

Gender Role towards Child Health and Care; A Study among Oraon Pre-School Children of West Bengal, India

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INTRODUCTION:

“We are evolving a new style of fatherhood, in which young fathers share very fully with mothers in the care of babies and little children... One question one can ask is what effect this is likely to have on the next generation and the life of the wider community.”

-----Margaret Mead (1980)

“Gender” is referred as a complicated whole of cultural form comprising of norms, values and behaviors that are particularly oriented to a minimum of one biological sex or another during a given society. In a given context where sex and gender are confined as a set of cultural norms and practices, “sexuality” is mostly referred to as an individualized concept. Cultural affinity have large impact on how males and females are interacted in a society, resulting many researchers to prefer the terms gender differences or gender roles so that it reflect the impact of culture on differences between sexes. In the realm of social science it is hard to acknowledge these particular difference as biological or cultural, or both because in different societies, parents start nurturing their boy and girl child differently which often varies from society to society (Ember and Ember, 2004).

According to Rubin (1975) each society has their own sex/gender system which is arrangement of a set of biological raw material of human sex and procreation, which is shaped by human’s social interventions. These arrangements vary between different societies according to their culture conventionally structuring kinship and marriage. In the course of interventions, Anthropologists proposed that men and women have different roles because of their biological differences where sociologists asserts that confinement of women to domestic roles and subordinations were because of men’s engagement in economic activity and becoming property owner. Feminists also argue that assignment of domestic role to women and non-domestic to men was not due to their biological differences. Thus there are various assertions for gender role differentiation (Sudha, 2000).

I. Review of Literature

At the beginning of British advent in India the status of women was at its worse. Child marriage, Sati Dahi, Devdasi system was prevalent among Hindus. Purda was strictly enforced among Muslim women (Majumdar, 2005). Childhood is the first platform to develop gender identities and strategy. From the very beginning of preschool, children learn to classify themselves and others into particular gender identity. The blossoming of a gender identity and apprehension of the expectations associated with it continue throughout childhood (McCabe, Fairchild, Grauerholz, Pescosolido & Tope, 2011). Evidence shows that these disparities in children's chances to get older healthy, educated and safe stem chiefly from three factors: poverty, with children within the poorest quintile faring significantly worse than others; geographic residence, with children who reside within the poorest regions and countries, also as in remote rural areas and concrete slums within countries, facing significant disadvantages; and gender, with girls facing disproportionate threats to their well-being and to the belief of their human rights. In most societies round the world, gender norms favor men and boys. Boys and men, particularly those that conform to the masculine norm, typically enjoy gender inequality because it gives them more power and standing, a stronger voice in decision-making, greater access to resources, greater personal freedom, more agency and more robust rights than girls and ladies. In another example, a woman from an ethnic group living in poverty may find her life chances dramatically curtailed as each sort of discrimination – supported gender, ethnicity and socio-economic status – shuts the door on a definite set of choices and opportunities (UNICEF, 2011).

Natality inequality is ardent in many of the male dominated societies and these manifests in the form of parents wanting their newborn to be a boy rather than a girl and thus sex selective abortions has become common in India (Jha & Nagar, 2015). In a tribal society woman occupies an important place in constructing the socio-economic structure. The Dhebar Commission Report (1961) mentions that tribal women, generally enjoys more freedom related to her social life, in comparison with non tribal. Moreover, the status of tribal women has gone from bad to worse as a result of the impact of social change which has affected the social organization of tribal society (Chauhan, 1990). Women health among tribes is a grossly neglected concept. Almost all tribal women follow unhygienic practices as far their maternal health cares. Vaccination and immunization of Infants and youngsters are inadequate among tribal groups. In addition, extremes of magic-religious beliefs and taboos tend to aggravate the problems (Naidu, 2015). Health problems and health practices of tribal communities are profoundly influenced by the inter-play of complex social, cultural, educational, economic and political practices (Balgir, 2005). Studies revealed critical nutritional statuses and care giving facilities among Oraon and KoraMudi children of West Bengal, recommended to enhance care giving practices and facilitate Nutritional Rehabilitation Programmes (Sasmal & Jana, 2002; Bisai & Mallick, 2011).

Objectives

The objectives of the present study are:

- (i) To find out the health care facilities provided to Oraon pre-school children and possible gender equity among them.
- (ii) To quantify health status and the effect of gender among Oraon pre-school children from different anthropometric parameter by means of standardized reference values.

II. Methodology

Study Area

The present study has been conducted among both Urban and Rural settlements. For Oraon population residing in rural areas, four tea gardens namely Nepuchhapur Tea Garden (26°47'16.27"N & 88°43'57.71"E), GurjangJhora Tea Garden (26°54'00.20"N & 88°43'39.89"E), Oodlabari Tea Garden (26°49'42.15"N & 88°37'0.82"E) and Rangamati Tea Garden (26°53'27.21"N & 88°41'47.27"E) of Jalpaiguri District of West Bengal was selected. For Urban settlement the data was collected from two corporation areas namely Howrah Corporation [Prem Nagar Colony (22°34'41.01"N & 88°18'11.02"E) and Rup Nagar Colony (22°35'7.05"N & 88°17'39.84"E)] of Howrah District and Chandannagar Corporation [Saoli Bat tala (22°52'41.86"N & 88°21'54.59"E) and Dhangor Para (22°52'34.97"N & 88°22'10.81"E)] of Hoogly District.

Study Participants

Total 400 Oraon pre-school children below six years of age was selected from the study area among which 200 children (100 of each sex) from each Urban and Rural areas of West Bengal. For the present study purpose, parents of the selected children were also taken in concern and interviewed to acquire information about child health care practices.

Inclusion criteria- In the present study, families having at least one child of each sex below six years of age were selected to understand possible gender role in health and care practices.

Sampling

Data has been collected from the study area through multi stage random sampling method keeping in minds the objectives and availability of participants for the present research.

Data Collection

In the present study the health care related data i.e. place of birth, type of delivery, drinking water provided to the children, exclusive breast feeding practices, immunization status and disease treatment facilities provided to the children were collected from parents of the selected children with cross verification of the official documents viz. birth certificates, immunization card and doctors prescriptions. Along with that general demographic information and standard anthropometric measurements of the children were collected like age, sex, height and weight.

Data Analysis

Collected data were primarily tabulated in Microsoft excel 2007 version. Anthropometric data were compared with WHO (2006) standardized reference values by age to find out the health status of the children by means of height-for-age, weight-for-age, weight-for-height and BMI-for-age. Health care data were analyzed by standard guidelines such as type of drinking water, exclusive breast feeding practices, immunization status and disease treatment facility providers. Later the classified data were analyzed statistically in IBM SPSS 24.0 to understand if there is any differences exists between boys and girls of Oraon pre-school children holding 0.05 significance level as standard.

Research Ethics

The study was conducted following ethical guidelines obtained from Institutional Ethics Committee of West Bengal State University and oral consent was taken from the parents in time of data collection.

III. Results And Discussions

The results are classified in to two main groups, first one deals with the health care practices of the children and second part explains the outcome i.e. health status of the children by sex.

Health Care Practices(Table 1):

Different type of health care and awareness was taken in concern to understand if there is any gender difference present between children from the parent’s side. Though Place of birth and type of birth data were taken just to understand parent’s health care related awareness.

It was found that 93.5% children were born in hospital where as only 6.5% children were born in home. Though there is statistical difference between boys and girls but it is irrelevant to the present study. According to the data it was also found that 77% children were born normally where as 23% children were born by seizure operation.

Among pre-school children, drinking water is very crucial for health care purpose. It was found in the present study that 35% boys and 42% girls are provided boiled or purified drinking water where as 61.5% of the children are getting normal water from well or tube well. There is a small difference between boys and girls but that is not statistically significant.

Table 1: Distribution and statistical comparison of child health care practices by boys & girls.

Health Care Practices	Caring Status	Sex		Total (%)	Chi-square Value	p-value
		Boys (%)	Girls (%)			
Place of Birth	Hospital	192 (96)	182 (91)	374 (93.5)	4.114	0.043*
	Home	8 (4)	18 (9)	26 (6.5)		
Delivery Type	Normal	148(74)	160 (80)	308 (77)	2.033	0.154
	Seizure	52 (26)	40 (20)	92 (23)		
Drinking Water	Boiled or Purified	70 (35)	84 (42)	154 (38.5)	2.069	0.150
	Normal	130 (65)	116 (58)	246 (61.5)		
Exclusive Breast Feeding	Yes	188 (94)	186 (93)	374 (93.5)	2.333	0.675
	No	12 (6)	14 (7)	26 (6.5)		
Immunization Status	Full	182 (91)	178 (89)	360 (90)	2.203	0.332
	Partial	18 (9)	22 (11)	40 (10)		
Disease Treatment	Registered Doctor	196 (98)	197 (98.5)	393 (98.25)	0.145	0.703
	Quack Doctor	4 (2)	3 (1.5)	7 (1.75)		

* p-value less than 0.05; Difference is significant.

Awareness about exclusive breast feeding is very satisfactory. 93.5% of the total children found having exclusive breast feed where only 6.5% children haven’t get exclusive breast feed up to six months. There is also no statistical difference found between boys and girls.

When concentrating on immunization of the children, it was found that 90% of the children (91% boys & 89% girls) getting every dozes of immunization where 9% boys and 11% girls have missed some dozes of vaccines. No statistical difference was found between boys and girls in this respect.

In the last part of health care practices, the parents were asked about the disease treatment facilities provided to their children. It was observed that 98% boys and 98.5% girls are getting treatment from registered medical practitioners were only 2% boys and 1.5% girls are being treated by quack doctors. The result also showed no gender discrimination among Oraon children in disease treatment facilities.

Health Status (Table 2):

The second part of the study seeks to understand the impact of health care facilities in the nutritional statuses of the children under study.

The first parameter taken to understand the nutritional status is height-for-age status. It was found from the study that 66.5% boys and 64.5% girls are normal in respect of height-for-age where 33.5% boys and 35.5% girls are stunted according to WHO (2007) reference values. Though there is no statistical difference found between boys and girls in this respect but the result is showing a huge level of long term malnourishment among the Oraon children (34.5%).

The second parameter is weight-for-age status. It was found from the collected data that 54% boy & 48% girl showing normal weight-for-age where as 46% boys and 52% girls having low weight-for-age i.e. underweight according to WHO reference. Though girls in this respect showing higher rate of being underweight, but statistically this difference is insignificant.

Table 2: Distribution and statistical comparison of child nutritional status by boys and girls according to WHO cut-off values.

Nutritional Parameter	Nutritional statuses	Sex		Total (%)	Chi-square Value	p-value
		Boys (%)	Girls (%)			
Height-for-age	Normal	133 (66.5)	129 (64.5)	262 (65.5)	0.177	0.674
	Stunted	67 (33.5)	71 (35.5)	138 (34.5)		
Weight-for-age	Normal	108 (54)	96 (48)	204 (51)	1.462	0.481
	Underweight	92 (46)	104 (52)	196 (49)		
Weight-for-height	Normal	126 (63)	117 (58.5)	243 (60.75)	5.583	0.061
	Wasted	74 (37)	83 (41.5)	157 (39.25)		
BMI-for-age	Normal	131 (65.5)	120 (60)	251 (62.75)	5.010	0.082
	Underweight	69 (34.5)	80 (40)	149 (37.25)		

* p-value less than 0.05; Difference is significant.

Weight-for-height status was taken as the third parameter where it was seen that 63% boy and 58.5% girl are normal. In comparison 37% boy and 41.5% girl possessing low weight-for-height status i.e. wasted according to WHO (2006). Here also no significant difference found between boys and girls at 0.05 levels.

The last parameter is BMI-for-age status. The BMI-for-age data showed 65.5% boy & 60% girl are within normal reference range where as 34.5% boy and 40% girl found below -2 standard deviation of the reference value, i.e. underweight. The difference between boys and girls are though statistically insignificant.

Thus both the section of the result does not provide any indication of discrimination between boys and girls in health care practices or nutritional statuses.

IV. Conclusion

The study was directed to understand if there is any gender discrimination exists among the Oraon pre-school children from their parent's caring facility providing and the possible outcomes in children's health statuses. The results from the collected data showed that among the Oraon tribe, parents does not possess any kind of discriminating attitudes towards care giving of their boy or girl child in the selected area and people under study. The same result also observed when concentrating on the nutritional statuses of the children, i.e. no statistically significant difference exists between boys or girls in height-for-age, weight-for-age, weight-for-height and BMI-for age statuses according to WHO (2006) classified reference values.

But one very alarming fact was found in the study that all the children irrespective of sex showing large number of malnutrition both in long term (stunted) and short term (underweight or wasted). This is very crucial fact that might have a great impact on the future generation of the Oraon tribe, if not solved earlier.

V. Recommendations

Half of adolescents' girls of India are below the normal body mass index, which has an impact on the health of their future pregnancies and children. Preventing stunting is critical to survival in the immediate term, and in the longer-term, to ensure healthy, well-educated and productive adults. Thus to prevent this kind of health problems and disease and to ensure healthy life cycle is a critical aim for UNICEF India. Also it is imperative to focus on enhancing the overall development of tribals to try and bridge the prevailing inequalities and disparities in the country (Narain, 2019).

The present research shows a huge problem of malnutrition among the Oraon pre-school children under study. If this kind of nutritional deficiency persists among the tribal children, it could be an alarming factor for their survival. Thus the governments both at the Centre and States must recognize improvement in the health status of the tribal population as well as children residing in the rural areas as among the topmost priorities from policy point of view and ensure adequate budget allocations made including under the National Tribal Plan along with proper supervision.

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