provider can depend on the attitude of the staff in that health facility. Patients do not accept being treated unfairly: they avoid visiting the health facility when they have not been treated in a friendly and fair manner (C-chw-m). The advantage of local practitioners is that they are known in the community, therefore there is mutual trust and better acceptance.

Quality

There is a lack of qualified health staff in East Champaran because of the difficult living conditions (A-d-f). Most doctors prefer to work elsewhere in India. This affects the quality of healthcare that is provided for patients. Local

healthcare providers have no formal health education, and therefore their treatment is of doubtful quality (A-d-f). Guardians don't want to take the risk of this doubtful healthcare quality for their sons and rather choose to seek health care in the hospital (j-lhcp-m).

- Intervening condition

Socio-economic situation

The socio-economic situation of families influences their healthcare-seeking behaviour. Families are not ready to spend money in high amounts on treatment for girls (C-chw-m). It was stated that the wealth of a family would not influence whether children received healthcare. In a mothers' FGD it was stated that they would spend money for the girls equally (FGD-2-f). 'Yes, why would we not spend on her treatment too?' (FGD-2-f). A doctor at Duncan Hospital said that guardians would not say so, but in their actions in healthcare provision they prefer to invest in the healthcare of their sons (B-d-f). 'They won't say that, but in their action you see that it is different' (B-d-f).

Preventive health care for children

Knowledge of ways to prevent children from becoming sick is limited. Sometimes it is not recognised that the child might be sick (A-d-f). If this is the case, timely help will not be possible.. Guardians do have only very basic knowledge of preventing children from getting sick. The benefits of immunisation are not well known. In terms of health check-ups, guardians are more likely to attend them only with their sons (FGD-8-f).

Women have no voice in healthcare decisions

The decision about which healthcare provider should be used to seek help from is made by male family members (FGD-2-f; FGD-3m). Women's participation is refused in these affairs, because of their low value in the strong patriarchal society. It is claimed that in any case women are not able to give financial support for the healthcare treatment (FGD-4-f).

Nutrition

In many situations, guardians claim to feed their children equally and make no distinction because of sex (FGD-4-f). The numbers in the literature are more consistent with the statement that guardians would give the same amount of food to a boy and a girl, but they would motivate the boy more to eat well. The desire of guardians to nourish daughters well does not have priority. An extremely negative expression was used: 'What is the point of feeding girls?' (FGD-7-f-20). It means there is no reason to nourish a girl. If someone does not get food, survival is not secured, and it can be concluded that survival of girls does not have value and relevance.

- Strategy

Differences in seeking healthcare for boys and girls

The various factors of the context and intervening conditions explained earlier influence the health-seeking behaviours of guardians. Differences in response to the child's gender have a direct impact on gender equality or inequality in healthcare provision.

Guardians make differences in the speed with which they look for medical treatment when the child is sick. For girl children, healthcare provision is not seen as urgent, whereas boys have the importance to receive healthcare immediately (FGD-2-f). With a boy they would go where good-quality healthcare is provided, whereas with a girl medicine is bought in the pharmacy.

If one favours girls, there is fear of being discriminated against in the society. This person is doing something different from normal in the traditional context. If children have equal value and equal healthcare is provided, this is something new and this behaviour may be despised. Therefore, if an individual is convinced that children should be treated equally, this is hidden in order so they do not to lose recognition in the society (C-chw-m), and families who would favour the boy.

- Consequence

Gender inequality in healthcare provision

From these strategies that have been clarified, a conclusion can be drawn that daughters do not deserve the same priority and quality of healthcare as sons.

A daughter impairs the living conditions of a family substantially because of traditional practices such as dowry. The fear of putting the whole family at risk because of expenses for a daughter (FGD-1-m) means that parents save on healthcare costs and quality of healthcare and do not respond timely since they regard the daughters as being in a disadvantaged position. Female children have less value in the society and therefore their healthcare provision does not have priority.

6.4 DISCUSSION

In this chapter, the third research objective, namely to investigate the reasons for persistent gender inequality, was answered through open and axial coding of empirical data, and is further discussed.

The first research objective, namely to evaluate determinants of child development and child survival in developing countries concerning global child rights and the child rights policies specially defined in India was answered in Chapter 2: Child rights approach: a conceptual framework of human development.

The second research objective to examine the current health situation for children under five years in North India is contained in Chapter 3: India: Brief overview of socio- economic status and culture, and Chapter 4: Literature review on child development and gender inequality in India.

6.4.1 Gender inequality through the status of women in North Indian tradition

The cultural characteristics in North India found in literature (Arnold et al 1998:7; Chakrabarti 2012:28; Krishnan et al 2013:424; Dyson & Moore 1983:35; Pande 2007:4; Das Gupta et al 2003:153) were confirmed through the empirical research findings. The strong patriarchal kinship system and the devalued status of women in North India determine guardians' behaviour patterns on how the right to health for children is provided. This is one of the many consequences to which women in North India are exposed. The first step of discrimination in the trajectory of life starts before birth with the practice of sex-selective abortion (Krishnan et al 2013:419; Sahni 2008:1; Dréze & Sen 2010:258). Although guardians claim to love their children equally, daughters

bring massive disadvantages to the family, and therefore their healthcare and nutrition are neglected or not provided in the same quality as those of sons.

Discriminatory features and suppression continue to be present in women's lives. They must obey exogamic marriages and dowry practice. Women are prohibited from owning property and have no voice in important decisions concerning the family such as healthcare provision for their children (I-chw-f; Dyson & Moore 1983:44-48; Aparna & Thakur 2012:360). Important aspects of the trajectory are illustrated in Figure 6.3 below.

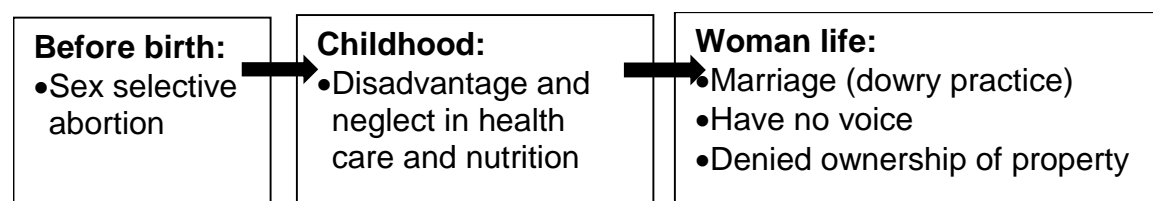


Figure 6.3: Trajectory of women life (Source: own representation)

The rights, needs and capabilities of girls and women in health, nutrition, education, and their economic rights in access to property and social security are denied. Despite women having equal rights according to the law in India in legislation such as Hindu Succession Act (1956); Dowry Prohibition Act (1961) and Protection of Women from Domestic Violence (2005) (Kakar 2015:94) and Prohibition of Sex Determination (Krishnan et al 2013:425), traditional practices still predominate in North India (Dyson & Moore 1983:44:48; Das Gupta et al 2003:166-168; H-chw-m).

With such a predetermined way of life for a woman, it is not considered that a daughter could be an asset and successor of the family, which makes it worth supporting her healthcare, nutrition and education. Instead, men prevent the empowerment of women (H-chw-m) in society. If women begin to have a say in society and try to claim the legal right to property, this is rejected by the locally responsible power-holders, who are men. There is a fear of losing the advantaged position if women start to have more power, for example through possession of property. A successful woman who is able to voice her rights could potentially become a positive example for many more to follow. The positive impact women have in the development of children, families, communities and countries when they are empowered (Kotzè 2009:7;

Nuscheler 2012:100) is not applicable in North India's traditional norms. Persistent gender inequality is a barrier to development in North Indian society. The current traditional practices prevents women and girls from enjoying human rights and child rights.

6.4.2 Gender inequality and the right of health for children

In the CRC and the Declaration of Alma Ata the right of children to health is set out (UNICEF 2016; Bajpai 2012:375). The current government's healthcare system in East Champaran has gaps in complying with these standards. To fulfil the right to health important requirements such as the availability, accessibility, acceptability and quality of healthcare are provided unsatisfactorily (J-lhcp-m; C-chw-m; Kumar & Ray 2013:422-423; Deb 2016:118). The standards set in the NHM in India such as free healthcare provision for the population are not implemented (Kumar & Ray 2013:425). Therefore, the health needs of children are not being met. This is reflected in the high child development indicators U5MR and IMR and their differences in relation to gender in Bihar, compared with other states in India (NFHS-4).

Different circumstances in the society prevent equality in the right of health. Four important ones emerged in the research findings. The first is the neglect of daughters by their guardians. They deserve only minimal effort to have their health needs fulfilled. Their healthcare provision is less important. For sons, guardians ensure a timely response; for girls a delay is common (FGD-2-f). The son preference in India's healthcare provision was confirmed in earlier studies (Victora 2003:235; Dréze & Sen 2013:248; Cleason et al 2000:1194).

The 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.

Healthcare costs are not the only reason for the neglect of girls. Even if money were not an issue, families would favour the boy child in healthcare provision (C-chw-m). A similar statement was made in the literature, namely that the availability of resources would not automatically support the healthcare of girls (Krishnan et al 2013:424).

Second, the education and knowledge of women influence how the health needs for children are provided. Bihar is one of the Indian states with the lowest literacy rates (Census 2011). Beside this, only very basic knowledge was present of ways of keeping a child healthy (FGD-f-f). The knowledge of the community in preventive health care for children, which includes immunisation in childhood, supports raising a healthy child (Deb 2016:118). The services of immunisation are less used for girls (FGD-8-f; FGD-5-f), and are another indication of gender inequality. Duncan Hospital intern data showed that 64% of the vaccinated children were boys and 36% girls. The immunisation coverage of Bihar's children under five years that are fully immunised is 62% (NFHS-4). In the NFHS-3 it is documented that 11% more boy children are immunised (NFHS-3) than girl children.

Third, the socio-economic situation influences healthcare provision. Families are required to pay healthcare costs. They are limited in financial resources because the majority of the population in Bihar live below the poverty line (Kumar & Ray 2013:417) and mostly they need to take out loans to pay healthcare costs. The financial support system of EHA Duncan Hospital is not always appropriate to the community's circumstances. It was said in a FGD with fathers that the poverty conditions of the community are not recognised (FGD-1-m).

Fourth, the services of the ICDS (Chapter 4.2.2) would support the healthy development of the child including regular health check-up for children. Guardians are less likely to attend the health check-ups with their daughters. (FGD-8-f; FGD-5-f). Growth monitoring is essential to assess the nutritional status of children and to recognise an unhealthy development. The measurements of height and weight for children are not regular done because the staff is not qualified to do so or is missing necessary equipment (Nandini & Naresh 2006:83; A-d-f; C-chw-m). The significant gender difference in the number of children being severely malnourished in Bihar (NFHS-3 Bihar) confirms the findings that it is a priority to nourish the son well and make sure that he gets good food to develop well (J-lhcp-m).

6.4.3 Gender inequality and the obstacle to development

The persistent gender inequality in healthcare provision for girls has a negative impact, limiting the development of their capabilities from childhood onwards and shaping their future. Furthermore, it not only prevents the realisation of the right to health, it contributes to other social failures such as discrimination against girls, sex-selective abortion, and differences in child mortality rates (Dréze & Sen 2010:273). These contradict the requirements of the three Ps (participation, provision and protection of children) in the child rights approach supporting human development (Chopra 2015:18).

The whole life of a woman in East Champaran is affected by the limited healthcare provision for girl children. Her suppression, rooted in tradition, affects her development and the opportunities she will have in future. The trajectory of women's lives in North Indian tradition prevents the healthy development of families, communities, the state of Bihar, and India in a broader sense. The positive influence women could have in development is not considered in North Indian tradition (Regan 2007:162). Gender inequality becomes a central obstacle to human development. The dependence of gender equality to human development is described as a creating condition in the human development approach (UNDP 2015:viii). Its achievement was a priority in the development agenda of the SDGs (UN 2015). The findings that gender inequality is an obstacle to development supports the statement of Kotzé that gender equality leads to the realisation of development goals (Kotzé 2009:15). 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, which demands a rethinking of tradition. That is a great opportunity that human potential supportive of development would not remain unused.

6.4.4 Conclusion

In this chapter the reasons for persistent gender inequality in the right to healthcare for children under five years in East Champaran were explored. First, the findings of the empirical research were analysed, interpreted and then discussed with the findings in the literature in Section 6.4. Gender inequality caused by the status of females in North Indian society is the guiding phenomenon, which means that the right to health for children in relation to sex

is provided unequally and does not fulfil what is defined in the child rights approach (UNICEF 2014b:2). The strong patriarchal kinship system devalues the female sex, starting before birth and continuing throughout life. The obstacles to equal healthcare for girls are caused by the disadvantaged status and value of daughters in society, guided by the dowry practice, suppression of women in the society and the refusal of property rights for women. This means that daughters have fewer benefits for a family, and therefore their healthcare provision has less priority than sons. The devaluing of girls influences behaviour patterns imposed by male family members when providing their children with their health needs. Gender inequality in healthcare has a negative impact on girl child development, which affects the future development of women, family, society and the state of Bihar.

CHAPTER 7 CONCLUSION AND RECOMMENDATIONS

7.1 INTRODUCTION

The main findings, which were outlined and discussed in chapter 6, are summarised in this chapter. The research into the obstacles to gender equality in the right to healthcare took place in East Champaran. The chosen region was an appropriate context for researching persistent gender inequality in healthcare provision for children under five years, as this was found to be a current problem in the area. Recommendations are given for ways in which the gender inequality in healthcare provision for children could be addressed, so that children's rights break through the predominant traditional standards more and more. Finally, some thematic areas are highlighted that are seen as important for further research.

7.2 RIGHT TO HEALTH FOR CHILDREN IN BIHAR, NORTH INDIA

The right to health is a fundamental human right and child right, which also applies in North India. The realisation of the right to healthcare secures children's healthy survival and development. Growing up under healthy conditions, especially in the first years of life, supports the development of individual skills, which influence the quality of life and wellbeing for future development (UNICEF 2014b:9). In states such as Bihar, which have gaps in the public healthcare system, the provision of the right to health faces many challenges, as it is a key component in covering the health needs of a population, including children. A mature healthcare system is still being developed, together with strengthening the capacity to provide sufficient quality healthcare that is accessible, affordable and acceptable to the population. The conditions that were found are a long way from meeting the requirements of the standards in the NHM (NHM 2016). Underlying factors that prevent effective treatment are different qualities of formal and informal healthcare providers, inadequate qualified human resources, the attitudes of staff, and the socio-economic situation of families in providing healthy living conditions and being able to pay healthcare costs.

Duncan Hospital and its community health programme, led by EHA, a faith-based NGO, fill some healthcare gaps. However, it does not provide healthcare free of charge and not all patients are able to use its services.

Certain patterns of health-seeking behaviour by guardians influence the healthcare provision of their children. Access to timely and appropriate health services and to essential medicine free of charge is limited. Without a functional public healthcare system, the survival and healthy development of children can easily be affected when opportunities for healthcare treatment are lacking. The results are reflected in alarming child development data in Bihar.

Persistent gender inequality in children's healthcare provision (Sen 2010:273-274; Cleason et al 2000:1194; Klasen 2004:10; J-lhcp-m) is perpetuated in cultural traditions.

The unfortunate trajectory of a woman's life starts before birth and continues during childhood through disadvantages in healthcare and nutrition. In addition, the lives of women are limited by their value in society, by dowry payments, and by not being allowed to own property. In important decisions they do not have a voice.

The reduction of gender inequality and women's empowerment are important in achieving the SDG. Women need to be enabled to develop skills, have own resources, and participate in decision making, for example about the healthcare of their children.

So long as sons are valued more than daughters in the society, this will be a guiding principle in the decision to seek healthcare and will disadvantage girls.

The achievement of gender equality is a priority in the current development agenda of the SDGs (UN 2015). Gender equality based on child rights would build a sustainable and just environment in the society. Gender inequality caused by the neglect of girls in healthcare provision affects their survival and development (Nussbaum 2015:188). Gender equality can be realised only when children are valued equally in society. Persistent gender inequality in healthcare provision hinders children in developing the capabilities that would shape their future. Great opportunities of human potential would remain unused

and limit the development of a community, society and the state of Bihar. Therefore, persistent gender inequality in healthcare provision for children calls for a strengthening of the government's healthcare system to fulfil the right to healthcare for children. It can be agreed that gender inequality in health care provision, which is rooted in traditional norms, needs to be addressed (Dréze & Sen 2010:701) in order to support human development in North India effectively.

The realisation of India's equal rights is important to protect children and women against their disadvantaged positions. However, the realisation of those rights requires a change of tradition. As long as law requirements are not pursued, the tradition of violating human rights and child rights regularly is likely to continue. North India needs to work on the realisation of these rights. This would raise the value of women, and would be a step towards achieving gender equality in healthcare provision for children to secure their survival and healthy development.

7.3 BRIEF RECOMMENDATIONS

Based on the findings of the study, the researcher gives brief recommendations of steps towards addressing gender equality in healthcare provision for children under five years. This could be a useful source for governments and development activities to promote child rights to health.

Recommendations for government

- The government should be aware of its roles and responsibilities in terms of children's protection, participation and provision rights (three Ps).
- The government needs to improve the infrastructure for the implementation of the policies through improving work conditions and educating the staff to enable them to work according to ICDS requirements.
- There is need to access a functional and justice legal system in which rights are respected and can be claimed. Persons who do not follow the standards of the rights should be held accountable.

- The public healthcare system needs to be strengthened to meet the standards of the NHM, including gender equality in healthcare provision.
- Women should be given a voice in political decision making and be enabled to take appropriate actions to demand their rights.
- The government must provide qualified human resources to work in healthcare, make the area attractive to outside workers by improving living conditions, and avoid a brain drain of staff that are currently available.
- Healthcare providers should continue to monitor sex-disaggregated data: U5MR, IMR, immunisation data, nutrition data, child admission data in health facilities and sex ratio at birth. These data are meaningful in monitoring gender inequality in healthcare provision and would help early recognition if the development of the health system should lead to a rise in of sex-selective abortion.
- Government should control local health providers and traditional healers and consider registering them according to education and quality.

Recommendations for Emmanuel Hospital Association, North India

- EHA should attempt to make the community aware of their rights and support families, especially women and children, to claim their rights.
- EHA should remind government of its responsibilities to fulfil child rights and support their implementation.
- The EHA and the community health department in North India must network with the government health department to address gender equality in healthcare provision for children under five.

- EHA should monitor sex-disaggregated data to use as indicators for projects that address gender equality and measure their effectiveness at community level.
- Duncan Hospital needs to continue to provide healthcare for children that is available and accessible in any circumstances for the population. Therefore, Duncan Hospital should find a simplified system to support the treatment of children when guardians are not able to afford healthcare costs and transport.
- EHA community health programmes in North India need to address gender equality in general and in healthcare provision for children under five. The first step could be awareness training of guardians in gender differences caused by traditional norms. The community need to think critically about discriminatory traditional behaviour patterns that disadvantage women. Second, gender equality needs to be promoted through the empowerment of women and raising their value through education and awareness of their rights.
- EHA community development programmes should address gender inequality and implement social and behavioural change concepts in the community such as health education and women's empowerment through social networking.
- EHA is required to support the education and build the capacity of local healthcare providers and Anganwadi to raise the quality of their work and improve the outcomes of children's healthcare treatment.

Recommendations for the community

- Community men and women need to be aware of their rights, allow their implementation and realisation, and claim these rights.
- Community leaders should allow women to participate in socio-economic and political activities. In addition, women could be community leaders.

- Men are required to respect women and support them to become empowered.
- Society needs to reflect on traditional behaviour patterns and modify traditions to achieve gender equality and no longer to hold to a practice that discriminates against women.
- Guardians need to provide gender-equal healthcare for their children and support their development.

7.4 RECOMMENDATIONS FOR FURTHER RESEARCH

These important areas of research would build on this topic.

1. To study the influence of the family's economic status and its impact on gender inequality in healthcare provision for children and establish whether higher economic status would tighten gender inequality in a patriarchal culture.
2. To research the effects of women's education on gender inequality in healthcare and whether the education of women raises their value in society. This knowledge would show whether a focus on female education could reduce gender inequality in healthcare for children.
3. To evaluate the impact of local practitioners and their work quality on healthcare provision for children.

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Appendix 1: Convention on the Rights of the Child

In 1989 the Convention on the Rights of the Child was adopted by the General Assembly (UNICEF 2016)

Article 1: Definition of the child: The Convention defines a 'child' as a person below the age of 18, unless the laws of a particular country set the legal age for adulthood younger. The Committee on the Rights of the Child, the monitoring body for the Convention, has encouraged States to review the age of majority if it is set below 18 and to increase the level of protection for all children under 18.

Article 2 Non-discrimination: The Convention applies to all children, whatever their race, religion or abilities; whatever they think or say, whatever type of family they come from. It doesn't matter where children live, what language they speak, what their parents do, whether they are boys or girls, what their culture is, whether they have a disability or whether they are rich or poor. No child should be treated unfairly on any basis.

Article 3 Best interests of the child: The best interests of children must be the primary concern in making decisions that may affect them. All adults should do what is best for children. When adults make decisions, they should think about how their decisions will affect children. This particularly applies to budget, policy and law makers.

Article 4 Protection of rights: Governments have a responsibility to take all available measures to make sure children's rights are respected, protected and fulfilled. When countries ratify the Convention, they agree to review their laws relating to children. This involves assessing their social services, legal, health and educational systems, as well as levels of funding for these services. Governments are then obliged to take all necessary steps to ensure that the minimum standards set by the Convention in these areas are being met. They must help families protect children's rights and create an environment where they can grow and reach their potential. In some instances, this may involve changing existing laws or creating new ones. Such legislative changes are not imposed, but come about through the same process by which any law is created or reformed within a country. Article 41 of the Convention points out the when a country already has higher legal standards than those seen in the Convention, the higher standards always prevail.

Article 5 Parental guidance: Governments should respect the rights and responsibilities of families to direct and guide their children so that, as they grow, they learn to use their rights properly. Helping children to understand their rights does not mean pushing them to make choices with consequences that they are too young to handle. Article 5 encourages parents to deal with rights issues 'in a manner consistent with the evolving capacities of the child'. The Convention does not take responsibility for children away from their parents and give more authority to governments. It does place on governments the responsibility to protect and assist families in fulfilling their essential role as nurturers of children.

Article 6 Survival and development: Children have the right to live. Governments should ensure that children survive and develop healthily.

Article 7 Registration, name, nationality, care: All children have the right to a legally registered name, officially recognised by the government. Children have the right to a nationality (to belong to a country). Children also have the right to know and, as far as possible, to be cared for by their parents.

Article 8 Preservation of identity: Children have the right to an identity – an official record of who they are. Governments should respect children's right to a name, a nationality and family ties.

Article 9 Separation from parents: Children have the right to live with their parent(s), unless it is bad for them. Children whose parents do not live together have the right to stay in contact with both parents, unless this might hurt the child.

Article 10 Family reunification: Families whose members live in different countries should be allowed to move between those countries so that parents and children can stay in contact, or get back together as a family.

Article 11 Kidnapping: Governments should take steps to stop children being taken out of their own country illegally. This article is particularly concerned with parental abductions. The Convention's Optional Protocol on the sale of children, child prostitution and child pornography has a provision that concerns abduction for financial gain.

Article 12 Respect for the views of the child: When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account. This does not mean that children can now tell their parents what to do. This Convention encourages adults to listen to the opinions of children and involve them in decision-making -- not give children authority over adults. Article 12 does not interfere with parents' right and responsibility to express their views on matters affecting their children. Moreover, the Convention recognises that the level of a child's participation in decisions must be appropriate to the child's level of maturity. Children's ability to form and express their opinions develops with age and most adults will naturally give the views of teenagers greater weight than those of pre-schoolers, whether in family, legal or administrative decisions.

Article 12 Respect for the views of the child: When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account.

Article 13 Freedom of expression: Children have the right to get and share information, as long as the information is not damaging to them or others. In exercising the right to freedom of expression, children have the responsibility to also respect the rights, freedoms and reputations of others. The freedom of expression includes the right to share information in any way they choose, including by talking, drawing or writing.

Article 14 Freedom of thought, conscience and religion: Children have the right to think and believe what they want and to practise their religion, as long as

they are not stopping other people from enjoying their rights. Parents should help guide their children in these matters. The Convention respects the rights and duties of parents in providing religious and moral guidance to their children. Religious groups around the world have expressed support for the Convention, which indicates that it in no way prevents parents from bringing their children up within a religious tradition. At the same time, the Convention recognizes that as children mature and are able to form their own views, some may question certain religious practices or cultural traditions. The Convention supports children's right to examine their beliefs, but it also states that their right to express their beliefs implies respect for the rights and freedoms of others.

Article 15 Freedom of association: Children have the right to meet together and to join groups and organizations, as long as it does not stop other people from enjoying their rights. In exercising their rights, children have the responsibility to respect the rights, freedoms and reputations of others.

Article 16 Right to privacy: Children have a right to privacy. The law should protect them from attacks against their way of life, their good name, their families and their homes.

Article 17 Access to information; mass media: Children have the right to get information that is important to their health and wellbeing. Governments should encourage mass media – radio, television, newspapers and Internet content sources – to provide information that children can understand and to not promote materials that could harm children. Mass media should particularly be encouraged to supply information in languages that minority and indigenous children can understand. Children should also have access to children's books.

Article 18 Parental responsibilities; state assistance: Both parents share responsibility for bringing up their children, and should always consider what is best for each child. Governments must respect the responsibility of parents for providing appropriate guidance to their children – the Convention does not take responsibility for children away from their parents and give more authority to governments. It places a responsibility on governments to provide support services to parents, especially if both parents work outside the home.

Article 19 Protection from all forms of violence: Children have the right to be protected from being hurt and mistreated, physically or mentally. Governments should ensure that children are properly cared for and protect them from violence, abuse and neglect by their parents, or anyone else who looks after them. In terms of discipline, the Convention does not specify what forms of punishment parents should use. However, any form of discipline involving violence is unacceptable. There are ways to discipline children that are effective in helping children learn about family and social expectations for their behaviour – ones that are non-violent, are appropriate to the child's level of development and take the best interests of the child into consideration. In most countries, laws already define what sorts of punishments are considered excessive or abusive. It is up to each government to review these laws in light of the Convention.

Article 20 Children deprived of family environment: Children who cannot be looked after by their own family have a right to special care and must be looked

after properly, by people who respect their ethnic group, religion, culture and language.

Article 21 Adoption: Children have the right to care and protection if they are adopted or in foster care. The first concern must be what is best for them. The same rules should apply whether they are adopted in the country where they were born, or if they are taken to live in another country.

Article 22 Refugee children: Children have the right to special protection and help if they are refugees (if they have been forced to leave their home and live in another country), as well as all the rights in this Convention.

Article 23 Children with disabilities: Children who have any kind of disability have the right to special care and support, as well as all the rights in the Convention, so that they can live full and independent lives.

Article 24 Health and health services: Children have the right to good quality healthcare – the best healthcare possible – to safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy. Rich countries should help poorer countries achieve this.

Article 25 Review of treatment in care: Children who are looked after by their local authorities, rather than their parents, have the right to have these living arrangements looked at regularly to see if they are the most appropriate. Their care and treatment should always be based on ‘the best interests of the child’. (see Guiding Principles, Article 3)

Article 26 Social security: Children – either through their guardians or directly – have the right to help from the government if they are poor or in need.

Article 27 Adequate standard of living: Children have the right to a standard of living that is good enough to meet their physical and mental needs. Governments should help families and guardians who cannot afford to provide this, particularly with regard to food, clothing and housing.

Article 28: Right to education: All children have the right to a primary education, which should be free. Wealthy countries should help poorer countries achieve this right. Discipline in schools should respect children’s dignity. For children to benefit from education, schools must be run in an orderly way – without the use of violence. Any form of school discipline should take into account the child’s human dignity. Therefore, governments must ensure that school administrators review their discipline policies and eliminate any discipline practices involving physical or mental violence, abuse or neglect. The Convention places a high value on education. Young people should be encouraged to reach the highest level of education of which they are capable.

Article 29 Goals of education: Children’s education should develop each child’s personality, talents and abilities to the fullest. It should encourage children to respect others, human rights and their own and other cultures. It should also help them learn to live peacefully, protect the environment and respect other people. Children have a particular responsibility to respect the rights their parents, and education should aim to develop respect for the values and culture of their parents. The Convention does not address such issues as school

uniforms, dress codes, the singing of the national anthem or prayer in schools. It is up to governments and school officials in each country to determine whether, in the context of their society and existing laws, such matters infringe upon other rights protected by the Convention.

Article 30 Children of minorities/indigenous groups: Minority or indigenous children have the right to learn about and practice their own culture, language and religion. The right to practice one's own culture, language and religion applies to everyone; the Convention here highlights this right in instances where the practices are not shared by the majority of people in the country.

Article 31 Leisure, play and culture: Children have the right to relax and play, and to join in a wide range of cultural, artistic and other recreational activities.

Article 32 Child labour: The government should protect children from work that is dangerous or might harm their health or their education. While the Convention protects children from harmful and exploitative work, there is nothing in it that prohibits parents from expecting their children to help out at home in ways that are safe and appropriate to their age. If children help out in a family farm or business, the tasks they do be safe and suited to their level of development and comply with national labour laws. Children's work should not jeopardize any of their other rights, including the right to education, or the right to relaxation and play.

Article 33 Drug abuse: Governments should use all means possible to protect children from the use of harmful drugs and from being used in the drug trade.

Article 34 Sexual exploitation: Governments should protect children from all forms of sexual exploitation and abuse. This provision in the Convention is augmented by the Optional Protocol on the sale of children, child prostitution and child pornography.

Article 35 Abduction, sale and trafficking: The government should take all measures possible to make sure that children are not abducted, sold or trafficked. This provision in the Convention is augmented by the Optional Protocol on the sale of children, child prostitution and child pornography.

Article 36 Other forms of exploitation: Children should be protected from any activity that takes advantage of them or could harm their welfare and development.

Article 37 Detention and punishment: No one is allowed to punish children in a cruel or harmful way. Children who break the law should not be treated cruelly. They should not be put in prison with adults, should be able to keep in contact with their families, and should not be sentenced to death or life imprisonment without possibility of release.

Article 38 War and armed conflicts: Governments must do everything they can to protect and care for children affected by war. Children under 15 should not be forced or recruited to take part in a war or join the armed forces. The Convention's Optional Protocol on the involvement of children in armed conflict further develops this right, raising the age for direct participation in armed

conflict to 18 and establishing a ban on compulsory recruitment for children under 18.

Article 39 Rehabilitation of child victims: Children who have been neglected, abused or exploited should receive special help to physically and psychologically recover and reintegrate into society. Particular attention should be paid to restoring the health, self-respect and dignity of the child.

Article 40 Juvenile justice: Children who are accused of breaking the law have the right to legal help and fair treatment in a justice system that respects their rights. Governments are required to set a minimum age below which children cannot be held criminally responsible and to provide minimum guarantees for the fairness and quick resolution of judicial or alternative proceedings.

Article 41 Respect for superior national standards: If the laws of a country provide better protection of children's rights than the articles in this Convention, those laws should apply.

Article 42 Knowledge of rights: Governments should make the Convention known to adults and children. Adults should help children learn about their rights, too. (See also article 4.)

Articles 43–54 implementation measures: These articles discuss how governments and international organizations such as UNICEF should work to ensure children are protected in their rights.

Appendix 2: Community charity grading:

Socio – Economic status Assessment tool- Duncan CHDP

Name of the Patient:Guardian name:

.....

Aadhar Card Number..... / Voter ID
card.....

Referred from :Project / Camp

Address: Block Panchayat

Village

SE Status:

1. Caste: General [3] BC/ OBC [2] SC [0]
2. House: Pucca [3] Semi pucca [2] Katcha [0] Rent
and If rent then amount /month if more than 2000 [3] [House made by Indira
Awas Yojana [-1]
3. Animals: No [-1] Hen/duck [0] Goat [1] Cow [2] Buffalo [3]
.Own [+1] Hire [-2]
- 4.Assests: No [-1] Basic Mobile phone [0] T.V [1] Two wheeler
[3] cycle [0] LPG GAS [1] Own Tanga and
bullock cart [3]

Demographics:

5. Highest educational status: Illiterate [0] till primary education [1] till 10th [2]
> 10 [3]

If govt then [0] private school [2] Not applicable

6. If Chronic condition (Disability / HIV / Cancer / PwMDs / COPD / Seizure
disorder / TB / Diabetes/ Paralysis / Stroke / Leprosy) [-2] How many
members > 1 member [-2]

7. Number of employed persons: not employed (-1) / 1-2 people (0) / > 2 people (1)

8. If Land then: No land / 10 Dhur to 1 katha (-1) / 2-4 Katha (1) / 5-9 Katha (3) / >10 Katha [5]

9. If DWL then highest income per day < 165 [-1]/ 165-300 [1] / 300-500 [3] / > 500 [4]

If In Kind then[-1]

10. If salaried then monthly income - <5000 [1] / 5000-10,000 [2]/ 10,000-20,000 [3] / > 20,000 [5]

11. Debt/ Loan Yes [-1] No [0]

Loan Reason Health [-1] / non health [0] If child labour / bonded labour -2

Field level verification date: Done by: Signature supervisor
PM signature

Grade of charity

(maximum 36 marks, minimum -16 marks).

Grade	0	No Charity	21-36 points
Grade	1	25% Charity	11-20 points
Grade	II	50% charity	-2 to 10 points
Grade	III	75% Charity	-9 to -1 points
Grade	IV	100% Charity	-16 to -10 points

Appendix 3: Informed consent

Informed consent form for participating in research related to caretakers' behaviour with regard to seeking healthcare for their children under five years in East Champaran, Bihar State, India.

Name of researchers: XXXXX

Name of organisation: Duncan Hospital Raxaul

Part I: Information Sheet

Introduction

In Bihar a large number of children die before their fifth birthday. Some of these deaths are preventable and we want to assess some of the issues related to how and why parents care for the sicknesses of children in the under-five age group.

Purpose of the research

To find out ways we can help, we need to interview you as parents or caretakers about the children in your care who are under five years old. We will ask questions about the illnesses and how they were cared for and why you decided to care in the given way. We also want to ask some other questions about the situation of the family.

Type of Research Intervention

This research will involve your participation in either FGD or participation in an interview. It would take about 45 minutes to an hour of your time.

Voluntary Participation

Your participation in this research is totally optional/ voluntary and so it is your choice whether you participate or not. If you choose not to participate you will get all the same opportunities as you would have otherwise with respect to our project work. If you change your mind and stop responding to the interview or FGD you can choose to leave the interview at any stage.

Procedures

We will record the interview using an audio recorder and then write down the discussion in a document. This document will be stored safely so that only those who are directly related to the study can read it. We do not think there is any negative thing that can happen as a result of your participation in this research.

Benefits

Your participation in this research will be important for the health programmes operating in your area. The research will increase understanding on caretakers' behaviour in seeking healthcare for the children and thereby help us to suggest ways to improve their survival and development.

Sharing the Results

The knowledge that we get from this research will be summarised and given to the community health team in Duncan Hospital.

Whom to Contact

This proposal has been reviewed and approved by the EHA ethics committee, which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find about more about this research, please contact Duncan Hospital - 06255220653.

Do you have any questions?

Part II: Certificate of Consent

I have been invited to participate in this research that seeks to know more about caretakers behaviour to seek healthcare for their children under the age of 5 years.

I understand the information above. I have had the opportunity to ask questions about it. I consent voluntarily to be a participant in this study

Name of Participant:

Signature of Participant:

Date:

Statement by the researcher/person taking consent

I have provided the information sheet to the potential participant, and to the best of my ability made sure that the participant understands it.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this part 1 has been provided to the participant.

Name of Researcher/person taking the consent:

Signature of Researcher /person taking the consent:

Date:

Appendix 4: Themes: focus group discussion

Healthcare for children under five in East Champaran, North India

1. What did you do when your child was sick last time?

(treatment sought or not, reason for choosing one health facility over the other)
2. Why did you decide to do so? (Responses to be further explored)
3. How can children be kept from not getting sick? Do you think some children need more help than others? Explain!
4. In your opinion, does any sex of the child get sicker? Why do you think so?
5. If there was a poor family with a number of sick children, which ones would they decide to take for help? (How do they usually decide this? What do you feel about these decisions?)
6. Suppose there is a family with a very sick child who has to keep going to the hospital and whose illness is likely to be prolonged. What will the family do and how will they decide this? (What is your opinion about these decisions?)
7. How did you celebrate the birth of each of your children?
8. Do you think children need different food depending on the sex? Why do you think so? Explain!

Appendix 5: Key informant interviews

Healthcare for children under five years

Participant information:

Name:

Age:

Sex:

Village:

Panchayat:

Block:

How do you make your living?

Education:

Key question	Eventual Question (for probing)
Treatment	
How is the behaviour of parents/grandparents when their children fall sick?	Why? Explain! Probe on healthcare quality; availability, access; costs and sex differences
How is the decision to seek healthcare made? Who decided?	How did you feel about this?
Nutrition:	
How are you feeding your children?	There are any preferences?
Social:	
How do people feel when they have born a daughter/son?	How is the birth of a son/ daughter celebrated? (if any probe on differences)
What is your dream for your son/ daughter in the future?	Expectations? Why? (family advantage or disadvantage)

Appendix 6: CD

1. Focus group discussions
2. Key informant interviews
3. Data analysis maxqda