

HUMAN RESOURCE DEVELOPMENT AND HEALTH: A STUDY OF GIRL CHILD HEALTH (6-16 YEARS)

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ABSTRACT

Human resource development is very significant for the growth and development of North Western region including Jammu and Kashmir in which health constitutes an important dimension. Gender based health discrimination against girl child is very pervasive across the region. Evidence from literature suggests that girl child receive less health care than boys and therefore have lower health status. The same is true for girl child health status in Kashmir. The study is based on a sample of 150 respondents and has been carried out in the rural and urban areas of Srinagar district of the Kashmir valley. The objective of the study has been to analyse the social implications of gender health status of children (6-16 years) like frequency of illness, recovery time, doctor consultations, anaemia, mental health and nutritional intake. The socio-economic background of children is of pivotal importance; though there are numerous indicators of socio economic status yet household income and mothers' education were found to be important indicators of socio economic status which have a serious impact on health of girl child. This is evidenced from statistics released by Census 2011 which shows that overall sex ratio of 889 females per 1000 males in Kashmir as compared to 940 at the national level.

Key words. Human Resource Development; Health status; Girl child; Gender discrimination; Srinagar district.

Introduction

The health status of the people is the wealth of a nation as it is one of the major attributing factors of development. It is now globally acknowledged that investment in human resource development is a pre requisite for any nation. Human resource development is very significant for the growth and development of North Western region including Jammu and Kashmir in which health constitutes an important dimension. Childhood constitutes the most crucial period in life, when the foundations are laid for cognitive, social and emotional language, physical/motor development and cumulative lifelong learning. The young child is most vulnerable to the vicious cycles of malnutrition, disease/ infection and resultant disability all of which influence the present condition of a child at micro level and the future human resource development of the nation at the macro level¹. Rural areas are mostly backward areas and lag behind in development indicators. In all spheres of life including health, sanitation, awareness, education, income and political participation, they are accorded low status. Due to limited knowledge, skills and resources at their disposal, rural people are engaged in informal and unorganised sectors where wages are very low. As a result, the income is very low, thus degrading their quality of life and lowering their standards of living. They tend to get marginalised due to their low visibility and also due to the fact that their health issues tend to be confined within the domestic sphere.² Hence, it is clear that children form weaker sections of society due to their vulnerable position. Children need extra care because they are our supreme assets as the children of today form the human resource of tomorrow. Health is important because

it is better living and not because it is an instrument for better living. Better health can have interpersonal benefits. There are many externalities of morbidity and malnutrition. In the instrumental sense good health has an economic rationale. While good health leads to reduced medical costs of the government and households, ill health leads to loss of income for poor families subsisting on daily income, pushing them to hunger and malnutrition. Improving child health and nutrition is not only a moral imperative but also a rational long term investment. In reality, healthcare is one of the inputs that go in to the generation and maintenance of health. The health production function is symbolically represented as, $GOOD\ HEALTH = f(\text{nutritious food, pollution free environment, safe drinking water, mental peace, opportunity for work and recreation, genetic endowment, and use of health services})$ 3. Good health is essential for both individual and society. Good health is not a means towards an end but it is an end in itself. The provision of all the facilities for ensuring proper health therefore is a long term investment for the creation of a healthy and productive society.

Health is not simply a biological phenomenon but is rooted within the society. Gender is one the most influential of the social determinants of health. Gender inequality damages the health of millions of girls and women across the globe. It can also be harmful to men's health despite the many tangible benefits it gives men through resources, power, authority and control. Gender relations of power constitute the root causes of gender inequality. They determine whether people's health needs are acknowledged, whether they have voice or a modicum of control over their lives and health, whether they can realize their rights. Health gradients can be significantly different for men and women; medical poverty may not trap women and men to the same extent or in the same way. Gender systems have a variety of different features, not all of which are the same across different societies. Women may have less land, wealth and property in almost all societies; yet have higher burdens of work in the economy of care - ensuring the survival, reproduction and security of people, including young and old. Girls in some contexts are fed less, educated less, and more physically restricted; and women are typically employed and segregated in lower paid, less secure and informal occupations. Gender hierarchy governs how people live and what they believe and claim to know about what it means to be a girl or a boy, a woman or a man. Girls and women are often viewed as less capable or able, and in some regions seen as repositories of male or family honour and the self-respect of communities. Restrictions on their physical mobility, sexuality, and reproductive capacity are perceived to be natural; and in many instances, accepted codes of social conduct and legal systems condone and even reward violence against them⁴. Hence, it is clear that women constitute one of the vulnerable sections of society and their health status is influenced by their social standing. Preference to boys over girls is one of the influential factors in determining health of girl child. It determines their nutritional intake and healthcare. Girl child is mostly neglected by family due to less importance attributed to their very being.

2. Methodology

2.1. Rationale of the study

Children constitute one of the most vulnerable sections of society. They are understood as dependents on their families, society and state for their welfare and wellbeing. In spite of several focused initiatives addressing the various needs of children, it is very evident from the statistics that the health condition of children remains a cause of concern. The gender inequality is wide in terms of health, calling for special attention on girl child. It is estimated that every sixth female death is directly due to gender discrimination. The difference in sex ratio bears a testimony to such discrimination. Srinagar district has

worse sex ratio as compared to the country as well as the state. Hence, it is necessary to look into the impact of gender discrimination on health of children in Srinagar.

2.2. Hypothesis

1. The health status of girls is worse than boys mainly because of gender discrimination.
2. Nutritional status of girls lags behind boys.
3. Health care practices are undertaken more for boys compared to girls.

2.3. Objectives of study

1. To analyze the role of gender in determining the health status of girls.
2. To find out the difference in nutritional status of boys and girls.
3. To see the role of gender in seeking health care practices for boys and girls.

2.4. Sources of information

Data for the study is based on both primary as well as secondary sources. The secondary sources include official documents, schemes, government statistics, census data, books, Journals, research papers and studies carried by various Non Governmental Organizations, Newspaper reports etc. For generating further data and analyzing the impact of various socio-economic variables on health status of children, an extensive household survey was conducted.

2.5. Research design

This study has an explanatory research design and is conducted in a single situation (S1) and time period (S2).

a) Universe of the study

The universe of the study was district Srinagar which is the summer capital of J&K. It is divided in two Tehsils viz north Tehsil and south Tehsil. The district also consists of four medical Zone and one Block namely; Khanyar Zone, S.R.Gunj Zone, Batmaloo Zone, Zadibal zone and Hazratbal Block. As per 2011 census, Srinagar city's population was 1,192,792 and Srinagar urban agglomeration population was 1,273,312. The child population of both the city and the urban agglomeration is approximately 12% of the total population. Males constituted 53.0% and females 47.0% of the population⁵.

b) Sampling

The specific population selected for the sample was children between the age group of 6-16 years. Children selected for this study between the age group of 6-16 were further divided in two groups viz; 6-11 and 12-16 and an equal number of children i.e. 50% of the total sample was taken from each age group. This was done to provide equal assessment of health status of children belonging to different age groups and sex. The total sample consisted 150 (75 boys and 75 girls) children from different areas of Srinagar district. Stratified random sampling technique was used for the collection of sample in which population was stratified on the basis of age, sex, area, family income and mothers' education.

c) Locale

The locale for the study was district Srinagar from Kashmir region. The data was collected from both the North and South Tehsil of Srinagar district. In the North Tehsil the sample was drawn from 10 areas namely Hazratbal, Buchpora, Khanyar, Rainawari, Nowhatta, Nishat, Cheshmashahi, Shivpora, Batwara and Sonwar. Similarly, in the South Tehsil, the sample was drawn from 10 areas namely Baghimehtab, Chanapora, Natipora, Rambagh, Nowgam, Mehjoornagar, Padshahibagh, Barzulla, Hyderpora and Rawalpora.

d) Techniques of data collection

The techniques of interview schedule, observation and in-depth interviews were used for collecting data from the field.

e) Data Analysis

The data obtained through questionnaire was consolidated, analyzed and interpreted as per the requirement of the objectives. MS excel, SPSS and Minitab, Software were used for data analyses. The data was presented with the help of tables.

3. Results and Discussions

The major findings of the study are as under:

Frequency and recovery time of illness episodes provides insight into the health status of children as lower nutrient and immunity levels among children results in frequent and long illness episodes. Quick recovery from illness means better immunity level of the body which in turn means better health condition of the person. Table 1 provides details about frequency of illness episodes among children.

Table 1: Illness episodes and recovery time among children

Health indicators	Boys						Girls						Total responses	
	6-11 years		12-16 years		Total		6-11 years		12-16 years		Total		6-16 years	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Frequency of illness episodes														
Frequently falls ill	7	4.66	3	2.00	10.0	06.6	05.0	03.3	09.0	06.0	14.0	09.3	24.0	16.00
Frequently does not fall ill	31	20.6	34	22.6	65.0	43.3	32.0	21.3	29.0	19.3	61.0	40.6	126.	84.00
Total	38	25.3	37	24.6	75.0	50.0	37.0	24.6	38.0	25.3	75.0	50.0	150.	100.0
Time taken to recover from illness														
Recovers quickly without medication	03.0	02.0	05.0	03.3	08.0	05.3	04.0	02.6	02.0	01.3	06.0	04.0	14.0	09.33
Recovers quickly only after medication	27.0	18.0	26.0	17.3	53.0	35.3	24.0	16.0	25.0	16.6	49.0	32.6	102.	68.00
Takes time to recover without medication	01.0	00.6	03.0	02.0	04.0	02.6	04.0	02.6	02.0	01.3	06.0	04.0	10.0	06.66
Takes time to recover even after medication	07.0	04.6	03.0	02.0	10.0	06.6	05.0	03.3	09.0	06.0	14.0	09.3	24.0	16.00
Total	38.0	25.3	37.0	24.6	75.0	50.0	37.0	24.6	38.0	25.3	75.0	50.0	150.	100.0

Source: Field Data for health status of children, 2014 in Srinagar District of Kashmir Valley

Table 1 shows that boys have better health status compared to girls in all the indicators of low immunity, however girls fared better than boys in the lower age group of 6-11 years. Maximum (43.33 percent) boys and 40.66 percent girls do not fall ill frequently with majority of boys (22.66 percent) in 12-16 years age group and majority of girls (21.33 percent) in the age group of 6-11 years. 6.66 percent boys and 9.33 percent girls were reported to fall frequently ill with majority of boys (4.66 percent) in 6-11 years age group and majority of girls (6 percent) in the age group of 12-16 years. Only 5.33 percent boys and 4 percent girls recover quickly without medication. The above findings reveal that boys have slightly lesser illness episodes and recover quickly with or without medication (40.66 percent) as compared to girls (36.66 percent). These findings fall in line with a number of studies which highlight low health status among girls due to preferential treatment given to boys as compared to girls in India. Study of Suresh Sharma in Haryana clearly shows that gender inequalities prevail in work, education, allocation of food, and health care. Similarly, studies like Arnold et al, 1992; Sen and Sen Gupta 1983; Pebley and Amin, 1991 show that girls are more likely to be malnourished than boys in both the northern and southern states⁶.

Doctor s consultation is important at the time of illness and acts as an important indicator in showing how much importance parents attribute to the wellbeing of their children. It reveals the level of awareness among parents about the need to consult a doctor for their children instead of self medicating them at the time of illness. It also brings forth various possible reasons responsible for parents inability to consult a doctor.

Table 2: Doctor Consultations among children

Responses	Boys						Girls						Total responses	
	6-11 years		12-16 years		Total		6-11 years		12-16 years		Total		6-16 years	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Often takes child to the doctor when ill														
Yes	27.00	18.00	32.00	21.33	59.00	39.33	31.00	20.66	25.00	16.66	56.00	37.33	115.00	76.66
No	11.00	07.33	05.00	03.33	16.00	10.66	06.00	04.00	13.00	08.66	19.00	12.66	35.00	23.33
Total	38.00	25.33	37.00	24.66	75.00	50.00	37.00	24.66	38.00	25.33	75.00	50.00	150.00	100.00
Reasons for no treatment														
Poverty	08.00	22.85	04.00	11.42	12.00	34.28	03.00	08.57	11.00	31.42	14.00	40.00	26.00	74.28
Treatment not necessary	00.00	00.00	01.00	02.85	01.00	02.85	02.00	05.71	00.00	00.00	02.00	05.71	03.00	08.57

Health facility too far	00.0 0	00.0 0	00.0 0	00.00	00.0 0	00.0 0	00.0 0	00.0 0	01.0 0	02.8 5	01.0 0	02.8 5	01.0 0	02.8 5
Any other	03.0 0	08.5 7	00.0 0	00.00	03.0 0	08.5 7	01.0 0	02.8 5	01.0 0	05.7 1	02.0 0	05.7 1	05.0 0	14.2 8
Total	11.0 0	31.4 2	05.0 0	14.28	16.0 0	45.7 1	06.0 0	17.1 4	13.0 0	37.1 4	19.0 0	54.2 8	35.0 0	100. 0

Source: Field Data for health status of children, 2014 in Srinagar District of Kashmir Valley

Table 2 reveals that majority of boys (39.33 percent) and girls (37.33 percent) were often taken to the doctor at the time of illness, while 10.66 percent boys and 12.66 percent girls were not often taken to the doctor when ill. These findings reveal that girls are a little less likely to be taken to the doctor at the time of illness as compared to boys, however the difference is small i.e. only 2 percent. Among the reasons responsible for no treatment of children, poverty was the main reason. Out of 74.28 percent children who couldn't receive treatment due to poverty, majority of boys (22.85 percent) belonged to 6-11 years age group, while majority of girls (31.42 percent) belonged to 12-16 years age group. 2.85 percent boys and 5.71 percent girls were not taken to the doctor because their parents didn't consider treatment necessary for their children. The findings reveal that income status of the family plays an important role in doctor consultations and treatment options for children at the time of illness. Even when health services are provided free of cost by government, the findings show that these services are not sufficient to cover all costs of treatment as inability to meet the medical expenses forces people to skip treatment of their children. A similar result has been obtained by Bermana, Zeitlina, Roy and Khumtakar in their study which was carried in Haryana state of India. The study reveals that 20.3 percent children were not taken to the doctor at the time of illness mainly due economic reasons⁷.

Signs and Symptoms of ill health are essential in ascertaining the health status of children. Illness and sickness are generally used as symptoms for disease. However, this term is used to refer specifically to the patient's personal experience of his or her disease. In the present study the children's personal account of illness has been taken into consideration. A number of symptoms were used to check the health status of children. Most of these problems are caused by lack of proper nutrition and health care which are beneficial in revealing both the health status of children and the underlying causes of the same.

Table 3: Signs and symptoms of ill health among children

Signs and symptoms	Boys						Girls						Total responses	
	6-11 years		12-16 years		Total		6-11 years		12-16 years		Total		6-16 years	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Ill health symptoms														
Lack of energy	02.0 0	01.3 3	03.0 0	02.0 0	05.0 0	03.3 3	03.0 0	02.0 0	04.0 0	02.6 6	07.0 0	04.6 6	12.0 0	08.0 0

Lack of appetite	04.0 0	02.6 6	03.0 0	02.0 0	07.0 0	04.6 6	04.0 0	02.6 6	02.0 0	01.3 3	06.0 0	04.0 0	13.0 0	08.6 6
Dizziness	02.0 0	01.3 3	00.0 0	00.0 0	02.0 0	01.3 3	01.0 0	00.6 6	05.0 0	03.3 3	06.0 0	04.0 0	08.0 0	05.3 3
All of these	07.0 0	04.6 6	03.0 0	02.0 0	10.0 0	06.6 6	05.0 0	03.3 3	09.0 0	06.0 0	14.0 0	09.3 3	24.0 0	16.0 0
None of these	23.0 0	15.3 3	28.0 0	18.6 6	51.0 0	34.0 0	24.0 0	16.0 0	18.0 0	12.0 0	42.0 0	28.0 0	93.0 0	62.0 0
Total	38.0 0	25.3 3	37.0 0	24.6 6	75.0 0	50.0 0	37.0 0	24.6 6	38.0 0	25.3 3	75.0 0	50.0 0	150. 0	100. 0
Health problems														
Under weight	02.0 0	01.3 3	01.0 0	00.6 6	03.0 0	02.0 0	02.0 0	01.3 3	00.0 0	00.0 0	02.0 0	01.3 3	05.0 0	03.3 3
Over weight	00.0 0	00.0 0	01.0 0	00.6 6	01.0 0	00.6 6	00.0 0	00.0 0	02.0 0	01.3 3	02.0 0	01.3 3	03.0 0	02.0 0
Anaemia/other deficiency	05.0 0	03.3 3	02.0 0	01.3 3	07.0 0	04.6 6	04.0 0	02.6 6	11.0 0	07.3 3	15.0 0	10.0 0	22.0 0	14.6 6
Both under weight and anaemic	03.0 0	02.0 0	01.0 0	00.6 6	04.0 0	02.6 6	01.0 0	00.6 6	06.0 0	04.0 0	07.0 0	04.6 6	11.0 0	07.3 3
None	28.0 0	18.6 6	32.0 0	21.3 3	60.0 0	40.0 0	30.0 0	20.0 0	19.0 0	12.6 6	49.0 0	32.6 6	109. 0	72.6 6
Total	38.0 0	25.3 3	37.0 0	24.6 6	75.0 0	50.0 0	37.0 0	24.6 6	38.0 0	25.3 3	75.0 0	50.0 0	150. 0	100. 0

Source: Field Data for health status of children, 2014 in Srinagar District of Kashmir Valley

Table 3 shows that majority of boys (34%) and girls (28%) had no symptoms like lack of energy, lack of appetite and dizziness, while 22% girls and 16% boys have one or all of these symptoms. Also, on seeking information about health issues like underweight, overweight, anaemic or other deficiency, majority of boys (40%) and girls (32.66%) were found to have none of the problems, while 10% girls and 4.66% boys had anaemia or other deficiency. 4.66% girls and 2.66% boys were both anaemic and underweight and 2% boys and 1.33% girls were under weight. A similar trend has been provided by National Family Health Survey 3 which shows that one-fourth (26%) children in Jammu and Kashmir are underweight, which takes into account both chronic and acute undernutrition. Among children between the ages of 6 and 59 months, the majority (59 percent) were reported to be anaemic⁸. However, NFHS 3 reveals that boys and girls are equally likely to have anaemia but in the present study girls were seen to be more anaemic as compared to boys. In all cases boys seem to have better health compared to girls especially in the age group of 12-16 years.

Nutrition is a basic human need and a prerequisite to a healthy life. It is a major determinant of the health and wellbeing of children. Inadequate or unbalanced diets and chronic illness are associated with poor

nutrition among children. A proper diet is essential from the very early stages of life for proper growth, development and to remain active. Lack of proper diet may result in malnutrition. Malnutrition commonly affects all groups in a community, but infants and young children are the most vulnerable because of their high nutritional requirements for growth and development.

Table 4: Nutritional intake among children

Health indicators	Boys						Girls						Total responses	
	6-11 years		12-16 years		Total		6-11 years		12-16 years		Total		6-16 years	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Takes meals adequately														
Yes	23.00	15.33	28.00	18.60	51.00	34.00	24.00	16.00	18.00	12.00	42.00	28.00	93.00	62.00
No	15.00	10.00	09.00	06.00	24.00	16.00	13.00	08.60	20.00	13.30	33.00	22.00	57.00	38.00
Total	38.00	25.33	37.00	24.60	75.00	50.00	37.00	24.60	38.00	25.33	75.00	50.00	150.00	100.00
Reason for not taking meals														
Lack of appetite	10.00	17.54	06.00	10.50	16.00	28.00	09.00	15.70	12.00	21.00	21.00	36.80	37.00	64.90
Doesn't take lunch to school	03.00	05.26	02.00	03.50	05.00	08.70	03.00	05.20	05.00	08.70	08.00	14.00	13.00	22.80
Poverty	02.00	03.50	01.00	01.70	03.00	05.20	01.00	01.70	03.00	05.20	04.00	07.00	07.00	12.20
Total	15.00	26.31	09.00	15.70	24.00	42.10	13.00	22.80	20.00	35.00	33.00	57.80	57.00	100.00

Source: Field Data for health status of children, 2014 in Srinagar District of Kashmir Valley

Table 4 depicts that 22 percent girls do not take their meals adequately compared to 16 percent boys. 34 percent boys do not miss any major meals compared to 28 percent girls. Majority, 28.07 percent boys and 36.84 percent girls miss their meals due to lack of appetite. 5.26 percent boys and 7.01 percent girls miss their meals because of their inability to consume adequate meals due to poverty which again shows a relation between nutrition and socio-economic status. The above findings show that girls have low dietary intake as compared to boys which can be attributed to gender bias as parents tend to take proper care of diet of boys as compared to girls. Although the percentage of girls missing meals due to poverty is more than boys, however the difference is small in comparison to the difference in the consumption of adequate meals among boys and girls. Hence, the differences in dietary intake can be attributed to discrimination in the provision of adequate meals to girl and boy child. These findings are in line with the study of Das Gupta which shows that gender differentials in nutritional status start during infancy, with discriminatory breastfeeding and supplementation practices. Infant girls are breastfed less frequently, for shorter duration,

and over shorter periods than boys⁹. Similarly, Sen and Sen Gupta (1983) show that girls are more likely to be malnourished than boys in both the northern and southern states¹⁰.

Mental health can be ascertained by the checking the prevalence of various signs and symptoms. Children suffering from mental health problems show signs like nervousness, intense fear under normal situations, frequent outbursts of anger and prolonged sadness. Children also complain of symptoms like stress, nightmares, lack of concentration etc. Table 4.5 provides detail of children suffering from various mental health problems in Srinagar.

Table 5: Mental health problems among children

Mental health problems	Boys						Girls						Total responses	
	6-11 years		12-16 years		Total		6-11 years		12-16 years		Total		6-16 years	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Complaints of the following problems														
Stress	06.0 0	04.0 0	11.0 0	07.3 3	17.0 0	11.3 3	07.0 0	04.6 6	13.0 0	08.6 6	20.0 0	13.3 3	37.0 0	24.6 6
Nightmares	01.0 0	00.6 6	00.0 0	00.0 0	01.0 0	00.6 6	00.0 0	00.0 0	00.0 0	00.0 0	00.0 0	00.0 0	01.0 0	00.6 6
Intense fear	01.0 0	00.6 6	02.0 0	01.3 3	03.0 0	02.0 0	02.0 0	01.3 3	00.0 0	00.0 0	02.0 0	01.3 3	05.0 0	03.3 3
Nervousness	02.0 0	01.3 3	03.0 0	02.0 0	05.0 0	03.3 3	03.0 0	02.0 0	04.0 0	02.6 6	07.0 0	04.6 6	12.0 0	08.0 0
Any other	00.0 0	00.0 0	02.0 0	01.3 3	02.0 0	01.3 3	00.0 0	00.0 0	01.0 0	00.6 6	01.0 0	00.6 6	03.0 0	02.0 0
None	28.0 0	18.6 6	19.0 0	12.6 6	47.0 0	31.3 3	25.0 0	16.6 6	20.0 0	13.3 3	45.0 0	30.0 0	92.0 0	61.3 3
Total	38.0 0	25.3 3	37.0 0	24.6 6	75.0 0	50.0 0	37.0 0	24.6 6	38.0 0	25.3 3	75.0 0	50.0 0	150. 0	100. 0
Existence of the following problems														
Sleeping too much or too little	00.0 0	00.0 0	02.0 0	01.3 3	02.0 0	01.3 3	01.0 0	00.6 6	02.0 0	01.3 3	03.0 0	02.0 0	05.0 0	03.3 3
Lack of concentration	07.0 0	04.6 6	05.0 0	03.3 3	12.0 0	08.0 0	02.0 0	01.3 3	05.0 0	03.3 3	07.0 0	04.6 6	19.0 0	12.6 6
Frequent out bursts of anger	03.0 0	02.0 0	01.0 0	00.6 6	04.0 0	02.6 6	01.0 0	00.6 6	00.0 0	00.0 0	01.0 0	00.6 6	05.0 0	03.3 3
Prolonged sadness	01.0 0	00.6 6	06.0 0	04.0 0	07.0 0	04.6 6	02.0 0	01.3 3	06.0 0	04.0 0	08.0 0	05.3 3	15.0 0	10.0 0
None	27.0 0	18.0 0	23.0 0	15.3 3	50.0 0	33.3 3	31.0 0	20.6 6	25.0 0	16.6 6	56.0 0	37.3 3	106. 0	70.6 6
Total	38.0 0	25.3 3	37.0 0	24.6 6	75.0 0	50.0 0	37.0 0	24.6 6	38.0 0	25.3 3	75.0 0	50.0 0	150. 0	100. 0

Source: Field Data for health status of children, 2014 in Srinagar District of Kashmir Valley

Table 5 reveals that majority of the children (31.33 percent boys and 30 percent girls) had no complaints of mental health problems like stress, night mares, intense fear, nervousness etc. Similarly, majority of the children (37.33 percent girls and 33.33 percent boys) had no complaint of prolonged sadness, lack of concentration, frequent outbursts of anger etc. Girls (13.33 percent) had higher complaints of stress as compared to boys (11.33 percent), while boys (8 percent) had higher complaints of lack of concentration as compared to girls (4.66 percent). Similarly, among the problems like prolonged sadness and nervousness girls fared worse than boys, while among other issues like intense fear, frequent outbursts of anger etc. boys fared worse than girls. These findings reveal that among boys and girls the difference between the incidences of mental health issues is little. These results are in not consonance with some studies like the study carried by Saima and Sharma on mental health status of children (12-18 years) from intact and disrupted families of Kashmir belonging to District Anantnag which reveals that girls have poor mental health (76.66 percent) compared to boys (66.66 percent)¹¹. This may be due to the fact that in my study more boys were reported to be affected by conflict situation prevalent in Kashmir as compared to girls. Some studies have also shown that girls mature quickly than boys and are more resilient to chronic stress than boys. Also, since boys were reported to be more affected by conflict, the mental health problems faced by girls are not solely due to the impact of conflict on their health. These findings can be explained by the previous findings where it was revealed that girls have lower physical health compared to boys. Since physical health condition also has an impact on mental health of children so these results are in consonance with the previous results.

4. Conclusions

The findings show that boys have better health status compared to girls in all the indicators of low immunity. 6.66 percent boys were reported to fall frequently ill compared to 9.33 percent girls. The findings reveal that boys have slightly lesser illness episodes and recover quickly with or without medication (40.66 percent) as compared to girls (36.66 percent). The findings reveal that majority of boys (39.33 percent) and girls (37.33 percent) were often taken to the doctor at the time of illness, while 10.66 percent boys and 12.66 percent girls were not often taken to the doctor when ill. These findings reveal that girls are a little less likely to be taken to the doctor at the time of illness as compared to boys, however the difference is small i.e. only 2 percent. The main reason for seeking no treatment was poverty. Out of 23.33 percent children who couldn't receive treatment 74.28 percent were due to poverty. The findings depict that majority of the boys (34 percent) and girls (28 percent) had no symptoms like lack of energy, lack of appetite and dizziness, while 22 percent girls and 16 percent boys have one or all of these symptoms. 10 percent girls and 4.66 percent boys had anaemia or other deficiency. On asking about Nutrition of the children which is a basic human need and a prerequisite to a healthy life, it was found that 22 percent girls do not take their meals adequately compared to 16 percent boys. It can be said that girls have lower health status and low dietary intake as compared to boys which can be attributed to gender bias as parents tend to take proper care of diet of boys as compared to girls. The findings of the study show that girls (13.33 percent) had higher complaints of stress as compared to boys (11.33 percent), while boys (8 percent) had higher complaints of lack of concentration as compared to girls (4.66 percent). These findings reveal that among boys and girls the difference between the incidences of mental health issues is little. Since boys are

reported to be more affected by conflict, the mental health problems faced by girls are not solely due to the impact of conflict on their health.

In the light of above findings it can be concluded that most of the children in Srinagar have good health and the health status of children is correlated with their household income and level of maternal education. Comparing health status of girls with boys, it can be concluded that boys have better health status than girls in Srinagar district. Girls had inadequate nutritional intake and were less taken to the doctor at the time of illness compared to boys. Though, income was strongly correlated treatment seeking yet some elements of gender discrimination can be inferred from the nutritional intake and immunity level among boys and girls.

5. Recommendations

Differential health status was seen among boys and girls. Health status of girls was lagging behind boys. Hence, it is recommended that awareness should be spread against the evil of gender discrimination. Schemes to prioritize the provision of opportunities, equitable rights, benefits and status of a girl child who is exposed to gender discrimination should be started in the state. Parents should also support their children by providing equal opportunities to both boys and girls in health care so that there will be no gender discrimination. Thus, effective economic, social and political changes, nutrition education program especially for mothers and school children are few interventions and tools to bring about change in child health.

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