

## Editorial

# The girl child in India: Investing early for equity

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India's progress in health, education, and economic development has transformed childhood for millions, yet the earliest years of girls' lives continue to be marked by inequities rooted in longstanding societal gender norms.<sup>1</sup> Although national programmes increasingly focus on adolescents, particularly on menstrual health, early marriage, and skills development, the foundational disadvantages shaping girls' trajectories begin far earlier, from pregnancy through the first decade of life. A lifespan-development perspective highlights the first 10 years a powerful window for achieving gender equality and long-term wellbeing for women and families.<sup>1</sup>

### Bias before birth and in infancy

Gender bias manifested as greater value placed on boys relative to girls remains normative in India and often begins before birth.<sup>1</sup> Persistent son preference, combined with declining fertility and access to prenatal technologies, continues to drive sex selection in several States, resulting in sex ratios at birth below biological norms in parts of Haryana and Sikkim.<sup>2</sup> The Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act was designed to curb sex selection, yet structural gender inequities—including patrilineal inheritance, dowry expectations, and perceptions of daughters' lower economic value—continue to shape reproductive decisions and sustain imbalances.<sup>3</sup>

These skewed sex ratios contribute substantially to India's low global ranking on gender equality in health and survival.<sup>4</sup> Although child mortality has declined nationally, NFHS-5 data reveal excess female infant and under-five mortality in several northern States, driven by delayed care-seeking and gender-differentiated treatment and healthcare seeking.<sup>5</sup> In contrast, States

such as Kerala, Tamil Nadu, Himachal Pradesh, and Telangana demonstrate more balanced sex ratios and lower gender gaps in child survival, illustrating how policy, health systems, and gender-equitable norms can improve outcomes.

### Imbalance in early childhood (Ages 0–5 yr)

Gender inequities extend beyond survival into nutrition and early childhood development, which are critical determinants of later health, learning, and economic participation. Gendered differences in feeding practices, parental investment, and access to healthcare continue to disadvantage girls.<sup>1</sup> Early nutritional deficits contribute to the high prevalence of anaemia among adolescent girls, a persistent public health concern. A recent systematic review documents widespread anaemia among girls aged 10–19 yr,<sup>6</sup> with evidence of disproportionate iron deficiency among rural girls.<sup>7</sup> These disparities often originate in early childhood due to limited dietary diversity, inequitable intra-household food allocation, and insufficient micronutrient supplementation.

Access to early childhood education and stimulation through *Anganwadis* and pre-primary programmes remains inconsistent, with evidence that boys are more likely than girls to attend higher-quality preschool settings.<sup>8</sup> Girls may also receive fewer opportunities for play, motor development, and cognitive stimulation due to domestic responsibilities and gendered expectations, contributing to early learning gaps evident by primary school age.<sup>1</sup> Nutrition, early learning, and equitable opportunities for play and exploration form the physical, neurological, and emotional foundations for later wellbeing, yet these investments are too often skewed toward boys.<sup>8</sup>

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### Gender equity in primary school (Ages 6–10 yr)

India has achieved near-universal primary school enrolment for girls and boys, a major accomplishment. However, primary school is also a critical period for gender socialization.<sup>9</sup> Children learn who is expected to lead, speak, move freely, and aspire in career and earning, as well as who is expected to manage domestic labour and family and community relationships. By the end of primary school, many girls have already experienced restricted mobility, disproportionate domestic labour, limited encouragement for sports or outdoor play, and lower expectations for educational or career achievement.<sup>1</sup> These norms predict later vulnerabilities, including early marriage, fertility pressures, constrained economic participation, and increased emotional distress.<sup>1,10,11</sup>

Menstrual stigma often begins during late primary school, before menarche. A systematic review<sup>12</sup> shows that girls frequently receive misinformation or fear-based messages about menstruation during this period, undermining confidence and contributing to early absenteeism. Interventions that address norms early—through curricula, parental engagement, equitable household expectations, and visible representation of girls in leadership and sports can meaningfully reshape trajectories, yet such efforts are often delayed until adolescence.

Girls are more likely than boys to be lost during the transition to secondary education, particularly among socioeconomically vulnerable populations.<sup>5,13</sup> Importantly, these losses are driven more by external constraints than by lack of interest.<sup>5</sup> Contributing factors include distance to upper-primary schools and safety concerns,<sup>14</sup> inadequate school infrastructure such as toilets and water facilities,<sup>12</sup> household labour burdens,<sup>10</sup> and perceptions that girls' education yields limited economic returns.<sup>10</sup> States with stronger infrastructure, female teacher recruitment, and gender-equitable norms demonstrate better retention through upper primary grades.<sup>5</sup>

### What can we do?

These findings underscore the need for greater investment in gender equity for girls aged 0–10 yr and for a shift in mindsets recognising that early gender bias in childhood compromises health, education, autonomy, and future opportunity. Investments in the first decade yield exponential returns: nutrition, active play, and early anaemia prevention build physical resilience; early stimulation and foundational learning support academic success; and encouragement of broad

aspirations expands girls' sense of possibility. Equitable treatment at home and in school fosters girls' agency and aspirations, while early gender-equitable environments also serve as primary prevention for violence and poor mental health. These early investments are the foundation upon which adolescent interventions must build. Without these, many programmes arrive too late.

Overall, India's experience demonstrates that equality for girls is achievable, yet it remains uneven. While adolescent-focused initiatives are important, gender inequality is fundamentally a developmental process that begins well before adolescence. Evidence across health, nutrition, education, and socialization shows that disadvantages established before birth and through age 10 shape girls' later risks for early marriage, constrained autonomy, poor health, and limited economic participation. Sustained gains in women's health and empowerment will require coordinated national and State investments that prioritize the first decade of life, as well as in adolescence. Investing early is not preparatory to later interventions—it is the necessary foundation for advancing gender equality, improving population health, and strengthening India's human capital.

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