CHAPTER I
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Empowerment of women or women's empowerment has emerged as an important issue in the domain of development in recent times. Scholars, women's groups, social activists and policy makers refer to empowerment as one of their goals. Empowerment is generally seen as the only effective answer to oppression, exploitation, injustice and the other maladies with which a patriarchal society is beset. It is also felt increasingly that women's subordination and exploitation is a result of their powerlessness in patriarchal society, hence the need for women's empowerment.

In the recent past, various international, national conferences and conventions recognise that women need to be empowered for social development. Since then, there is growing awareness among nations that women need to play a significant role in all aspects of development process. The World Bank has suggested that empowerment of women should be a key aspect of all social development programs. The World Bank also reported that empowerment of women is an important policy goal for improving not just the well-being of women themselves but also for its positive impact on the family and society. The concept of empowerment is thus closely related to the concept of social development.

Social development is a process of developing people's welfare. It aims at producing a social well-being that makes people capable of acting and making their own decisions in the broadest sense. To achieve the goal of social development, women need to be empowered so that they have freedom of choice, equal access to domestic and community resources, opportunities and powers. Further, if women are empowered, they can realise their full potential and voiced their concern over their health and development needs. Such conditions have
consequences not only for the women themselves but also for the well-being of their children, the functioning of households and the distribution of resources and the society as a whole. Many researchers have argued that women’s empowerment is closely linked to positive outcomes for families and societies.²

Manipur is not an exception from the various health problems concerning women. A study on the problems to find solution is the pressing need of the hour. The present study attempts to give a clear sociological outline about the empowerment of women in Manipur in respect to their health particularly reproductive health, within the social, economic and political context of their lives. To meet their health needs, women need to be empowered throughout the evolving stages of a women’s life i.e., girl hood, adolescent girls and women. As the health of women is critical in every stage of her life, adolescent girls are also included under this study, as they belong to the initial stage of the reproductive age groups.

Conceptual framework

Empowerment means having the capacity to make decisions and gain control over one’s own live and the society. The term empowerment has three important components: multidimensional, social and a process. It is multidimensional because it occurs within sociological, psychological, economic, and other dimensions. Empowerment may occur at individual, group, and community level. Further, empowerment is a social process, since it occurs in relationship to others. To add, empowerment is a process that it leads to a path of development. Other aspects of empowerment may vary according to the specific context and people involved, but these remain constant. Empowerment of women would mean the process of improving the condition of women from a state of powerlessness to that of decision making power for themselves, their children and the society as a whole.
Empowered women who are well informed, enjoy good health, and understand the wonderful capacity of their bodies can respect and care for themselves and better care for their families. Women's contributions to the society increase, in direct proportion to their health and level of self respect and self esteem. Well-informed women will get access to healthier and safer pregnancies and births and develop a better sense of themselves as strong and able, and more capable of speaking for themselves with the capacity to better shape their life experiences. They will also make better choices and have access to better health care services. Thus, empowered women may have freedom to shape their lives, their control over resources, their access to basic facilities, their level of political participation, their ability to take their own decisions and get them accepted by family and society and their ability to remove hindrances in their path to progress. What women think and how they feel about themselves, including their personal satisfaction and fulfillments have importance in the empowerment of women in the society for any development.

Empowerment of women has been recognised through many international, national and regional conferences as a basic human right and also as an imperative for national development, population stabilisation and global well-being. Thus empowerment of women is an essential key for social development. The International Conference on Population and Development (ICPD), 1994 and the Fourth World Conference on Women (FWCD), 1995 have given higher emphasis on health issues particularly reproductive health and reaffirmed that it is an indispensable part of women's empowerment and for enhancing their quality of life. It is also recognised that empowering women and improving their status in respect of education, health and economic opportunity is a highly important end in itself that will enhance their decision-making capacity in all spheres of life and especially in the area of reproduction, as reproductive rights are the basic rights for all couples and individuals.
Social development is a process to achieve and integrate a balanced and unified social and economic development of the society that gives expression to the value of human dignity, equality and social justice. It aims at holistic development of human beings, i.e., human development. While income and economic growth are necessary conditions for improving quality of people's lives, they are not always sufficient. Social development is about freedom of expression, participation, decision-making and freedom to work without social bondage. Social development also requires equality of opportunity such as equal access to economic, social, political and cultural opportunities to all citizens. Social development aims at holistic development of human beings that is human development. The Human Development Report 1990, states that people are the real wealth of a nation and the basic objective of development is to create an enabling environment for people to enjoy long, healthy and creative lives.

According to Bilance, 'Social development is the promotion of a sustainable society that is worthy of human dignity by empowering marginalised groups, women and men, to undertake their own development, to improve their social and economic position and to acquire their rightful place in society.....'.

James Midgley has had a decisive impact on the international discussion on social development. To him social development is a 'process of planned social change designed to promote the well-being of the population as a whole in conjunction with a dynamic process of economic development'. The goal of social development in the context of modern welfare is to produce a social well-being that makes people capable of acting and making their own decisions in the broadest sense.

Social development first attracted widespread attention through the principles set out in the millennium goals of the United Nations in 1995 (the Copenhagen Declaration - 'World Summit for Social Development'). It recognised that social development is central to the needs and aspiration of the people
throughout the world, and to the responsibility of the government and all sector of
the civil society. The summit proposed a renewed conception of social
development and made the world understand its great significance. It provided an
opportunity for rethinking on development goals and strategies amenable and
conductive to the promotion of social well being.

There is growing realisation to view women's health in a holistic way
within the social, economic and educational context of their lives. The Human
Development Index covers three dimensions of human welfare such as income,
education and health. Loses in human welfare is linked to life expectancy for
example woman's poor health can constrain economic growth and performance in
education, and slow growth reduces the resources available for social investment.

The various United Nations conferences and conventions also brought
India's attention to the issue of women's health problems. For empowering
women, the Government of India has ratified various global conferences and
conventions such as the International Conference on Population and Development,
1994; the Fourth World Convention on the Right of Child, 1990 etc. This can be
seen in the Government's efforts of looking at women's health within a life-cycle
perspective in the Tenth Five Year Plan. Further, the Government of India has
made several commitments by way of constitutional provisions, legislations,
policies and programmes to bring women to the center stage of development
planning. The principle of gender equality is enshrined in the Indian constitution
in its Preamble, Fundamental Rights, Fundamental Duties and Directive
Principles.

Concerning empowerment of women as agents of social development,
various measures that have been undertaken by the government of India proved to
have considerable progress in social and economic development. The following
several health-related aspects do show considerable improvement in the case of
women. A reduction in the total fertility rate from 3.4 in 1990-2 to 2.9 in 1996-8,
and an increase in the contraceptive prevalence rate from 41 per cent to 48 per cent, mostly due to increase in female sterilisation. However the disparity in fertility reduction is seen between different regions. In 1951, an Indian woman could expect to live no longer than 32 years; this figure has increase to 65 years in 1996-2001. According to the National Family Health Survey (I, II, III); a reduction of the maternal mortality rate from 468 per 1000 live births in 1980 to 424 in 1992-3 can be seen but it is still high. In the field of education, there is a considerable improvement in female literacy as it come up to the present rate of 39.19 per cent from 8.9 per cent in 1951.

Thus, the data shows that the situation of women has improved to some extent. From this it can be said that women can be active participants in the process of social development if they are provided the necessary health and developmental needs.

However, there still exists a wide gap between the goals enunciated in the constitution, legislation, policies, plans, programme and related mechanisms on the one hand and situational reality of women's status and women's health particularly reproductive health. Thus, women who constitute about half of the total Indian population are not contributing to development because they are always trapped in a cycle of ill health exacerbated by childbearing and hard physical labour. In India, women's poor health status is bound up with social, cultural and economic factors. So, cultural, social and economic barriers can delay or prevent women from seeking reproductive health care at any stage either antenatal delivery or postnatal. Again, women as a part of the social system are meted with various types of inequalities, which give a raw deal in the society. The male dominated patriarchal system of Indian society gave women the subordinate status where she has been living under the control of first their fathers, then their husbands and finally their sons. Thus in a society like India, where there is inequality between men and women; preference for sons; poor nutrition and health
care in childhood; lack of decision-making power; early marriage; lack of knowledge on reproductive health; contraception; family size and poor state of pre-natal and post-natal and maternal health care services, etc deepens women's health problems.

Adolescents are tomorrow's adult population and their health and well-being are crucial. Yet, the focus on the health of adolescents is relatively recent. According to a report of WHO 2005, adolescence can be divided into three developmental stages based on physiological, psychological and social changes. This period of adolescence is different from childhood and adulthood because it is a time of rapid physical and psychological (cognitive and emotional) growth and development, a time in which new capacities are developed, a time of changing social relationships, a time of different needs, changing needs, changing social relationships, expectations, roles and responsibilities. Thus, lack of awareness on their health care, reproductive health, sexual activity and substance use leads to a risky future health condition such as too early pregnancy, risks to mother, risks to baby, health problems during pregnancy & child birth (including unsafe abortion), Sexually Transmitted Infections including HIV/AIDS, mental health problems and so on.

In the context of the above mentioned discussion on women, this study tries to understand the change that women undergo in becoming empowered. It is worth to look at two sets of literature. In the first set of literature, a review of what is empowerment in general, and in the second set of literature, review of what is understood as women’s empowerment is discussed. Further, empirical studies done on women’s empowerment and its link to their health outcome are also presented.

To clearly understand women’s empowerment, one must begin to build an understanding of what empowerment means. Although the notion of women’s empowerment has long been legitimised by international development agencies,
what actually comprises empowerment, and how it is measured, is debated in the
development literature. The study does not attempt to resolve this debate, but to
examine how women's empowerment and its contributing factors that affects their
reproductive health needs and health care services. Empowerment in general and
women's empowerment in particular is defined differently by different people in
different contexts.

Narayan have converged upon a common conceptual framework for
understanding empowerment, first outlined in the World Bank publication
Empowerment and Poverty: A Sourcebook. Empowerment is viewed broadly as
increasing poor people's freedom of choice and action to shape their own lives. It
is the process of enhancing an individual's or group's capacity to make effective
choices, that is, to make choices and then to transform those choices into desired
actions and outcomes. Narayan emphasize on the importance of having a clear
definition of the concept of empowerment and the need to specify a framework
that shows the linkages between empowerment and improved development
outcomes and which indicates determinants of empowerment itself. According to
her, empowerment is the expansion of freedom of choice and action to shape one's
life which implies control over resources and decisions.

Further, Narayan outlines a conceptual framework containing four building
blocks which will be necessary in understanding the main underlying factors that
facilitate or constrain poor people's efforts in improving their own well-being
leading to broader development outcomes. The four building blocks are:
institutional climate, social and political structures, poor people's individual assets
and capabilities, and poor people's collective assets and capabilities. All these four
components are related to each other and if put together can lead to development
outcomes. Out of these four components, the first two building blocks constitute
the opportunity structure that poor people face, while the second two make up the
capacity for agency of poor people themselves. The opportunity structure of a
society is defined by the broader institutional, social, and political context of formal and informal rules and norms within which actors pursue their interests. Agency is defined by the capacity of actors to take purposeful action, a function of both individual and collective assets and capabilities.

Malhotra and Schuler, also provide an excellent review of this debate. They review the many ways that empowerment can be measured and suggest that researchers pay attention to the process in which empowerment occurs. In the view of Malhotra and Schuler \textsuperscript{12} 2005, available literature shows wide diversity in the emphases, agenda, and terminology in discussing empowerment i.e., it is always not clear what writers are referring to similar or different concepts, when they use terminology such as ‘women’s empowerment, gender equality female autonomy or women’s status’. Malhotra and Schuler give two defining features of the term ‘women empowerment’ i.e., process and agency. They add that no other concept emphasise on processes of change that is ‘towards greater equality, or greater freedom of choice and action’. The second feature ‘agency’ stress that women themselves are the main agents in the process of change. Unless and until the intervening processes involved women as agents of that change there can be no real empowerment. Malhotra and Schuler also view that most of the literature stress on the importance of resources. Access and control over certain resources makes some groups control over others in the society for example control over material resources, productive resources and human resources and intellectual resources such as knowledge and information and also the capacity to have ideas and think in new ways. However, Malhotra and Schuler refer to resources not as a feature of empowerment per se but, as ‘enabling factors’ that can foster an empowerment process.

Another definition given by Kabeer \textsuperscript{13} serves as good reference point for conceptualising women’s empowerment. It contains both the process and agency elements and that distinguishes empowerment from the general concept of power.
as exercised by dominant individuals or groups. Empowerment is defined by Kabeer as 'the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them'. According to Kabeer, empowerment cannot be reduced to a single aspect of process or outcome. How women exercise choice and the actual outcomes will depend on the individual. Choices will vary across class, time and space. Moreover, impacts on empowerment perceived by outsiders might not necessarily be those most valued by women themselves.

The scholarly discussion on empowerment has therefore been context driven rather than theory driven according to Andre Beteille. The context is the contradiction between a hierarchical social order and a democratic political system. Indian society has been a traditional society based on caste and gender where there is inequality between different castes and sexes. In the past the deep rooted ideas of purity and pollution governed the social standings of different castes and sexes; men and women were deemed to be of unequal moral worth as were the different ‘Varnas’ and the social hierarchy was underpinned by a legal order in which privileges and disabilities were carefully modulated according to caste and gender. Now the law has changed; social attitudes have also changed to some extent. However, despite the changes, the disadvantage group that is women and persons of inferior caste continue to suffer. With the passage of time, there is a growing realisation that the social order cannot be transformed quickly by the laws and plans but the focus is on empowerment of the people. It is in this context that the concept of empowerment emerges. Beteille is of the view that empowerment is both a means to an end and an end in itself.

The most conspicuous feature of the term empowerment is that it contains the word power. In fact, the understanding of the term empowerment is not so easy without understanding of the term power. The concept of power adapts differently to different situations. Andre Beteille is of the idea that the sociological conception of
power may be best understood by viewing in opposition to the anarchist and the populist conceptions of it. In the anarchist conception, power itself can be abolished and human life reconstituted in such a way that the exercise of power becomes redundant. While in populist conception, the emphasis is not about abolishing power but on its radical redistribution where all sections of society participate equally in the exercise of power.

Vilfredo Pareto\textsuperscript{15} has greatly influenced the sociological discussion of power. Pareto argued the abolition of property would lead to equality but real basis of inequality was not property but power. Max Weber\textsuperscript{16}, who has had the largest influence on the sociological study of power, defined power as the chance of a man or a number of men to realise their own will in a social action against the resistance of others who are participating in the action. This conception of power includes coercion, domination and manipulation\textsuperscript{17} and thus; the power relationship is by nature an asymmetrical relationship\textsuperscript{18}. This conception of power may be called the Zero-sum approach to power where the power of one party can be enhanced only by reducing the power of some other party. Empowerment and disempowerment go hand in hand where the empowerment of some sections of society has to be accompanied by the disempowerment of other sections of it. Parsons argued that power might be viewed not simply as what some have over others, but as a resource of the community as a whole, which it may use more or less effectively in the attainment of its goals.

Thus, power is seen as a source of evil, which can be made into a source of everything that is good by being transferred from the wrong to the right hands, from the landlords to the peasants, from men to women etc. It is for this reason that we cannot conceive of empowerment without taking into account the structure of a particular society. Empowerment can be described as a changed from a hierarchical towards a democratic society. The above-mentioned dimensions of power can be simultaneously applied in the case of empowerment of women. The term
empowerment is most widely used in the context of development. It is also conceived as a process that people undergo, which eventually leads to changes.

Various feminist scholars and activists within the context of their own regions define empowerment as the process of challenging existing power relations and of gaining greater control over the sources of power. Thus, empowerment has different meanings to different actors at different levels. Empowerment in its simplest form means the redistribution of power that challenges patriarchal ideology and the male dominance.¹⁹

To broaden the understanding of empowerment, the following are some proposed definitions of empowerment (of communities or individuals, as the case may be).

According to a report of WHO 2008, ‘Empowerment is both a process as well as an outcome. As a process empowerment helps relatively powerless people. They work together to increase control over events that determine their lives. It gives them freedom of choice and action. Power or control is not granted to them by other agencies, rather they themselves must obtain it... As an outcome, empowerment is the product of redistribution of resources and decision-making authority. It is reflected in the increased sense of self-esteem in the empowered individual or group of individuals’.²⁰

Karl feels that empowerment is a word, which is widely used but not properly defined. One important thing to understand here is that no one empowers anyone else but the people themselves through their own efforts achieve true empowerment. Karl says, ‘Empowerment is a process and is not, therefore, something that can be given to people’. She further says that, ‘the process of empowerment is both individual and collective, since it is through involvement in groups that people most often begin to develop their awareness and the ability to organised to take action and bring about change’²¹.
Greatly influenced by Karl’s definition of empowerment, Prasad, R.R is of the view that empowerment is a process geared towards participation, greater decision-making and transformative action through awareness and capacity building. Here participation means that people are closely involved in the economic, social, cultural and political process that affects their lives. The United Nations Development Programme (UNDP) identifies four areas of participation such as household participation, economic participation, social and cultural participation and political participation. Since participation can take place in the economic, social, political, and cultural areas, each person necessarily participates in many ways at many levels. Hence, empowerment would increase participation of women in decision-making in all the above-mentioned spheres.

Laishram Suresh is of the opinion that the equitable participation of women in development has to be seen and that society’s responsibilities to support their participation have to be defined, so that women can contribute without detriment to their own society for any development or women’s movements, and to oppose any social discrimination and injustice and in so doing fully realise their potential.

The International Conference on Population and Development (ICPD), 1994 held in Cairo, broke new ground by winning acceptance in the mainstream population policy discourse for a range of new concepts concerning women’s health rights and women’s empowerment. It is recognised that the empowerment of women is about enabling women to know, have access and assert their reproductive and sexual rights. It is the absence or denial of the rights that deprives them of the autonomy decision-making power and control over resources that are essential to achieving the highest standards of sexual and reproductive health.

From the Guidelines on Women’s Empowerment, put out by the United Nations Task Force on ICPD Implementation: Women’s empowerment has five components: women’s sense of self-worth; their right to have and to determine choices; their right to have access to opportunities and resources; their right to...
have the power to control their own lives, both within and outside the home; and their ability to influence the direction of social change to create a more just social and economic order, nationally and internationally’.

According to Mira Shiva, ‘empowerment of women means that women no matter where they are, are healthy, have enough for their needs, their own survival and that of their family and community, to be able to live with dignity, live and work in safe and caring environment, which allows their growth and holistic development, i.e., physically, emotionally, socially, economically. Women’s empowerment means that they can take decisions about their life, their children and family and also contribute to the community decisions, where women’s right to personhood, bodily integrity is respected where their reproductive rights, social, economic and political rights are respected, i.e. their work and contribution to the family, society is recognised, where there is no fear of sexual and social violence, where women feel a sense of acceptance and belonging, where their right to their home and to their children as guardians is respected’.

To Batliwala, women’s empowerment is a process, and the outcome of the process, by which women gain control over material and intellectual resources, and challenge the ideology of patriarchy and the gender-based discrimination against women in all the institutions and structures of society. She states that: ‘... the goals of women’s empowerment are to challenge patriarchal ideology (male domination and women’s subordination); transform the structures and institutions that reinforce and perpetuate gender discrimination and social inequality (the family, caste, class, religion, educational processes and institutions, the media, health practices and systems, laws and civil codes, political processes, development models, and government institutions); and enable women to gain access to, and control of, both material and informational resources’.

Stromquist, in her article on educational empowerment for women, interprets empowerment as a ‘socio-political concept that goes beyond formal political
participation and consciousness raising'. She argues that a 'full definition of empowerment must include cognitive, psychological, political and economic components' and she notes that these components are interrelated. She states:

- the cognitive dimension refers to women having an understanding of the conditions and causes of their subordination at the micro and macro levels. It involves making choices that may go against cultural expectations and norms;
- the economic component requires that women have access to, and control over, productive resources, thus ensuring some degree of financial autonomy. However, she notes that changes in the economic balance of power do not necessarily alter traditional gender roles or norms;
- the political element entails that women have the capability to analyse, organise and mobilise for social change; and
- the psychological dimension includes the belief that women can act at personal and societal levels to improve their individual realities and the society in which they live.

In addition to the above, Monkman\(^{29}\), adopts a fifth component that is a physical element - having control over one's body and sexuality and the ability to protect oneself against sexual violence - to the empowerment process.

Thus, it can be seen that empowerment can be viewed as both a process, and an outcome, a practice of change, of community restructuring from the inside, outwards. Although in many cases facilitated by an outside force, the process begins within and changes with the community, itself. It is a continual process of growth, realisation of self-worth, hope, and action that evolves with the addition of new ideas, new problems, and new faces within the community group.

Several different efforts have been made in recent years to develop comprehensive frameworks delineating the various dimensions along which women can be empowered.
The frequently used Gender Empowerment Measure (GEM) is a composite measure of gender inequality in three key areas: Political participation and decision-making, economic participation and decision-making and power over economic resources. It is an aggregate index for a population and does not measure empowerment on an individual basis. It consists of two dimensions: Economic participation and decision-making (measured by the percentage of female administrators and managers, and professional and technical employees), and political participation and decision-making (measured by the percentage of seats in parliament held by women). However, GEM is limited keeping in view the multidimensional nature of women’s empowerment.

Many researchers have stressed the importance of considering the empowerment in multiple domains. Some of them have attempted to measure women empowerment with a variety of determinants and dimensions by different methods and techniques. They have also developed separate indices with different variables in their studies.

Malhotra et al., argues that empowerment is a multidimensional concept. Further, reviewing existing frameworks, they explained many ways in which empowerment can be measured with six dimensions: economic, socio-cultural, familial-interpersonal, legal, political and psychological. It cannot be assumed that if a development intervention promotes women’s empowerment along a particular dimension that empowerment in other areas will necessarily follow. A number of studies have shown that women may be empowered in one area of life while not in others. Conversely, Mason observes that women in Kumasi, Ghana, are powerful economically (they work as traders, control a large market and hire men to do their bookkeeping), but they are sexually and socially submissive to their husbands in the domestic arena and peripheral to the political process.

According to Handy and Kassam, women’s empowerment can be measured by factors contributing to each of the following: their personal,
economic, familial, and political empowerment. They also include household and interfamilial relations as they believe is a central locus of women’s disempowerment in India. And by including the political, they posit that women’s empowerment measures should include women’s participation in systemic transformation by engaging in political action.

Amin, Becker and Bayes split the concept of women’s empowerment into three components each measured separately: Inter-spouse consultation index, Individual autonomy indexes and the Authority index. Inter-spouse consultation index seeks to represent the extent to which husbands consult their wives in household affairs; Individual autonomy indexes represents women’s self-reported autonomy of physical movement outside the house and in matters of spending money; and the Authority index, reports on actual decision-making power (which is traditionally in the hands of the patriarch of the family).

Hashemi rely on eight indicators for measurement of comparable components of empowerment: mobility, economic security, ability to make a small purchase, ability to make larger purchases, involvement in major decisions, relative freedom from domination by the family, political and legal awareness, and involvement in political campaigning and protests.

Review of literature

Very few studies have attempted to address the issue of women’s empowerment concerning women’s health especially based on empirical analysis. Here, attempt is made to present some of the literature that follows.

Education and labor force participation are among the most widely used indicator but, Presser, 1997 argues that they are only partially associated with empowerment. In the view of Caldwell, ‘a large number of studies have shown, almost as convincingly as anything can in the social sciences, that a mother’s education has an independent, strong, and positive impact on the survival of her
children'. However, in a study conducted by Das Gupta in Punjab suggest that the relative effect of discrimination against daughters is even greater when the mother is educated. So, there is only partial empowerment of women in a strongly gender inequitable culture.

Several other studies show the links between women's education and reduced fertility, decreased rates of infant mortality. In a study, Schultz found that the higher the level of female education, the lower is the desired family size and the greater the success of achieving it. Further, he found that each additional year of mother's schooling cut the expected infant mortality rate by 5–10 percent. Another study highlighted the value of secondary education of girls for reduced fertility and infant mortality. It showed that doubling the proportion of girls educated at the secondary level from 19 percent to 38 percent in 65 low and middle-income countries, holding constant all other variables (including access to family planning and healthcare), would cut the fertility rate from 5.3 children per woman to 3.9 and the infant mortality rate from 81 deaths per 1,000 births to 38.

To Sidramshettar, in his study of women's health status in Karnataka shows that the poor health status of women is inextricably linked with the socioeconomic and cultural factors. Illiteracy, low education, early age at marriage, rural residence and other cultural factors also constrain women in acquiring available health services.

Studies also show that empowerment may positively affect demand for and/or use of contraceptives. The Al Riyami et al., study reports on analysis of a 2000 National Health Survey for Oman. They measure empowerment using a composite of two indicators: involvement in decision-making in 8 areas and freedom of movement. Empowered women are more likely to use contraception, however, using logistic regression analysis, they find that education and employment are much more important predictors of contraceptive use than empowerment (empowerment becomes insignificant in specifications combining
the three variables). Empowerment emerges as a significant predictor of unmet contraceptive need (though education was a better predictor still). The Govindasamy and Malhotra study focuses on contraceptive use in Egypt and finds that freedom of mobility and influence in non-reproductive dimensions result in higher contraceptive use.

A study by Kishor, 2000 shows that women's empowerment affects a child's health. Kishor points out ten empowerment indicators in a study in Egypt, such as financial autonomy, participation in the modern sector, lifetime exposure to employment, sharing of roles and decision-making, family structure amenable to empowerment, equality in marriage, devaluation of women, women's emancipation, marital advantage and traditional marriage. These factors are derived from a combination of direct measures (e.g., decision-making ability, control of earnings) and indirect measures (education, time worked, and possession of a bank account). In operationalising empowerment, she is careful to include three elements: the setting of women’s lives, women’s access to potential sources of empowerment and evidence of empowerment. She finds that these empowerment measures, notably women’s lifetime exposure to employment, and family structure (denoting past & present residence with in-laws etc.), are negatively associated with infant mortality and positively associated with the probability of complete immunisation of young children.

However, Allendorf's, 2007 study presents a counterpoint. She finds that land ownership increases female empowerment and also child nutrition, she concludes that empowerment is not the mechanism through which this link occurs.

According to some scholars, Kishor and Bathliwala, the measurement of women’s empowerment needs to take on the current reality of their lives into consideration, their control over ‘material assets, intellectual resources, and ideology’.
Scholars argue that in traditional societies such as India, the focus should be on the building blocks, the process, of empowerment, rather than just the end result of empowerment. Thus, indicators of women's empowerment as end-result need to directly measure women's control over their lives and environment.

Financial autonomy, or 'control over material assets' according to Bathliwala 1994, has varying effects on both child health outcomes. Women who are allowed to keep money aside for their own (future) use, which is a possible reflection of their autonomy and relatively higher bargaining power within the household, have better-nourished offspring, a result that remains robust with the addition of socioeconomic and other controls. This could be partially ascribed to the fact that women, rather than men, tend to spend a higher share of their earnings/savings on child welfare (such as health, education, etc).

Other indicators of empowerment that have a positive effect on their health include women's access to the mass media (weekly exposure to newspapers, television, and radio) and the freedom to leave the confines of their home to visit the market or friends/relatives without asking for permission from the in-laws. Woman's marriage and household structure (spousal relationship, acceptance of wife-beating, and presence of a mother-in-law) is critical dimension of her ability to enhance the survival of her child.

Hierarchies based on gender and generation determines the course of household decision making in many societies. According to Visaria 1993, women in her sample in Gujarat, India indicate a remarkable feeling of constraint regarding cash expenditure. About 50 per cent of the women do not feel free to take a sick child to doctor without the approval of their husband or parent-in-law, and about 70 per cent do not make decisions regarding the purchase of their own or their children's clothing.

There is an extensive body of research that shows that women are more likely than men to spend the income that they control on food, education, and
health care for their children.

Hindin, 2000\textsuperscript{53} constructs a measure of empowerment that considers first whether a woman takes decisions with respect to major household purchases, whether she should work outside the home and the number of children she has – and second, whether she has a say in any of these three decisions. It was found that there is a link between a lack of empowerment with chronic energy deficiency (CED) and a low body mass index (BMI). Having no say in any of the decisions negatively affects these indicators while sole control of the husband has particularly acute effects: women’s BMI were 10 percent less and they were 1.3 times more likely to have CED, with implications for their ability to care for themselves and others.

To sum up, empirical evidence of the effects of empowerment is very sparse, but suggests some tentative positive effects of empowerment on outcomes related to the health of empowered women. There is thus a need for further work on this issue, both to identify potential linkages, quantify the effects of empowerment versus other factors, and to elaborate upon the conditions under which empowerment does and does not translate into particular outcomes.

Empirical studies have established that women’s empowerment is multi-dimensional, which do not necessarily evolve simultaneously and so measurement schemes should go beyond single indicators. It is also clear that empirical analysis of women’s empowerment stress heavily on the individual and household levels to gender relations. Various studies conclude that enabling factors such as education, employment, positive marriage or kinship conditions, lead to women having more choice, options, control, or power over their life conditions. Some other similar studies also conclude that women’s control of assets, income, household decision-making etc., yields positive results for themselves, their families, improved child well-being and reduced fertility rates. The variety of definitions regarding the concept of empowerment also shows that it varies from region to region and
culture to culture, so its determinants and measuring methods must also be varied.

Drawing on from many of the authors mentioned earlier, this study attempt to examine women’s empowerment more fully and in the broadest sense, using the following dimensions that affect women’s health: socio-economic, familial, psychological, practice of family planning, involvement in major decisions, spousal communication, etc. No study of this nature in Manipur more particularly on women’s health was carried out on the adolescent girls and women of Manipur, so this study tries to fill this gap.

**Objectives of the study**

1. To describe in brief the social, economic, political scenario along with the participation and role played by women.

2. To find out the male-female ratio in Manipur in general and Imphal districts in particular.

3. To assess the educational background of women and available facilities.

4. To assess health needs of women and facilities available to them.

5. To assess and determine the knowledge and awareness about the importance of preventive health check-up, reproductive health, antenatal care, various contraceptive methods and HIV/AIDS etc.

6. To assess and find out the various governmental policies and programmes available for the empowerment of adolescent girls and women in India.

7. To examine how far the adolescent girls in Manipur have been benefited from the policies and programmes.

8. To identify problems and opinions relating to physical and mental development and health concerns of adolescent girls in Manipur.
9. To examine how far women in Manipur have been benefited from the policies and programmes.

10. To assess the decision-making power of the women of Manipur.

**Hypotheses**

In order to achieve the above-mentioned objectives, the present study is directed to test the following hypotheses:

1. Women of Manipur are empowered right from adolescence period.

2. Women of Manipur are empowered till their last breath in socio-economic spheres.

3. Women of Manipur due to lack of awareness have different attitudes and practices regarding health which caused imbalance into the sex ratio.

4. Manipuri women are having knowledge of contraceptive methods but its use is low due to their concern about possible side effects.

5. Manipuri women who are economically independent are able to have their partners of their choice and are free to decide on the number of children they want.

6. Manipuri women are well aware about the illness of HIV/AIDS but knowledge to avoid it is low.

7. Majority of women in Manipur are not aware of the women oriented governmental programmes and hence fail to benefit from such programmes.
Research Design

The present study is exploratory-cum-diagnostic in nature. Various information relating to women's empowerment in Manipur have been explored by going through the secondary sources viz., Statistical Records (1995-2006) published by the Directorate of Statistics and Economics, Government of Manipur (GOM); Directorate of Census Operation (GOM), Election Department (GOM), Department of Information and Public Relations (GOM), Social Welfare and Family Welfare (GOM) etc. Apart of these, various relevant books and articles kept in the libraries of Manipur University, Manipur; Jawaharlal Nehru University, Delhi; Indian Council of Social Science Research, New Delhi and Maulana Azad Library, Aligarh Muslim University, Aligarh have been thoroughly examined and explored. Primary information (data) has been collected from the field by the help of Interview Schedule.

Methodology

Field data relating to the area of study has been collected by the help of structured interview schedule. The structured interview schedule is developed with the help of questionnaire used in similar studies like National Family Health Survey, District Level Health Survey. Simultaneously discussions with government officials, NGOs, local clubs are also carried out in order to include relevant questions to be explored. Two separate structured interview schedules were prepared – one for the adolescent girls and the other for the women to collect information separately. The Structured Interview Schedule consisted of independent and dependent variables such as age, religion, educational background, economic status, marital status, awareness regarding physical changes occurred in their bodies and use of facilities provided by the government through various programmes launched from time to time relating to use of contraceptives, fertility preferences and decision making etc.
Selection of Universe:

Selection of universe in terms of area and in terms of the respondents has been done by adopting multistage random sampling. In terms of an area, Manipur state has been selected for the purpose of study.

General Background of the Study Area

Manipur (93° 03' to 94° 47' east longitudes and 23° 50' to 25° 41' north latitudes) is an isolated hill grit state lying in the extreme North-eastern corner of India along the Indo-Myanmar border with Imphal as the state capital. The total geographical area of the state is 22,327sq.km with a total population of 23,88,634 (Males: 1,207,338; Female: 1,181,296 in 2001 Census). It could be broadly divided into two the hilly region and the valley region. The state comprises of districts of which five districts namely Churachandpur, Tamenglong, Ukhrul, Senapati and Chandel lies in the hilly region while remaining four namely, Imphal East, Imphal West, Thoubal and Bishnupur falls in the valley region. Manipur consists of fertile, oval shaped valley in the centre surrounded on all sides by hills. About 90 per cent of the state is mountainous and the rest of it is shared by the lacustrine plain of central or Imphal valley.

As per 2001 census, the sex ratio in Manipur is 978 of every 1,000 males. The literacy rate is 68.87 percent and male percentage is 77.87 where as female is 59.70 per cent.

The present study area, Imphal is the capital city of Manipur. It covered an area of 1,228 square kilometer. It covered nearly 50 per cent of the valley area of the state. The district Imphal was divided into Imphal East district and Imphal West district in 1997 (Fig. 1.1).
IMPHAL EAST AND WEST: LOCATIONAL SETTING

INDIA
LOCATION OF MANIPUR

Source: Census Atlas, India, 2001, Registrar General, Govt. of India.

MANIPUR
LOCATION OF IMPHAL EAST AND WEST


IMPHAL EAST AND WEST

Scale
1:300,000
The Imphal East district is situated in two separate valleys of the state namely central valley and Jiribam valley. The total area of district is 670 sq.km. As per 2001 census, the population of district is 394876, of which male population is 198371 whereas female population is 196505. The sex ratio of Imphal East is 991 females per thousand males. The literacy rate is 75.4 per cent, and male percentage is 85.5 per cent and that of females is 65.3 per cent.

Imphal West district falls in the category of Manipur valley region. The district is surrounded by Senapati district on the North, on the East by Imphal East and Thoubal district, on the South by Thoubal and Bishnupur district and on the West by Senapati and Bishnupur district. The total area of the district is 558 sq.km. The population of the district is 444383, of which male population is 221781 and total female population is 222601. The sex ratio is 1004 females per thousand males. The literacy rate is 80.2 per cent of which male percentage is 89.2 per cent and that of female is 71.3 per cent.

Being an isolated hill state, Manipur has a distinct type of population, culture, life style, ritual practices, social taboos, more etc. Manipur is composed of four major groups, the Meitei, the Tribals, the Muslims and the non-Manipuris (Singh, R.L., 1971; Singh, T.V., 1975; Singh, R.P., 1982). Meitei constitute the largest ethnic groups of the region. The Meitei language or Meiteilon is the mother tongue of all Manipuri.

Sampling Design:

Manipur state is located in the hilly track of the NEFA region. It is divided into nine districts. Out of these nine districts, two districts i.e., Imphal East and Imphal West have been selected randomly for the purpose of study. Both the districts have four sub-divisions each. Imphal East has four sub-divisions namely Jiribam, Sawombung, Porompat and Keirao Bitra. From these four sub-divisions Sawombung and Porompat sub-division are selected. Again, under Sawombung
and porompat sub-divisions, eight areas are selected for the study, out of which four are Urban (U) and four rural (R). The eight selected areas are namely Lamlai (U), Pangei (R), Taretkhul(R), Pungdongbam(R), Porompat(U), Khurai Thoudam Leikai(U), Khurai Sajor Leikai(U) and Ragailong(U).

The same selection is done in case of Imphal West also. Imphal West has four sub-divisions viz., Lamshang, Patsoi, Lamphelpat and Wangoi. The Lamphelpat and Wangoi sub-division is selected, from which eight areas both rural and urban are selected namely, Thangmeibian(U), Sagolband(U), Keishampat(U), Heinoukhongnembi(U), Samurou(U), Hiyangthang(R), Mongsangei (R) and Sangaiporou mamang(R).

So altogether sixteen areas, eight each from both rural and urban are selected from Imphal East and Imphal West districts. From these above-mentioned sixteen areas 100 adolescent girls (age group 10-19 years), 50 each from Imphal East and Imphal West are selected. In the same way 300 women (reproductive age group 15-45 years), 150 each from Imphal East and Imphal West are selected for sampling. The total sample size consisted of 400 women viz., 100 adolescent girls and 300 women. The mentioned 400 women are selected as respondents randomly using the simple multi-stage stratified random sampling.

Data Collection and Analysis:

Two-year time is spent in data collection. The selected respondents are interviewed personally by the researcher on the basis of Structured Interview Schedule. To make an in-depth study, the researcher secured co-operation from the respondents by giving a brief statement the reason for conducting the study. The confidential nature of the study is also explained. The interview is done at their household and researcher visited at least twice to cross checks the information provided. After completing the investigation, the processing of the
data and the task of analysis is done. The interview schedule is checked and errors are found to be few. The data collected from 400 respondents is then tabulated and entered in spreadsheet and using computer. Simple percentages have also been calculated for easy understanding of the data.

**Chapterisation**

The present study is organised into five chapters. The first Chapter I presents a review of studies on women's empowerment and provide the objectives and methodological details of the study. The following Chapter II provides a review of the past and present status of women in India and Manipur and also the various available government Policies and Programmes meant for adolescent girls and women. Chapter III presents a discussion of the data gathered from adolescent girls relating to their awareness and attitudes regarding reproductive health. Chapter IV also presents a discussion of the data collected from women relating to empowerment and its effects on their health and society. The last and the final Chapter V summarise the findings of the study and draw the conclusions.
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