CHAPTER III

REVIEW OF RELATED LITERATURE
CHAPTER III

REVIEW OF RELATED LITERATURE

The review of related literature has been done considering the main area of discussion which relates to Women Empowerment, Social Security and Status of Women in terms of Education, Health and Employment. Various national and international studies have been done so far in this regard, and they show a worldwide concern over the issues related to women empowerment. A review of some of the available literatures on these issues, that comprise various Government Reports, Books, Research Papers and Articles, has helped the Investigator not only in getting a better grasp of the related issues but also in arranging and discussing the content of the thesis in an exploratory manner. For reasons of space, it may not be possible to include all such literatures. However, for the convenience of reading and understanding, the reviewed works are arranged in chronological manner and the Investigator had taken every possible step to maintain authenticity of these literatures by citing the sources as correctly as possible in the Bibliography section.

The following are some of the studies or related literature that have been of immense help during the present study. These literatures have helped the Investigator in getting an overall picture regarding the status of women in terms of education, health and employment. Besides, they have also given proper guidance and direction during the study.

EMPOWERMENT AND WOMEN

The Five Year Plans of the Government of India provided many specific suggestions regarding empowerment and capacity building of women in the country for the last 60 years. The all round development of women has been one of the focal points of the planning process in India which is clearly visible in each Five Year Plan. For instance,
a) The First Five Year Plan (1951-56) envisaged a number of welfare measures for the women of the country. The establishment of the CSWB, Organisation of Mahila Mandals or Women’s Clubs, and the Community Development Programmes were a few steps in this direction.

b) The Second Five Year Plan (1956-61) closely linked the empowerment of women with the overall approach of intensive agricultural development programme.

c) The Third Five Year Plan and Fourth Five Year Plan (1961-66, and 1969-1974) supported female education as a major welfare measure. But the later also continued to emphasize women’s education.

d) The Fifth Five Year Plan (1974-79) emphasized training for women who were in need of income and protection. Besides these, functional literacy programmes got priority during the Planning period. This plan coincides with international women’s decade, and the submission of Report of the committee on the status of women in India. In 1976, Women’s Welfare and Development Bureau was set-up under the Ministry of social welfare.

e) The Sixth Five Year Plan (1980-85) showed a definite shift from welfare to development. In this plan, adult education was included as a part of the MNP, and the goal of reaching 100 percent literacy by 1990 was set under the Twenty-Point Programme. Adult education, centred exclusively on women, was set up, and it provided education in subjects like health, nutrition, and family planning. It recognized the lack of resources as a critical factor to access education for women. This plan introduced the schemes for women’s entrepreneurship and included a chapter on “Women and Development.”

f) The Seventh Five Year Plan (1985-90) emphasized the need for gender equality and empowerment. For the first time, emphasis was placed upon qualitative aspects such as inculcation of confidence, generation of awareness with regards to rights and training in skill for better employment.
g) *The Eight Five Year Plan* (1992-94) focused on empowering women; especially at the grass root level through Panchayati Raj institution.

h) *The Ninth Five Year Plan* (1995-2000) adopted a strategy of women’s component plan, under which not less than 30 percent of funds/benefits were earmarked for women-specific programmes and schemes.

i) *The Tenth Five Year Plan* (2002-07) aimed at empowering women through translating the recently adopted National Policy for Empowerment of Women (2001) into action and ensuring survival, protection and development of women and children through right based approach.

j) *The Eleventh Five Year Plan* (2007-2011) also focused on the need for faster reduction in poverty and greater attention in employment generation, gender budget, and better delivery in health and Education.

k) *The Twelfth Five Year Plan* (2012-2017) has given special emphasis on social mobilization where people should be active agents of change. Flagship Programmes need to provide human and financial resources for social mobilization, capacity building, and information sharing.

**The National Policy for the Empowerment of Women (2001)** clearly stated why empowerment of women is necessary for ensuring the welfare in a state. The goals and objectives of the document, as explicit in the following, were aimed at bringing about development and empowerment of women through:

a) Equal access to participation and decision making in social, political, and economic life.

b) Legal-judicial system to be made more responsive and gender sensitive to women’s needs.

c) Changing societal attitudes and community practices by active participation and involvement of both men and women.

d) Mainstreaming a gender perspective in the development process.
The policy also laid stress on economic empowerment of women by eradicating poverty, making micro credit system and agricultural facilities available. The 73rd Amendment (1993) of the Indian Constitution aimed at political participation of women so that empowerment could be sustained for the needy that would bring welfare to the whole nation.

National Institute of Rural Development (NIRD) (1999) conducted studies on the status of the Indian states in terms of HDI in the major states of India for the years 1961, 1971, 1981, and 1987-88. The studies revealed that the HDI scores had gone up in all the states over time. Poverty-stricken states like Bihar and Uttar Pradesh were at lower rung, while Gujarat had made considerable progress in terms of HDI.

Avasthi, Abha and A. K. Srivastava (2001) in their book entitled Modernity, Feminism, and Women Empowerment addressed the various forms of inequalities and discriminations still existing against women in many principal areas. For example, women have limited access to education, health and financial assets, the acquisition of which assure a good equality of life to an individual.

Mohammad, Noor and Mohammad Shahid (2004) conducted a study entitled: “Rethinking Women’s Participation, Empowerment, and Gender Equality: A Micro Analysis” in which they analysed the potentiality of outdoor participation by women; the process of women’s empowerment; and the interrelationships of women participation, empowerment, gender equality; and their functional dependency on age, education, income and caste. A sample of 90 grassroot level women workers were selected from Lodha block of Aligarh district, Uttar Pradesh, of whom 35 were CBDs, 35 were AWWs, and 20 were WPs. It was found that 60 percent of the sample were in the age group of 25-45 years, 22 percent were below 25 years, and 17.7 percent were above 45 years. 72 percent women were educated till primary and intermediate level, 7.8 percent were graduates, 3.3 percent were post-graduates, and 8.9 percent were illiterates.
80 percent WPs and all the sampled CBDs and AWWs had very limited income. The data showed that the CBDs were more articulate, mobile, active, and sent their children to schools. The AWWs were very vocal and authoritative. Due to outdoor participation, the respondents developed self-confidence and self-respect. At home also, they participated effectively in decision making regarding income expenditure, children's education, family planning, etc. It was revealed that the women in the 25-45 age group were more participative, vocal, and active than the women below 25 years and above 45 years of age. The CBDs and AWWs were equally participative whether they had higher or lower education. All the sampled WPs were illiterate, and the low caste WPs who had limited income, wanted to overcome their illiteracy by undergoing training and actively participating in the outdoor political and economic activities. It was suggested that there is a need to provide empowerment training to all voluntary workers and local leaders. A strategy should be adopted so that more and more women, particularly those who want to work, are educated, and belong to low income and low caste category, can be involved in the outdoor activities.

Acharya, Meena and Puspa Ghimire (2005) in their research paper entitled “Gender Indicator of Equality, Inclusion, and Poverty Reduction, Measuring Programme/Project Effectiveness” did an important study on the indicators that should be adopted for assessing women empowerment. They explained that the impact of gender development must be measured in terms of the changes in the options of life for women. These changes are not only determined by material assistance but also assessed by gender ideology and socio-economic structure. Gender relations may be examined in terms of how many women are able to access the rights to economic and technological resources, income earning opportunities, education and information, health services etc. Besides, the level of empowerment in women can be decided by examining their role in the decision making processes in the family as well as outside the family. The authors also stated that the capacity building of women in
the decision making process hints at the educational fields, ability to get proper and timely treatment when sick, and the decision to choose their marriage partners and when to marry etc. In the Public arena, women’s relative role in public decision making at various levels such as Community, State, and Nation must also be examined. The authors raised many questions regarding a woman’s decision making capacity in the public arena, whether her freedom to participate in community organisations (health club, library, saving-credit cooperatives, banking etc.) has really increased. Had her political awareness and interest been enhanced? How many decisions are made in the community? Whether women agreed to all such decisions, and if not, then why? What did they do to change them? etc. Thus, their paper addresses many of the contextually valid aspects that provide a better understanding of the issues related to women empowerment.

**Kelkar, Govind (2005)** in the research paper “Development Effectiveness through Gender Mainstreaming, Gender Equality and Poverty Reduction in South Asia” argued that many countries in the South Asian region have the disparities between men and women in their access to and control over resources. Women have lower access to community governance, health and education facilities, and less than optimal participation in economic decision making. This led to the lower status of women throughout the region. The GDP per capita for women is extremely low and is often less than half, or one third of that of men. In India, it is 38 percent; in Pakistan 30 percent; in Sri Lanka 41 percent; in Bhutan 51 percent, and in Bangladesh 58 percent. The reason for low GDP per capita for women is due to women’s being economically less active. When household and productive labour for market are considered, women work considerably for longer hours than men. This gap is particularly pronounced in poor households. The time devoted by women to agriculture or land based labour is three to four times greater than that of their male counterparts. However, it has been found that customary practices throughout South Asia prevent women from exercising their right to own and control land.
Sethuraman, Kavita, Richard Lansdown and Sullivan Keith (2006) in their research Paper “Women's Empowerment and Domestic Violence: The Role of Socio-cultural Determinants in Maternal and Child Under-nutrition in Tribal and Rural Communities in South India” stated that women's lack of empowerment is an important factor in the persistent prevalence of malnutrition. The objective of the study was to explore the relationship between women's empowerment, maternal nutritional status, and the nutritional status of their children aged 6 to 24 months in rural Karnataka. From the study, it had been found that malnutrition was more prevalent in the tribal community. The Tribal families had less access to electricity, education, and health care than the rural families. But the tribal women had greater decision making capabilities and freedom of movement than the rural women. The prevalence of domestic violence did not differ significantly between the tribal and the rural women, and it was experienced by 34 percent mothers among the sample. Women’s empowerment variables were significantly associated with child nutrition, and 5.6 percent of the variance in the sample could be attributed to women’s empowerment. Maternal experience of psychological abuse and sexual coercion increased the risk of malnutrition in mothers and children. The findings of the study suggested that better community based nutrition programmes should be designed which will help in reducing malnutrition.

Nayak, P. (2010) in his research paper entitled “Human Development in North East India” stated that in terms of HDI, Assam witnessed the lowest HDI value of 0.362 and Mizoram had the highest value of 0.552 in 2000. Besides, there is a yawning gap between the urban and the rural areas in this region. Human development in the rural areas of the region has been consistently lower than in the urban areas. The rural urban disparity index varied from the lowest figure of 0.113 for Manipur to the highest figure of 0.234 for Tripura in 1981. The situation did not improve much in 1991 and 2000. In 2000, the highest disparity was observed in Assam (0.283) and lowest in Sikkim (0.175). Besides
this disparity, the status of women in the region is far from being on equal footing with that of men. Particularly, gender disparity has been consistently very high in Tripura and Assam (GOI 2002). Assam is the only state in the region which has been consistently lagging behind the rest of India. Gender disparity was lower in four states namely—Manipur, Meghalaya, Nagaland, and Sikkim in the year 1981, as compared to the all India average. In 1991, Arunachal Pradesh and Mizoram were added to the list of better performing states. In 2001, Arunachal Pradesh, Assam, and Meghalaya were lagging behind other states which were doing well. Gender disparity has been varying widely from one state to another in the region.

Hancock, Peter et al. (2011) in their report “Gender Status and Empowerment: A Study among Women who work in Sri Lanka’s Export Processing Zones (EPZs)” focused on gender empowerment giving importance on GEM, GGGI, and GGI. This report is based on the research that was funded by AusAID’s Australian Development Research Award, and conducted by investigators from Edith Cowan University (ECU), Australia and The Centre for Research on Women (CENWOR), Sri Lanka. The research sampled 2304 women between 2008-2011 who worked in factories in Sri Lanka’s Export Processing Zones as well as 22 key stakeholders. The report stated that the majority of women in the developing nations had been dis-empowered due to global and national patriarchy. However, many women were found to be resisting these forces and were becoming successful. In short, empowerment and dis-empowerment were operating simultaneously for the majority of the participants, and they required great skill and fortitude to negotiate the enormous challenges they had faced. Through this report, they had shown clearly the complex and extraordinary ways in which women were empowering themselves and their families, while at the same time facing enormous forces that would make them dis-empowered. These included global forces of neo-liberal development, but also patriarchal powers within the nation and harsh working conditions.
The respondents living and working in the Export Processing Zones (EPZs) were relatively young and well educated; and a large majority had migrated from the rural areas in search of work. 74.8 percent women were 25 years or younger, with the average respondent aged 24.02 years. Only 10.3 percent women were aged 26-30 and 14.9 percent aged 31 and over. This indicates a relatively young workforce typical in EPZs in the developing nations. Most had worked less than three years. In fact, the average length of employment was 3.10 years. They worked for long hours in mostly low status positions with 95 percent women working overtime with limited opportunities for promotion. The data showed that 100 percent women worked 40+ hours per week, 80.6 percent women worked 50+ hours per week, and 15.1 percent women worked 60+ hours per week. These working hours were far higher than the national averages for women in other sectors. However, despite the hardships of working and living away from home, the women appeared resilient and focused on the benefits that employment had bought to them and their families. Besides, through this study it was found that the skills and economic power of women, gained from formal employment, had led to higher feelings of self worth for many, a sense of independence and pride in being able to help their families possibly to move out of poverty. Economic empowerment had also led to higher levels of decision making at home by women. 55.8 percent reported that they participated more at decision making at home since the time of working. This is more apparent among the married women who were more likely to be involved in collective decision making than the unmarried women.

SOCIAL SECURITY IN EDUCATION, EMPLOYMENT AND HEALTH

FOR WOMEN EMPOWERMENT

Dreze, Jean and Amartya Sen (1989) in their book *Hunger and Public Action* stated that the scope of social security is vast in the developing countries where the economy is characterized by large informal sectors and high level of
poverty. They argued that the provisions of social security in the developing countries need to be viewed from a broader perspective and essentially as an objective to be pursued through public means rather than as a narrowly defined set of particular strategies. Besides, protective (such as preventing a decline in the living standards in general, and basic conditions of living in particular) and promotional measures (such as employment generation schemes, assets distribution schemes, backward area development programmes, basic needs programmes such as subsidized housing for poor, slum improvement, primary education, health care, child nutrition, water supply and sanitation and PDS) should be adopted for ensuring social security in terms of education, health and employment.

**Human Development Report (1994)** published by UNDP revealed that Human security is an emerging paradigm for understanding global vulnerabilities. In the report, it was argued that the proper referent for security should be the individual rather than the state. Human security holds that a people-centered view of security is necessary for national, regional, and global stability. The HDR of 1994 is considered a milestone publication in the field of human security, as it ensured "freedom from want" and "freedom from fear" for all persons to tackle the problem of global insecurity. The famous economist Dr. Mahbubul Haq first drew global attention to the concept of human security and sought to influence the UN's 1995 World Summit on Social Development in Copenhagen. In this report of 1994, it was stated that the scope of global security should be expanded to include threats in seven areas: Economic Security, Food Security, Health Security, Environmental Security, Personal Security, Community Security, and political Security. Regarding *Economic Security*, the report explained that it requires an assured basic income for individuals, usually from productive and remunerative work or, as a last resort, from a publicly financed safety net. In this sense, only about a quarter of the world’s people are economically secure at present. While the economic security problem may be
more serious in the developing countries, concern also arises in the developed countries as well. The unemployment problems constitute an important factor underlying political tensions and ethnic violence. Regarding Health Security, the report stated that its aim had been to guarantee a minimum protection from diseases and unhealthy lifestyles. In the developing countries, the major causes of deaths were infectious and parasitic diseases, whereas in the industrialized countries, the major killers were diseases of the circulatory system. According to the United Nations, in both the developing and the industrial countries, threats to health security are usually greater for the poor people in rural the areas, particularly children. This is due to malnutrition and insufficient access to health services, clean water, and other basic necessities.

Prasad, E. K. V. (1995) in his research paper “Social security for Destitute Widows in Tamil Nadu” made an analysis of the social security schemes and programmes of the different states of India. The author revealed:

a) Almost all states and union territories have old-age pension schemes. A few states such as Andhra Pradesh, Gujarat, Kerala, and Tamil Nadu also have special pension schemes for agricultural labourer.
b) Tamil Nadu, Kerala, Gujarat, and Orissa have pension schemes for destitute widows and the physically handicap.
c) Maharashtra has introduced employment guarantee scheme, but other states like Tamil Nadu, Kerala, and Gujarat have unemployed relief schemes.
d) Maternity benefits for the landless agricultural labourers have been introduced in Gujarat, Karnataka, and Kerala to compensate for the loss of wages due to absence at work.
e) Health care as a part of social security does not seem to exist in any state.
f) Gujarat, Tamil Nadu and Maharasthra have certain welfare schemes exclusively for women and children while a number of other states offer welfare benefits for various categories of population below the poverty line.
Pillai, S. M. (1996) in his paper “Social Security for Workers in Unorganized Sector: Experience of Kerala” offered an empirical verification of the effectiveness of the welfare fund schemes in providing social security to the casual workers in the unorganized sectors through a case study of the oldest welfare fund scheme—the Kerala Head Load Workers Welfare Scheme.

Dev, S. Mahendra (2002) in his research paper “Growth-Mediated and Support-Led Social Security in the Un-organised Sector in India” provided an overview of the growth-mediated and support-led social security arrangement for the unorganized sector in India. The main argument of this paper is that in marketization there is a substantial section of the society which does not have resource power to enter into the market operation. This paper stressed that the Government and those who are already in the market have the responsibility in providing social security to the large sections of the un-organised workers, and to the other vulnerable groups who are out of the market. Thus, this paper concluded that there is a need of public-private partnership in providing the social and economic security to the un-organised workers.

World Bank in India (2003) undertaken a project entitled “Rural Women’s Development and Empowerment”. The Project had undertaken 17,587 Women’s SHGs involving 240,236 women in 7274 villages from total 56 districts of 9 states. The work was done in collaboration with the Government and 232 NGOs. Although certain improvements were required in financial matters, flow of funds, and procurement and staffing, excellent work was observed in many states like the earthquake-affected Gujarat, the gender biased Haryana and Bihar etc. The Project had successfully formed linkages with various agencies and departments providing services to the poor women in Uttar Pradesh. Bank accounts were opened for nearly 90 percent of the people on whom the project was done. However, sustainable improvement in livelihood was pointed out to be one of the most challenging issues faced by the investigators. It was suggested that sustainability issues need to be addressed in
the action plans of various annual plans undertaken by the state. It was recommended that participatory approach could be adopted for monitoring and evaluation of the project in each state.

**OKDISCD (2003)** conducted a project entitled “Evaluation Study on Rural Drinking Water Supply Programme (North East India)”. The study had covered 252 habitations from eighteen district spread over eight states (two districts each from Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Tripura and Sikkim and four districts of Assam). A total of 4965 households were covered from these sample habitations to assess people’s perceptions on the existing system and their awareness and willingness to join the community in decision making and financial costs. Piped water supply (PWS) as principal source of drinking water supply is common in the hill states than in the plain states. In the states like Mizoram, Nagaland, Meghalaya, Arunachal Pradesh and Sikkim more than 80 percent of the drinking water comes through pipe lines. In Assam and Sikkim, hand pumps and tube wells are most common in the plain areas. Regarding the fetching of water from various sources, it was found that in the hill states, the majority of the households fetched water from a distance of less than 100 meters—84 percent in Arunachal Pradesh, 67 percent in Mizoram, Meghalaya and Sikkim, and more than 80 percent in Nagaland. In Tripura more than 70 percent of the sample households fetched water from within a distance of 200 meters. In Assam and Manipur, the distribution of sample households to have covered a distance to carry water showed wide variation, e.g. in Assam, 30 percent of the households were reported to fetch water from a distance of less than 50 meters. While some 33 percent and 25 percent of the households had their sources of water located at a distance of 50-100 meters and 101-200 meters respectively. In Manipur, a majority (61 percent) of the sample households fetched water from a distance of beyond 100 meters.

**Mass Rehabilitation Society, Imphal (2003)** conducted a research study under the title “Evaluation study of various specific women related schemes
during the Eighth Five year Plan in Manipur” to assess the performance and impact of the development programmes on the status of women. Information was collected from 1000 women residing in two districts namely Imphal East and Imphal West. As part of the Eighth Plan period, the State Government had undertaken many development programmes like IRDP, TRYSEM, JRY, IAY, and DWCRA. The women specific programmes implemented during the 8th Plan by the Social Welfare Department were: Support to Training-cum-Employment Programme for Women (STEP), Construction of Working Women’s Hostels, Border Areas Welfare Extension Projects, Vocational Training Courses, Socio-Economic Programme, Voluntary Action Bureau, Orientation Training Programme, Self-Employment Scheme, Creche Programme, Nutritional Programme, DWCRA, Grant-in-Aid to Destitute Widows, and Family Counselling Centres. Based on the study, it was found that only 16.72 percent of the respondents were illiterate, 24 percent could read and write, 2.25 percent were educated up to the primary level, 10.69 percent and 21.20 percent were educated up to the middle and high school level respectively, and 27 percent respondents were educated up to matriculation. Of the 640 respondent families, the head of the 163 families were engaged in self-employment (25.47 percent), 128 families in agriculture (20 percent); 210 families in service sector (32.81 percent), and 212 families in domestic work 212 (33.13 percent). It was recommended that the Government should take up mass adult education/informal education programmes in the rural areas. Mass media and Information Technology should be utilized for creating awareness and benefiting people residing in rural areas. The voluntary organizations should be fully involved in implementing and monitoring the women-specific schemes so that they can be run more effectively and successfully.

Bakshi, J. D. (2003) had done a research entitled “Impact evaluation of women and girl beneficiary oriented programmes and schemes on their socio-economic status in Himachal Pradesh with executive summary.” The study
beautifully assessed the outreach and impact of various programmes and schemes in certain focal Panchayats. The 10 specific schemes taken up for the programme were: Scheme of Widow Pension, Balika Samridhi Yojana, Vocational Training for Destitute Girls/Women, Working Women’s Hostels, ICDS, Old Age Pension, Grant for Construction of House (SC/ST), Assistance to Women Victims of Atrocities (SC/ST), Incentive for Inter-Caste Marriages, and Hostels for SC/ST Girls. In this study, the beneficiaries were undertaken from 12 districts of Himachal Pradesh. A total of 1000 respondents from 125 House Holds were taken. The maximum number of women respondents (42.32 percent) was from the age group of 34-41 years, followed by the age group 26-33 years (17.23 percent), and 18-25 years (16.33 percent). Thus, most of the respondents were from the age group of 18-41 years (76 percent). Of the total respondents 39.53 percent were literate, 11.23 percent were educated up to primary level, 10.22 percent were educated up to middle standard, 9.24 percent up to high school level, and about 2.33 percent up to college level. Besides, 27.42 percent respondents were illiterate, 38.42 percent were SCs, 14.73 percent were STs, 7 percent were OBCs, and 40 percent belonged to General categories. Around 47.13 percent women were engaged in agriculture, 4.19 percent were self-employed, 1.77 percent were in service, and 34.12 percent were housewives. The awareness regarding development schemes was highest in ICDS (72.27 percent), MMP (71.21 percent), Safe Delivery Kits (70.57 percent), and the Widow Pension Scheme (60.59 percent). Besides, 40-60 percent respondents were aware of Old Age Pension Scheme (57.75 percent), Girls Education Incentive Scheme (54.56 percent), BSY (48.35 percent), and Health Education (43.30 percent). The study also reported that the Anganwadis generated almost 54.27 percent awareness regarding the schemes. About 37.94 percent respondents gained awareness from Mahila Mandals, about 17.10 percent from their husbands, 8.27 percent from village Pradhans, 4.98 percent from media, 19 percent from school teachers, and 4.38 percent from village Patwaris. Total 240 respondents got the benefits under the Widow Pension Scheme, 90 got the benefits from the National
Maternity Benefit Scheme. It was suggested that the inherent difficulties in implementing different schemes for women should be reduced, the financial norms should be revised to enhance the amount of assistance extended to women beneficiaries, provisions should be made for a single window system to reach the benefits, and mainstreaming of gender perspective should be introduced in different schemes.

**National Commission for Women (2004)** conducted a research study under the title "Research study on effectiveness of women self help groups in micro enterprises development in Rajasthan and Tamil Nadu" to assess the various enterprise models of community financial mediation promoted by Government, banks, and NGOs. Field survey was carried out in four districts of Rajasthan, namely Jodhpur, Alwar, Ajmer and Jaipur, and four districts of Tamil Nadu, namely Kanchipuram, Coimbatore, Thiruvarpur, and Kanyakumari. Initially 100 SHGs from each district were selected randomly for the study, but due to problems encountered during the survey, only 350 SHGs covering around 4195 women in Rajasthan, and 189 SHGs covering around 3136 women in Tamil Nadu, were covered. The main purpose of the SHGs was to increase the agricultural outputs. The number of SHGs increased from 75,247 in 2001 to 1,78,571 in 2004; women members increased from 13,01,597 in 2001 to 29,84,132 in 2004; savings by SHGs increased from Rs.81 crore in 2001 to Rs.532 crore in 2004; and loans received by SHGs increased from 22,829 in 2001 to 1,59,164 in 2004. The scheduled caste members covered were 14 (2.73 percent); OBC women covered were 341 (66.6 percent). No scheduled tribes were covered. Around 7 to 8 percent of the total SHGs in Tamil Nadu were defunct according to some evaluation studies. The activities of the SHGs had undertaken were provision of drinking water, plantation of flower and fruit trees, cashew nut production, formation of youth clubs, AIDS prevention groups, cooperatives and so on. However, it was found that there is an absence of relevant information on SHGs, and that the concept of SHGs should target the holistic
development of women. The study also recommended skill training through productions in bakery, paper products (file pads, bags), agarbathi, candle and chalk piece making, screen printing, spices, foot mats, leather products, catering, etc. as part of the income generation activities.

The National Rural Health Mission (2005) integrated health with sanitation and hygiene, nutrition and safe drinking water. This mission requires a holistic approach to integrate education and family planning that yield more substantial result. In the report it was stated that human security is concerned with reducing—and when possible—removing the insecurities that plague human lives. The workers in the unorganised sector of contemporary India face three major threats: poor health, shrinking livelihoods, and muted voice. Ill-health is among the leading causes of both impoverishment and vulnerability of the workers in the unorganized sector. The absence of an effective community-based health care system, even after 60 years of independence, is a sad reflection of the priority accorded by India to people's health. Public Health Expenditure in India declined from 1.3 percent of GDP in 1990 to 0.9 percent in 1999. Only 10 percent of Indians have some forms of health insurance. The curative services are known to favour the non-poor: for every rupee spent on the poorest 20 percent of the population, three rupees are spent on the richest quintile. Hospitalization accounts, on average, for 58 percent of the total annual expenditures incurred by Indians. Over 40 percent of hospitalized Indians borrow heavily or sell their assets to cover medical expenses. And over 25 percent of hospitalized Indians fall below the poverty line because of hospital expenses.

Vidyasagar School of Social Work, Kolkata (2006) had done an empirical study on the “Impact Assessment of Awareness Generation Project: A Comprehensive Project” The scheme of AGP has been implemented through NGOs by CSWB to create awareness on issues relating to status, rights and problems of women, especially the rural women. The objectives of the study were to assess the activities of AGP and its impact on the target population, and
also to check out the programmes undertaken by voluntary organizations during and after AGP. Data was collected from five states namely Uttar Pradesh, Tamil Nadu, Delhi, Gujarat, and West Bengal through interviews of 804 women beneficiaries who attended the camps, 119 chief functionaries of voluntary organizations, and 110 organizers. It was found that nearly 50 percent of all voluntary organizations were new, and they had been first time recipients of grants. The amount given for training participants was not sufficient for quality training. Most of the respondents pointed out that major problems of women which are—violence against them, alcoholic husbands, illiteracy, general and reproductive health issues, and lack of infrastructural facilities. They had little access to the formal or informal educational facilities and consequently lacked even the basic information on the issues and problems directly confronting them. The study showed that the AGP scheme suffered due to non-availability of support services, absence of a network at district and local level, shortage of funds, time lag in organizing camps, and lack of proper planning for sustained action. The study suggested that AGP activities should be planned, efforts should be made to build a strong communication network through the use of programmes and media tools. But there is a need to assess the activities of AGP.

Mukherjee, Tuhin (2006) did a study entitled “Impact assessment study of SGSY programme on empowerment of women at Babpur village, Kolkata” to assess the impact of SGSY programme on the empowerment of the women at Babpur village under Purbakhilkapur Gram Panchayat, Kolkata. The SGSY, launched by the Govt. of India in 1999, is a holistic programme covering all aspects of self employment like SHGs training, credit, technology, infrastructure, and marketing. Out of the total sample of 50, 25 women were taken from SHGs which constituted the control group, and the rest 25 women, not associated with SHGs, constituted the experimental group. The indicators used in the study were economic indicator, political indicator, household decision-making scale, and awareness level of the respondents with respect to social and health issues. About
64 percent women of the control group and 92 percent of the experimental group were found to be economically independent. 40 percent respondents of the control group, and only 4 percent of the experimental group had saving habit, and it was found that 8 percent respondents of the control group had created assets after taking loans from the SHGs. Political indicators showed that 72 percent respondents of the control group had access to the panchayat, 80 percent attended gram sansad (village) meetings regularly, and 72 percent cast their vote in favour of the candidate of their own choice. But, it was interesting to note that only 4 percent respondents of the experimental group had access to the panchayat, only 28 percent attended gram sansad meetings regularly, and 56 percent respondents cast their votes freely. On the decision making parameters it was found that 50-75 percent respondents of the control group took decisions regarding various important aspects of the household management like expenditure on education of child, marriage of child, medical care, etc. But in case of the experimental group, the decision making power was exercised only by 24 percent women, while 52 percent women could take decisions regarding daily meal and dress. All the respondents from both the groups were of breastfeeding and immunization (100 percent). On an average, 80 percent respondents of the control group were aware of social and health related issues, but the percentage of respondents from experimental group on similar matters was below 40 percent, which was quite poor. The study suggested that awareness generation campaigns regarding the importance of SHGs should be launched, and attention should be paid to the formation and sustenance of more SHGs.

Kour, Amarjeet (2008) in “Self Help Group (SHG) and Rural Development” stated that the SHGs in rural India help more than 17 million village women to improve their income, educate their children and buy assets. In the formation of SHGs, the women SHGs are dominating in the North Eastern Region. In Assam also, out of total 1, 70,779 SHGs, more than 93 thousand SHGs belong to women. Through such SHGs women gradually become self-
confident, self-dependent and competent to involve in decision making processes. The most effective form of the SHGs in the country is that it creates the concept of women’s credit and also encourages those hard workers who want to start small business with innovative ideas such as making handicraft items. Thus, SHG is one of the most influential sources for making women empowered economically.

Rout, Himannshu Sekhar, and Prasanta Kumar Panda (2008) in their edited book *Gender and Development in India: Dimensions and Strategies* stated that small loans can be a good source for enhancing the sense of business among the women in the rural areas. Although the SHGs are not enough for developing the much-needed scope for entrepreneurship, the women in particular gain a lot from micro-finance, because it builds the attitude of independence from which women get inspiration to generate wealth and become self-reliant in a society. The women who themselves have developed economic credit enjoy better life, have better access to food, shelter, health care, and education compared to the non-earning women. They are also able to contribute a lot to the betterment of their family. Thus, the SHGs enable the members to learn to co-operate and work in a group environment. The savings of the members in the SHGs help them to take loans from the bank, and thus enable them to start their business or enterprises at their own interest.

Assamiya Pratidin on 7th April, 2010 published a news that NREGA had failed to ensure its targets in Assam. The Newspaper had identified some facts and figures on the implementation of the scheme in Assam which are as follows:

a) Although the working days should be 31.85 cores of days, it has covered only 41.64 lakhs days.

b) Only 0.23 percent people get the benefits from the scheme for full 100 days.
c) Only 28.01 percent labourers got the job-card from whom 78 percent could not get the chance to do any work for 30 days and 30 percent were not able to get the work for nearly 10 days.

d) 15 Panchayats has no formal registration of the NREGA Scheme, although the schemes are still going on.

e) 1642 Panchayats are not able to target this scheme.

f) Nearly 79,655 numbers of families are still deprived of getting the benefits of the scheme.

g) Only 10.96 percent workers have bank account under the scheme.

*The Sentinel, on 9th January, 2012* reported about a research conducted by the North East Social Trust (NEST) in collaboration with the Centre for Microfinance and Livelihood (CML) to understand the rural livelihood status under MGNREGA in the State. Only three months remained for the completion of the financial year 2011-12, and it was found that despite the Government’s claims about rural development, the implementation of the MGNREGA during 2011-12 (till December 31, 2011) had been rather poor. At a press conference in Guwahati, NEST executive director Tasaduk Ariful Hussain commented on the situation like this: “One of the main reasons for the poor implementation of the MGNREGA schemes is the fact that there should be a programme officer in every block to supervise all the works related to the scheme. In Assam there are 217 blocks and as yet no programme officer has been appointed in any block. As a result, the Block Development Officers (BDOs) have to look after the implementation of MGNREGA schemes in their respective blocks. As the BDOs already have a lot of work, they cannot give due importance to the MGNREGA schemes and their implementation.

**EDUCATION, EMPLOYMENT, AND HEALTH STATUS OF WOMEN:**

Bhattacharyya, Aradhana (1994-95) conducted a study under the title “The Role of Women in Decision Making in the Family”. This study was
conducted in the Ward No.5 in the Dibrugarh Town, where the number of total households is 834. Out of all these households, 200 were selected with the help of lottery sampling method. Women belonging to the age group from 25 years to 60 years were interviewed. The respondents included different religious groups like Hindu, Islam, Sikh, Christian etc. From the study it was found that 90 percent women had equal status in the family and could take any decision in the family. 70 percent women took decision about choosing their children’s schooling. From the study, it was found out that both parents were equally responsible regarding family matters.

Singh, Yash Kumar (1994-95) conducted a study entitled “Health Culture among the Mishing: A Case Study in Ramnagar Village, Sibsagar District, Assam.” The study revealed that environmental sanitation practices of the people was very poor. The drainage system in the village, specially the household drainage system, was not satisfactory. Personal cleanliness among the people is also not hygienic. Very few persons used to wash their hands and faces before taking meal. Rice beer is very popular drink among the people which they take at any time of the day. In terms of ability to do the day-to-day activities, it had been found that the female had the ability to carry water from long distance, collect firewood from jungle, and do the day-to-day agricultural and domestic activities. This study took total 101 families in the village the members of which were interviewed. The people in the village believed that the diseases are the cause of sorcery (black magic). The Sorcerer may be a male or a female who can harm a person with his or her magical power.

Borthakur, B. N. (1997) in his research paper “Social Justice and Tribal Women: A Case Study of Mishing women in Assam” explains that over the years it has been found that the Mishing women enjoy less rights and privileges than their male counterparts. As regards to inheritance of property, the Mishing women cannot claim share in her father’s or husband’s property as a matter of right. Similarly, she plays a marginal role in the important decision making
process in the family. Through this study, it was found that women’s decision
making process in purchasing or disposing of agricultural land, marriage of
children, holding of social and religious function, and acquiring or selling of any
movable property is far from satisfactory in this society. In this study, it was
observed that 73.3 percent respondents answered that all important decisions of
their families were being taken by their husbands. While 26.66 percent answered
that it is their father-in-law who is the prime decision-maker in the family.
Besides, regarding the involvement in decision making process, 96.66 percent
respondents opined that their status is relatively low, and only 3.33 percent stated
that they enjoy equal status with their male counterparts. Despite their enormous
contribution to the family or the society, they are not given importance in the
society. Such contribution remains unnoticed and un-recognized, although in
India, the property right to the Hindu women is guaranteed by the Constitution

During a religious ritual, either in the Mishing family or the Mishing
society, women do not play any role other than cooking food. It is significant to
record that Mishing women are not even permitted to remain present at the place
where the rituals are to be performed. The traditional priest of the Mishing is
called ‘miboo’, and only the male person is entitled for the duty of priest in the
ritual ceremony. During the course of such rituals, the Mishing women prepare
apong- a kind of rice beer, which is used for drinking during the ritual. Thus, the
participation of women in the proceeding of a ritual is restricted to preparing and
serving apong only. In terms of the political right too, this paper highlighted that
the Mishing women are not given their due right. The traditional political
organization of the Mishing is called kebang, which means the public meeting.
This kebang is generally convened to solve disputes of any nature in the village.
A kebang is presided over by the gam, i.e. the village headman. The Head of the
household of the village, and the senior male persons are invited to take part in
the deliberation of the kebang. Women are always deprived of taking part in the
meeting of *kebang*. Women can attend the *kebang* as an appellant or witness to a case of litigation only.

**Basu, S.K. (1996)** in his paper “Need for Action Research for Health Development in Tribal Communities in India” revealed that the concept of health culture refers to a sub-culture within a totality of the population. It encompasses a vast complex of knowledge, beliefs, techniques, roles, norms, values, ideologies, attitudes, customs, rituals and symbols, which are related to health and diseases. The study of health culture of a particular community is important, because:

a) The health problems and the procedure to handle such problems and other health practices are influenced by the complex interplay of socio-cultural factors, and

b) Implementation of health services (health centre, immunization, or any kind of health programme) would be difficult without the knowledge of the community’s traditional health culture.

**The World Bank (1996)** studied the needs of women in the rural areas where mortality levels are substantially higher than in the urban areas, and access to care is limited. The report focused on the measures necessary to address the existing policy and implementation constraints, and improve the quality, acceptability and utilization of services essential to women’s health.

**Agarwal, Bina (2001)** in her paper “The Idea of Gender Equality: From Legislative Vision to Everyday Family Practice” explained that employment-status of women has unequal prospect. Women’s possibilities of economic independence are severely limited within agriculture; they are either un-waged workers in male-owned family farms, or poorly paid labourers in the farms of others.

**UNICEF Report (2002)** stated that education and health are social investment, and not simply a single public expenditure. The National Common Minimum Programme aims to increase public expenditure on education to 6
percent and on health to 2-3 percent of the GDP. However, the total investment on health and education in India remains dismally low. Less than 1 percent of India's GDP is spent on public health, which is even lower than the public health expenditure of countries like Sri Lanka and Sierra Leone. Public expenditure on education in India is a little over 3 percent of the GDP.

Dutta, S. K. and D. K. Ghosh (2002) in their *Empowering Rural Women* had given serious thought to women's development right through the programme like DWCRA with the purpose of improving the status and quality of the poor rural women through income generating activities.

Bokil, Milind S. (2003) conducted an empirical study under the title “Micro-enterprises and Gender division of Labour: An Empirical study of Self employed Women in Maharashtra.” A sample of 97 women from the rural areas and 57 from the urban were taken from Maharashtra, and data was collected through a questionnaire. Most of the respondents (61 percent) were in the age group of 31-45 years, only 25 percent were between 19-30 years of age. A large majority of the women (88 percent) were married, and 36 percent women were illiterate (rural 38 percent and urban 19 percent). The majority of the urban women (72 percent) were staying in permanent houses whereas most of the rural women (nearly 50 percent) were staying in kaccha (non-permanent) houses. Only in 21 percent urban cases, and 10 percent rural cases, the houses were owned by women. The rest of the houses were owned by families or by mothers-in-laws. In terms of the basic amenities like electricity, bathrooms, and toilets, only 28 percent in urban areas, and 26 percent in rural areas had private toilets. Domestic utilities in both rural and urban areas were found to be average. Majority of both rural (62 percent) and urban (75.4 percent) families had monthly income less than Rs. 3000. Most of the respondents from both the urban and the rural areas were engaged in petty trade such as selling of bangles, clothes, footwear, vegetables, plastic items, stationary, general utility items, and grocery. On other domestic chores, the rural women spent 5.23 hours and the urban women spent
4.96 hours per day. Being overburdened, around 60 percent urban, and 70 percent rural respondents reported health problems, the most mentionable being backache and body ache.

Vasantha Kumari, P. and G. Venkata Lakshumma (2005) in their research paper “Impact of Women's Education on Health and Family Welfare” assessed the impact of women’s education on various aspects of health and family welfare. This study estimated that about 850 million people in the world are illiterate, and out of them about 50 percent are in India alone. But the rate of illiteracy among women is more alarming. The sample comprised 100 mothers (50 illiterate and 50 literate) of school going children. Random sampling method was used in selecting the sample from Gyampalli village of K.V. Palle Mandal of Chittoor District. A questionnaire prepared for the purpose of data collection contained thirty questions and was broadly divided into 3 categories namely physical health, child care and sanitation, and nutrition and diet. Results stated that a large percentage of women were confined to old beliefs and faiths due to lack of knowledge which can be provided only through education on hygiene, sanitation, etc. Such knowledge would help in reducing child mortality by taking care of diseases like diarrhea. There were not many differences among the responses of literate and illiterate mothers regarding knowledge. Illiterate mothers lacked knowledge about nutrition and the effect of the surroundings on the child’s health. This paper suggested that to fill up the gaps in knowledge, it was essential to impart nutrition and health education, so that a great number of diseases could be prevented. So the education of adult women, who constitute an important and sizeable portion of the country’s population, is the need of the hour.

Sharma, Archana (2005) in her research article entitled “A Situational Analysis of Women and Girls in Assam” conducted a study to assess the condition of women and girls in Assam. According to the Census Report of 2001, the population of Assam was 26.6 million, comprising 13,787,799 male and
12,850,608 female. About 70 percent of the total population depended on agriculture. It was stated in the Report that Assam produced about 15.6 percent of the world’s tea, and 55 percent of India’s tea. In 1999-2000, the Planning Commission estimated that 26.10 percent people were living below the poverty line in India, and in Assam the percentage was 36.09. As per NSSO 58th Round figures, the status of availability of food in rural Assam was the lowest among all states of India, with only 943 households per thousand getting enough food throughout the year. In 2001, the sex ratio in Assam was 932 against the all India average of 933. In 1991, the child sex ratio in Assam was 975, which decreased to 964 in 2001. The death rate in Assam was 10.2 in 1993 but decreased to 9.5 in 2001. The SRS data of 1998-2001 confirmed that the birth rates in rural Assam continued to be higher than the corresponding all India rates, whereas in the urban areas, the picture was just the opposite. The total rural and urban IMR of Assam was 70, 73, 38 in 2002 compared to the all India figures of 63, 69, and 40 respectively. According to NFHS II of 1998-99, the neonatal and post-natal mortality rates in Assam were 44.6 and 24.9 respectively. In 2001, the male female gap in literacy was only 15.9 percent against the national average of 21.70 percent. FWPR was 20.7 percent in 2001 compared to 21.6 percent in 1991. In 2000, Assam had only 10 lady IAS officers compared to 216 male IAS officers. In 1997, there were 1113 cases of kidnapping, 717 rapes, 686 molestations, 775 cruelty by husbands, 22 dowry deaths, and 10 immoral trafficking cases, which increased respectively to 1229, 884, 754, 1560, 62 and 20 in 2002. There were 197 ICDS projects operational in Assam including 89 newly created projects. The social sector received around 35-40 percent of the total planned expenditure of the state. Women had very low representation in decision-making bodies, and did not even have complete freedom in the decision making processes of the household. In many insurgency-affected areas, women were victims of different forms of crime. Very little effort had been made to address the problems of these women in difficult situations. To address all these problems in their true
perspective, a State Policy Action Plan for the empowerment of women of Assam was urgently required.

Nayar, Gaurav (2005) addressed and analyzed in his article "Growth and Poverty in Rural India: An Analysis of Inter-State Differences" that gender bias is a big issue in India. Even after more than fifty years of independence, there are sharp inequalities in terms of caste, creed, tribe, rural-urban divide, and gender, making women and girls part of the disadvantaged group. Although education is very important for the development of the society and economy, still women remain un-educated compared to men.

Rao, R. K. (2005) in his book Women and Education has basically explained that in the context of illiteracy among the girl child or women there is a big disparity between men and women. Foeticide and infanticide are common occurrence if the sex is not detected to be male. Although there is a common legal system for both men and women, still women are deprived of many rights. For example, in the seats of power in the Governmental, in positions of prestige in public life, as well as in other offices which control political and economic power, women’s presence in very low. Besides, in the overall cultural matrix of society, she is a second class citizen, despite having the equal talent like men. In the religious sector, women often face inferior status compared to men. The employers often think that a woman will be giving most of her mind and body to her family and therefore must be given only second class jobs. Maternity leave and other demands necessitated by the discharge of the scared function of rearing the young generation are treated as handicaps for her in the employment market.

The Hindu on 9th January, 2005 reported a news based on an interview where Amartya Sen expressed that the inadequate reach of quality health services forces most poor citizens, particularly the women, to go to unqualified medical practitioners in India. Hence, they become easy victims and are neglected in
terms of the treatment of health. Lack of effective access to safe reproductive health services makes pregnancy a matter of high risk for many poor women.

Talwar, Sabanna et al. (2006) conducted a study entitled “Women education, Employment and Gender discrimination: A Socio-economic Study of Hyderabad-Karnataka State (in comparison with Mysore, Telengana and Marathwada regions)” to find out the socio-economic factors responsible for gender discrimination in the field of education and employment. 800 rural and 800 urban women were selected for the study. 34 percent women in the rural areas and 38 percent in the urban were from the upper castes. 25.25 percent rural and 21.25 percent urban women were SC/ST; 24.25 percent rural and 21.63 percent urban women belonged to backward classes; and 16.50 percent and 18.25 percent women belonged to the minority community in rural and urban areas.

From the study, it was found that 30.69 percent women was self-employed, followed by 24.25 percent Government employees, 23.37 percent employed in various private business agencies or enterprises, and 21.69 percent in the agricultural sectors. 23.63 percent women had permanent jobs, 34.63 percent had temporary jobs, and 41.75 percent women had daily wage jobs in the rural areas. Similarly, in the urban areas, 32.75 percent women were in permanent, 43.25 percent were in temporary, and 24 percent were in daily wage jobs. About 17.13 percent women in the rural areas were found to be less skilled, 15.63 percent women lacked education, and 14.25 percent lacked help in the household. 36.87 percent spent their own money but 43.13 percent women handed their money over to the husband in the rural areas. In the urban areas, 44.75 percent women spend money on their own and 39.62 percent handed it over to their husband.

Based on the study, the following suggestions were made to overcome the discriminations. Educational programmes for girls should be initiated in different fields. The number of government girls’ schools should be increased for easy accessibility of basic education for girls. Women must be facilitated to gain technical and higher education to obtain economic benefits from modern
occupations. Organizational capacity should be built among women, and formation of groups/professional organizations like SHGs, Credit Societies, etc. should be strengthened.

Sarkar, S. (2006) in his paper “Gender, Water and Health Linkages” established a positive relation between non-existence of safe drinking water and ill health of rural women. He argued that poor health caused by water related diseases also reduces their time and energy and productive economic efforts. Inadequate clean water also increases medical cost, reduces wages causing a great economic loss. He concluded that community participation and awareness activities may reduce the difficulties caused by insufficient water supply and improper sanitation.

Singh, Udai Pratap (2008) did a study on Tribal health and traditional health practices in the North Eastern part of India in his book entitled Tribal Health in North East India, A Study of Socio-Cultural Dimensions of Health Care Practices. He explained that the tribal women have less knowledge of how to protect their home from the unhealthy atmosphere, how to maintain health and hygiene in the family etc. The unhygienic condition plays a significant role in various communicative diseases in the tribal and rural areas. The conservative habits and traditional health practices of the tribal and their poor economic condition, illiteracy, absence of safe drinking water, poor maternal and child care services, nutritional deficiencies, lack of knowledge regarding personal hygiene and environmental hygiene, bathing habits, spitting habits, superstitions, overcrowding and the lack of knowledge of prevention or communications among the tribes are the major responsible factors for the spreading of diseases. The author revealed that the tribal people have their own choices regarding the traditional practices and beliefs for the treatment of various diseases. Attitudes, beliefs and practices which somehow have scientific explanations, are universally present in the form of oral tradition and personal observation handed down from generations to generation. The tribal men believe that diseases such as measles,
chicken pox, unsafe delivery, snake bite, fever, typhoid, malaria, tetanus, fits etc. are caused by evil spirits and curse of gods. The tribal people use incense sticks, ghee and offer liquor or sometimes even meat to please these gods. Thus, the socio-cultural tradition does play an important role in the context of health and treatment among the tribals. The common beliefs, customs and practices connected with the treatment of diseases have been found to be intimately connected to the treatment of diseases. When a person goes to traditional medical practitioner, he or she gets socio-psychological reinforcement which he or she cannot get from the modern medical practitioner. The social reinforcement based on the understanding of traditional beliefs and practices is often lacking, and it may be the one reason for which a modern medical practitioner is unsuccessful in the tribal areas.

Regarding health Nagar, N. S. (2008) in his book Women and Employment explained that health and well-being is a concept related to the substantial differences between women and men in their access to sufficient nutrition, health care and reproductive facilities, and to the issues of fundamental safety and integrity of person. According to the WHO, 5,85,000 women die every year, over 1,600 every day, from the causes related to pregnancy and childbirth. The Planned Parenthood Federation of America estimates that the annual 46 million abortions worldwide, some 20 million are performed unsafe, about 80,000 women die from complications that accounts for at least 13 percent of global maternal mortality, and which causes a wide range of long term health problems. Women's particular vulnerability to violence is perhaps the most obvious aspect of reduced physical security and integrity of person.

In the same book, he discussed the position of women in society and their level of employment. Most of the women are engaged in the unorganized sector. They are deprived of receiving equal pay like their male counterparts received for the same work. He has explained in his book that the absence of social services in care-giving may be a factor that relegates women to part time, low quality jobs.
Women are not in a favourable position in the labour market since patriarchal ideologies influence perceptions of the women workers. The patriarchal cultural norms relegate women into the secondary status in their family and society. The domestic chores and care giving activities performed by women remains unpaid and undervalued. Besides, women are deprived of getting their suitable jobs due to various other causes. For instance, it has been seen that women workers supposedly have high rates of absenteeism, turnover. Besides, they lack flexibility with reference to over time, night work, working on leave days and so on, that turn them into "high cost" workers. Sometimes, women have to leave their job for family reasons which directly and indirectly affect the profit of the employers and thus women are not in a position to get a suitable job although they have the necessary qualifications. In the primary sector, there is relatively good pay and work conditions in terms of job, more job security and career advancement. But the employers prefer men employees mainly because of the associated "cost employees" in matters of women employee. Consequently, there is a greater likelihood of women workers crowding into secondary sector employment, where wages and working conditions are low and have little upward mobility.

Apart from these, the gender division of labour reinforces occupational segregation by weakening the status of women in the labour market. The author had cited an example of the working conditions of the women of Pakistan. The activity of women in Pakistan is uncounted. The women workers in the agricultural sector are reported as part-time workers, because they engage in both domestic and agricultural activities. The husbands do not report women's work either because they fear losing respect, or such work is considered "wifely duties", or such work is done within the confines of home or in a sexually segregated environment. According to Labour Force Survey data, the activity rate for women workers in the rural and urban areas of Pakistan is 14.5 percent and
8.5 percent respectively. However, in reality, the estimated figures are 55.0 percent and 25.0 percent respectively.

In Sri Lanka, women’s labour force participation rates are the highest in the whole South Asian regions. The labour force participation rates for women during the 1985-86 and 1994 were 31 percent and 32.2 percent respectively. These official data imply that although the proper estimation of women work is undercounted, the participation rate of women is comparatively high in Sri Lanka than in other developing countries. Matrilineal and bi-lineal descent systems, female inheritance patterns, and women’s access to education are the factors that provide the Sri Lankan women a favourable position in the socio-economic structures. Similarly, in Bangladesh, wage discrimination is most severe: on average, women workers earn only 1/3rd of the earning of the men workers.

RGVN in its report “Gender and Development: A Broad Framework for Northeast India” (2008) surveyed and reported that in the NER, gender relations amongst the people in the hill states compared to the plains people are more flexible. Amongst the plains women, norms of patriarchy, caste and class are important factors affecting women’s mobility and their role play in the public domain. In the hills, these restrictions (with the exception of some communities) are not so rigid. With the advent of Christianity, many of the practices that were generally followed by the tribal people had changed. Physical mobility, the freedom to work and liberty to take decision had given women some confidence and identity. The egalitarian culture of the region, coupled with the absence of some of the rigid practices of the other parts of India, like seclusion (purdah) and dowry amongst the nontribal populace of the region, certainly provided the women of the region an edge over the others, in terms of visibility and mobility. Yet gender was never predominant among them. Throughout the region, women have no substantial property rights. Almost all communities in the region are patriarchal, while some communities like Khasi, Garo, Tiwa, etc. are matrilineal, tracing descent through the female line, but, authority lies with the male, the
mother’s brother. Traditionally, women were restricted to the private domain with no role in administration or decision making of the village. Besides, the overwhelming customs and traditions restrict women’s mobility to the household and at best within the village. In the face of economic stress, it has been observed that women, despite being bound by tradition, are breaking the barriers to earn an income. In this background of disadvantaged gender, the uplift of women both economically and socially becomes imperative to empower women. In the conclusion of the report, it was revealed that livelihood interventions must address gender keeping in mind the prevailing situation and the socio cultural fabric of the region. Besides, it was suggested that special focus should be given on some practical needs such as water, labour saving technology (gender friendly), transport services and inputs (flow of market information, market linkage, advice, training etc.), and strategic needs such as access to and control over resources. Besides these, some other strategies should also be adopted for protecting women against insurgency, military atrocities, ethnic strife, social customs, terrain, and patriarchy.

Abraham, Vinod (2009) in his paper “Employment Growth in Rural India: Distress-Driven?” explained that when the earning of the working members of the poor household do not meet the subsistence level of the family, the workers may increase their total time of work, cutting down on leisure. If the level of income rises and the primary earners’ income suffice to meet subsistence, then the secondary workers may withdraw from the labour market. The secondary workers mainly consist of women, elderly people and children.

Nayak, Purusottam, and Bidisha Mahanta (2009) in their paper “Human Development in Assam” presented a picture of economic empowerment of women in Assam by stating that women have less financial autonomy as compared to all India level. Only 26.9 percent of the total respondents in Assam take decisions by themselves about the use of their own earnings as compared to almost 50 percent in case of India. However, the awareness about micro-credit programme is slightly higher in Assam (41.7 percent) than in India (38.6
percent), yet an insignificant percentage of women have availed loan from micro-credit programmes both in India (4 percent) and Assam (1.4 percent).

The 11th Five Year Plan (2007-2012) explained the status of women's health after conducting a survey in the states. Encouraging the pregnant women to deliver in health centers/institutions has been one of the core strategies for reducing infant and maternal mortality. At the national level, the institutional delivery rate prior to the RCH Phase I, as per the NFHS-II (1998-99) was only around 33.6 percent. Several new initiatives were taken during RCH-I for improving safe motherhood. The rate of institutional deliveries as per the DHS-II (2002-04) was only 41.5 percent. Inter-state variations and variations among the different income groups have been quite significant. Though, results of 12 states as per the NFHS-III conducted in 2005-06 are showing an increasing trend too, a large number of women, especially from the poor families living in the weak states still deliver at home. Even among the weaker states, there are significant differences in institutional deliveries between rural and urban areas. In case of MMR, Assam has the highest number followed by Uttar Pradesh. JSY was launched by the Central Government on 12th April, 2005. The scheme has the dual objectives of reducing maternal and infant mortality by promoting institutional delivery among the poor women. Though the JSY is implemented in all States and UTs, focus is laid more on those states having low institutional delivery rate. The states namely Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam and Jammu and Kashmir, where the institutional delivery rate is abysmally low, have been categorized as LPS. The remaining states have been named HPS.

The Assam Tribune on 8th March 2010 published an article on the status of the Tea Tribe Women in Assam. This article stated that women from the tea gardens are unprivileged in many ways. In most of the tea estates of the state, according to health officials, there exist serious issues about the state of women's health. Many of them suffer from a range of diseases like anemia, allergy, gastrointestinal disorders, and under nourishment. The doctors say that with early
marriage widely prevalent in most of the tea estates, young women find themselves in a vulnerable position. The fact that multiple child birth is a common feature of the tea tribe women only adds to their difficulties. The absence of proper health care in most tea gardens is a hurdle that is yet to be surmounted. Although some tea estates have well-equipped hospitals, there are hundreds of tea estates without necessary health support in the form of infrastructure and doctors. For the women of such estate there is little resource to healthcare as they cannot afford private medical intervention, which may be available outside their estates. Pallab Lochan Das of the Assam Tea Tribes Students Association, pointed out that healthcare was one area that had not been taken seriously by the authorities concerned to the extent they should have. Consequently, the women in the tea gardens were among the worst sufferers. The lack of awareness regarding educational opportunities is another critical issue that needs to be addressed in greater detail.

SUMMARY OF THE REVIEW DONE:

The review of literature pertaining to the problem undertaken for study is essential for the Investigator in order to develop a thorough understanding of the work done in the area, in the state, in the country as well as outside the country. During the research, the Investigator scanned most of the relevant reported studies in their area carried out in other countries, in India, in the North East, in Assam and in different districts of Assam. Though various studies related to women empowerment and gender disparity have already been conducted, no study has been done so far to find out how the means of social security is related to women empowerment particularly in the rural areas in terms of education, health and employment in Sonitpur District of Assam.