

**EMPOWERMENT AND HEALTH STATUS OF HALAKKI
VOKKALIGA AND KUNBI TRIBAL WOMEN:
A STUDY IN UTTARA KANNADA DISTRICT
OF KARNATAKA**

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NOVEMBER, 2022

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OF KARNATAKA**

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By

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CERTIFICATE

This is to certify that the thesis entitled “**EMPOWERMENT AND HEALTH STATUS OF HALAKKI VOKKALIGA AND KUNBI TRIBAL WOMEN: A STUDY IN UTTARA KANNADA DISTRICT OF KARNATAKA**” submitted by Miss **PRIYA RAMESH HEGDE** for the degree of **DOCTOR OF PHILOSOPHY** in **HUMAN DEVELOPMENT AND FAMILY STUDIES**, of College of Community Science, University of Agricultural Sciences, Dharwad, is a record of bonafide research work done by her during the period of her study in this University under my guidance and supervision and the thesis has not previously formed the basis of the award of any degree, diploma, associateship, fellowship or other similar titles.

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1. INTRODUCTION

Tribal people are unique social and cultural groups with ancestry-related collective links to the lands and natural resources they live on, inhabit, or have been displaced from. Their identities, customs, and means of subsistence, as well as their bodily and spiritual well-being, are intricately linked to the land and natural resources on which they rely. For representations that are different or unique from those of the majority community or culture, they frequently follow their traditional leaders and organisations. Tribes are geographically remote, socially underdeveloped, and known as individuals who speak a different language and have a different culture, these people less interact with other people and cultures.

There are reportedly more than 370 million tribal people living in 70 different countries. The second-largest population on the continent, after Africa, the tribal people are an integral part of India's social fabric. According to the Census Survey Report of India -2011, the estimated 104 million indigenous people in India are split into 705 officially recognised ethnic groups. A considerable number of communities have also been denotified

Tribal populations, according to the World Health Organization (2005), are "communities that live within, or are attached to, geographically distinct traditional habitats or ancestral territories, and who identify themselves as being part of a distinct cultural group, descended from groups present in the area before modern states were created and current borders defined." They typically uphold social, economic, cultural, and political structures that are distinct from the mainstream or predominate society or culture. Tribal people are referred to as adivasis, indigenous people and aboriginals.

"Tribes" are described as "tribal communities, parts of tribal communities or groups within tribal communities that the President of India may identify by public notification" in Article 342 of the Indian Constitution. Bardhan (1973) described the tribe as "a sequence of socio-cultural entities at a given historical stage of development." It is a single endogamous group with a long history of cultural and psychological development. In this definition, the emphasis is placed on the psychological and cultural makeup.

The tribes of India are categorised into four major groups like the population of North-East India's tribes, the tribes living outside scheduled areas, the tribes living in blocks and districts with a predominant tribal population and the vulnerable tribal communities.

Indigenous tribes in Uttara Kannada district of Karnataka

Uttara Kannada is a district in the Indian state of Karnataka and the district's agroclimatic divisions include the coastal plain (including of the Karwar, Ankola, Kumta, Honnavar, and Bhatkal taluks) and Malenadu (consisting of Sirsi, Siddapur, Yellapur, Haliyal, Joida, and Mundgod taluks). In the Uttara Kannada region of Karnataka, there are five tribal communities: the Sidhi, Kunbi, Halakki Vokkaliga, Gond, and Gouli. The Halakki Vokkaliga and Kunbi tribes of Uttara Kannada are the most indigenous and vulnerable tribes of the district who are the subject of the current study.

Halakki Vokkaliga Community

In the coastal taluks of Uttara Kannada, the Halakkis' are one of the most vulnerable tribal group with Kannada as their key language. Halakki is a Kannada word that means "milk and rice" (Halu is milk and Akki is rice). White rice is grown by Halakki Vokkaliga (Gazetteer of the Bombay Presidency 1883). According to Bhat (1982), the name "Halakki" is likely because of the fact that these people are required to sprinkle milk and rice during the Havig Brahmin couple's wedding procession in order to ward off bad luck. People also claim that their jobs in agriculture and dairy may have contributed to the name's acquisition.

The Haalakki tribe's entire population has been split up into 7 areas and these areas form the boundaries of the religious rites. Chandaavara, Gokarna, Kadavaada, Ankola, Nushi Kote, Kumbaara Gadde, and Haritte Seemey are the seven regions. The Haalakki huts are known as "Koppa." A seemey is made up of many Koppas. Each Koppa is supported by a Gowda, a Budavantha, and a Kolkaara. Arasu or Gowda is the name of the Seemey's leader. The ability is inherited. If the Gowda of Koppa's decision is challenged, the leader of Seemey renders the decision. Halakki Vokkaligas possess land, which they till to grow vegetables, ragi (millet), and rice. They typically cultivate crops like groundnuts, melons, and other vegetables on a portion of their land. Cooked rice, millet broth, fish curry and various vegetables are among their staple foods.

The women have tanned complexion, and their necks are adorned with around six layers of beads. Tourists frequently see them in their rice fields or at community meetings, when they wear saris that are tied like sarongs. The women accessorise their hair with vibrantly coloured buds and flowers. They wear nose rings, necklaces, bangles made of metal

and glass, as well as beads. They use natural fibre and stones to create all of their jewellery. Their attire is made to allow them to operate comfortably and adapt to the environment.

Kunbi community:

This is a minor tribal group that predominantly inhabits the coastline as well as malenadu (westernghat) region of Karnataka. The taluks of Yellapur, Joida, Karwar, Ankola, and Haliyal in the Uttara Kannada District are believed to be where they settled after travelling from Gujarat to Goa via the coastline region. Kannada, a language based on Konkani, and Marathi are spoken by the Kunbi. According to Pandit Bhagawanlal, the Sanskrit term "Kutumbin," which means "one with a family or a home," is where the name "Kunbi" originates (Enthoven 1922). According to Singh (1994), the syllables "Kun" and "bi," which stand for "seed" and "person," respectively, are where the phrase "Kunbi" originates. Therefore, Kunbi are those who sow seeds, which indicates that they are farmers.

A collection of residences from the same clan is referred to as a Kunbi village. Joint families are no longer together, yet the oldest family member still owns the land. Individual family are given their own plots based on a shared understanding. New homes and restrooms have been built as a result of recent government initiatives.

Kunbi people are farmers. The majority of them own land, which they cultivate rice which is their main cuisine. They do not slaughter domestic animals for food, but they do consume the flesh of wild animals. Those without land are employed as day labourers for a daily salary. The border system (gadi padhati), in which each community rigorously abides by its established limits while fishing and gathering supplies from the forest, is one example of the pious nature-loving attitude of Kunbis. Agriculture was previously outlawed and in the 19th century they first engaged in it and produced vegetables, finger millet, and other pulse crops. The way they cultivate their land and the crops they choose have gradually changed, but their reliance on the forest for their livelihood has not changed. They are familiar with a variety of non-timber forest produce varieties. When the produce is ready to be harvested, the entire community congregates in one location, and the village priest, known as mirashi, performs a pooja to mark the start of the produce's harvest season. Numerous tuber kinds are grown by the Kunbis since they are vital food sources for them.

Empowerment and health of tribal women

Women constitute fifty per cent of the world's population and they have been crucial to civilization's advancement. Women are regarded as the foundation of every culture since they are adept at performing multiple duties with ease throughout the day. The majority of the world's women, however, are less affluent and have an uneven standing compared to men (Rahman and Naoroze, 2007). Everyone has been focusing on the empowerment of women recently. It's accurate to state that the time has come when women's empowerment is essential. In order to choose for their needs and expectations, women need to have the freedom, faith, and self-worth. Given the rise of women over the past few decades, discrimination against women is pointless and of no use. Women empowerment in India is heavily dependent on many different variables that include geographical location, social status, economic status and educational status. One key factor for the gap in implementation of laws and policies to address discrimination, economic disadvantages and violence against women at the community level is the largely patriarchal structure that governs the community and households in much of India. As such women and girls especially, tribal women have restricted mobility access to health facilities, and lower decision-making power, and experience higher rates of violence.

In tribal societies, women have a significant role in the social, cultural, economic, and religious tenets of the community and are valued as a source of income. They continue to trail far behind in a variety of spheres of life, including work, good health, and education. The tribal women frequently struggle with difficulties including losing control over natural resources, a lack of education, being uprooted and put through rehabilitation, problems with their health and nutrition, gender issues, losing their sense of self, not having access to health care, being raped, etc. (Heggade and Heggade, 2017)

Tribal women and communities lag far behind in terms of social networking. A key worry has been the empowerment of the aboriginal population. Over the past two decades, there has been a steady rise in awareness of the need to empower women. The empowerment of tribal women is influenced by a variety of factors, including age, education, employment status, cultural norms, etc.

Major international organisations like the United Nations and The World Bank considers the empowerment of women especially indigenous groups as an important criterion

for framing and implementing policies concerning fertility behaviour and demographic transition, child welfare, infant mortality, economic growth and poverty alleviation (Kabeer, 2001). The achievement of gender equality and women empowerment is the fifth Sustainable Development Goal (SDG-5) that is to be accomplished up till 2030.

Many research studies have found that women empowerment can play an important role on development outcomes. In the area of maternal health, several dimensions of women empowerment have been found to be important determinants of maternal health care utilization such as participation in household decision-making, financial autonomy, and freedom of movement (Bloom *et al.*, 2001; Furuta and Salway, 2006).

The concept of human health is as old as human's social history. Health is a natural state of human's and it is the result of living in accordance with the natural law pertaining to the body, mind and environment. Health is a function which is responsible for overall integrated development of society, cultural, economic, educational, social and political domains. Reproductive health of women consists of health of the women after puberty and before pregnancy, and health care, utilization of health services during pregnancy, delivery care and postnatal care. Balanced nutrition is required throughout life and is vital to women in terms of health and work. Nutritional anaemia and maternal malnutrition quite common among the rural and tribal women which is also a serious issue. Mother and children constitute a priority group of community and maternal health influences the fetus and neonatal health in a number of ways.

Women particularly of reproductive age groups 15-49 are more prone to health challenges like high-risk pregnancies, anaemia, malnutrition, sexually transmitted diseases and other chronic illnesses. Women health status has direct impact on the child development and family health due to their traditional roles [WHO-Women and Health Report, 2009].

Pregnant women from tribal groups exhibit significantly poor nutritional intake and dietary habits as compared to the national recommendations. (Tejaswini *et al.*, 2017) According to studies, 74.00 per cent of tribal women in Orissa and 76.30 per cent of tribal women in Kerala were anaemic, which presents an inescapable difficulty for socially disadvantaged groups.

The empowerment of tribal women and their participation significantly improves the health and standard of living in the community and the family. Nutritional status, reproductive

health, and health-seeking behaviour outcomes are all improved by empowerment. Very few studies have been conducted on the indigenous communities like Halakki –vokkaligas and Kunbi and hence the study throws the light on empowerment and health status of Halakki Vokkaliga and Kunbi women. Ethnographic case study method helps in understanding the situation of the Halakki and Kunbi tribal women in deeper sense and the changes in their social and economic role due to merge with civilization/modernization. In view of this, women empowerment and improving the health status of women are crucial for development of the society, this study is an attempt to address the issues related to women.

Significance of the study:

The present study highlighted the empowerment and health status of Halakki Vokkaliga and Kunbi tribal women. The outcome of this study will help to understand the livelihood status of these tribal communities in Uttara Kannada district and intervention help them to expand their empowerment knowledge, in turn empowerment status of the women will be improved.

Objectives of investigation:

1. To assess the empowerment status of Halakki Vokkaliga and Kunbi women.
2. To assess the health status of Halakki Vokkaliga and Kunbi women.
3. To conduct situational analysis on empowerment and health status of Halakki Vokkaliga and Kunbi women through ethnographic case-study.
4. To study the relationship between the individual and familial characteristics with the empowerment and health status of Halakki Vokkaliga and Kunbi women.
5. To develop the intervention package to improve the empowerment status of tribal women and test the efficacy of intervention package.

2. REVIEW OF LITERATURE

A comprehensive review is needed in order to give a ground for building a framework, insight into the methodology, and working out a basis for interpretation of findings. The following sections provide literature on women's empowerment, nutritional status, health status, and traditional medical procedures used by tribal women while keeping in mind the study's objectives.

2.1 Concepts and definitions

2.2 Empowerment status of tribal women

2.3 General Health status and health care practices of tribal women

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2.1 Concept of Empowerment

1. Women empowerment

Empowerment is the process of “enabling people to increase control over their lives, to gain control over the factors and decisions that shape their lives, to increase their resources and qualities and to build capacities to gain access, partners, networks, a voice, in order to gain control. (United Nations Department of Economic and Social Affairs, 2012).”

According to Sustainable Development Conference (2004) empowerment as an “emancipation process in which the disadvantaged are empowered to exercise their rights, obtain access to resources and participate actively in the process of shaping society and making decisions.”

Women empowerment refers to “promoting women’s sense of self-worth, their ability to determine their own choices, and their right to influence social change for themselves and others (United Nations Population Fund, 2005).”

Keller and Mbwewe (1991) described women empowerment as “a process whereby women become able to organize themselves to increase their own self-reliance, to assert their independent right to make choices and to control resources which will aid in the challenging and eliminating their own subordination.”

Hashemi and Schuler (1993) defined the empowerment of women through the use of six spheres: 1) Sense of self and a vision of the future, including resisting negative behaviors of the husband; 2) Mobility and visibility, including how women are treated when they are traveling; 3) economic security, including cash income, new skills and knowledge; 4) status and decision making power within the household, including making purchases on their own; 5) ability to interact effectively in the public sphere, such as joining credit programs, and 6) participation in non-family groups, such as credit programs and solidarity movements.

2. Health

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization (WHO) - 2011).

Karnataka Human Development Report (2005) stated that “Good health is an invaluable asset for better economic productivity both at the individual and national level, but above all it is valued by those who own it as prerequisite for better quality of life and better standard of living.”

Health status is an individual's relative level of wellness and illness, taking into account the presence of biological or physiological dysfunction, symptoms, and functional impairment. Health perceptions (or perceived health status) are subjective ratings by the affected individual of his or her health status.

Health status is a multidimensional concept, requiring multiple indicators and multiple methodologies for adequate measurement. Several different indicators of health status are usually included in health surveys, including single summarizing measures; questions relating to disease incidence and prevalence; and questions relating to functioning (physical, cognitive, emotional, and social) or disability (Stewart and Ware, 1992).

3. Nutritional status

Nutritional status is the current body status of a person or a population group, related to their state of nourishment (the consumption and utilization of nutrients). Nutritional status is

determined by a complex interaction between internal/constitutional factors and external environmental factors. Internal factors like age, gender, behaviour, physical activity and diseases. External/environmental factors like food safety, cultural, social and economic circumstances (National Research Council, 1989).

4. Reproductive Health

Reproductive health addresses the reproductive processes, functions and systems at all stages of life. It encompasses the sexual health of both men and women, as well as maternal and child health (Tekwu, 2013).

Medical literature defines reproductive health as “an organizational framework that incorporates maternal and child health programs, family planning, infertility, sexually transmitted diseases and maternal and child health related concerns”.

Reproductive health includes adolescent health, age of marriage and pregnancy, maternal health, contraception use, sexually transmitted infection, abortion, child and forced marriage, birth complications.

2.3 Empowerment status of tribal women

Empowerment status, social status of tribal women, factors affecting the empowerment status, decision making role, and women’s autonomy has been discussed through literature and thoroughly reviewed as follows:

Samanta and Sinha (2021) estimated the status and development of tribal women empowerment in Dibrugarh, Tinsukia and Dhemaji districts of Assam. Descriptive and analytical methods were used for the study. The study adopted a random method of data collection in rural and urban areas. Sample of the study comprised 150 households of tribal people (500 tribal women and 500 tribal men) were selected. Questionnaire was used to gather views pertaining to education, aspiration and socio-economic status of tribal people. Study found that, tribal population were somewhat isolated from mainstream and comparatively tribal women had very low level of awareness and aspiration. Only new generation were urging and undergoing primary and secondary level of education.

Poonam (2020) studied the role and socio-economic status of the tribal women in Jharkhand. Descriptive research design was adopted for the study. The study undertaken based on secondary sources of data. The secondary data includes published and unpublished

document of government departments, research reports, books, Census reports, research papers, journals, newspapers and website, etc. Study showed that tribal women status is high when they contribute substantially to primary subsistence activities. Even though they lack control over the material and social resources, their contribution of subsistence economy give them important and irreversible position. It is observed that the tribal women of Jharkhand has larger social and economic power and high status than the other cast women. The tribal women has greater freedom and independence in household and agriculture field. However, there are certain areas where men continue to dominate such as political and religious sphere. With the development programs, economic changes, the tribal women remain traditional in their dress, knowledge, language, culture, tools and resources.

Cornish *et al.* (2019) carried out a qualitative study on 10 communities in Pujehun district. A total of 29 in-depth interviews were conducted to explore the realities of women's day-to-day lives and how they negotiate health spending decisions. Explored how women perceived economic empowerment, and how experiences of power impacted their health decision-making. Study found that women were frequently involved in various income-generation activities. Almost all of the women interviewed were working in some capacity and enjoyed the financial independence and accompanying confidence boost. Several women expressed feelings of happiness and fulfilment when they earned money, and the additional income was reported to reduce relationship tensions. Women were considered by both men and women as custodians of family finances. Decision-making relating to health was considered to be within the man's domain. Participants described that men were responsible for the healthcare costs related to pregnancy, childbirth and for their children.

Paray (2019) examined the socioeconomic and educational life of tribes in general and Gujjar and Bakarwal in particular. A sample of 120 households was randomly selected from the villages of two districts Ganderbal and Bandipora. A qualitative and quantitative method was employed in the study. Women were contacted through structured schedule. Results revealed that work participation of scheduled tribe women was higher than national average in rural areas but it was very low in urban areas. Likewise, educational attainment of tribal women was found to be very less from the very beginning. Lack of education was found predominantly in tribal women.

Leoni and Indhumathi (2018) explored the status and empowerment of tribal women in Dindigul and Nilgiri district. The study was conducted in tribal dominated villages of Dindigul and Nilgiri Districts of Tamil Nadu. Fifteen villages from Dindigul district with 100 respondents and twenty villages from Nilgiri district with 200 respondents were selected and total sample consisted of 300 respondents. Data was collected through structured and pre-tested interview schedule using exploratory research design. Study found that, the living conditions and status of the tribal women were still backward. Tribal women faced problems and challenges, in getting a sustainable livelihood and a decent life, due to environmental poverty and the interference of outsiders. It was found from the study that tribal women play a vital role in the social empowerment of tribal area as they contribute in various social activities.

Frederick (2018) studied the social and economic status of tribal women with reference to their empowerment in selected mandals in Srikakulam district, in Andhra Pradesh. Women in the age of 18-60 years were selected for the study. An empirical study using a self-structured questionnaire was designed and used for primary data collection from respondents. The results revealed that education, vocational training, occupation, amenities in house, economic status, individual properties and health status of tribal women were the significant predictors of empowerment status of tribal women.

Leoni and Gunasekaran (2018) assessed the status and empowerment of tribal women in Dindigul and Nilgiri district. Fifteen villages from Dindigul district with 100 respondents and 20 villages from Nilgiri district with 200 respondents were selected and thus making a total of 300 respondents. Data was collected through structured and pre-tested interview schedule. From the findings it was observed that 117 tribal women (39.00%) were moderately empowered and the social empowerment of tribal women in Dindigul District was more empowered than Nilgiri District. Their miseries were compounded by a low level of infrastructural and social services and the existence of a greater inequality among the tribes.

Keeni *et al.* (2018) took a study to ascertain tribal women empowerment in a matrilineal society in Meghalaya. The study was conducted at one village from each of the two districts in Meghalaya- the East Khasi Hills and the West Khasi Hills. Fifty female respondents from each district were selected as samples for the study, they were interviewed using questionnaire. Probit regression was used to analyse the data. The results stated that

women who inherited land were more likely to have a savings account and be a part of a socio-economic group. Women who owned land through lineage were empowered.

Manjunatha and Gangadhar (2017) studied to know the socio-economic status of Jenukuruba tribal women in Chamarajnar district, Karnataka. Total sample consisted of 120 tribal women and the findings indicated that majority of respondents worked as agricultural labours, 16.70 per cent involved in agriculture and 24.10 per cent engaged in collection of minor forest products. About 3.00 per cent women working in government sector, while 11.70 per cent women were involved in business, tailoring, handicraft. About 40.00 per cent own less than 2 acres of land. Only few respondents possessed more than 4 acres of land (5.90 %). Education level, patriarchal system and insufficient awareness were the main responsible factors of their low socio-economic status.

The study by Panigrahi (2017) on tribal women in Chhattisgarh indicated that majority of tribal women were illiterate, 30.00 per cent of educated women had bank saving accounts. Majority of women worked in agriculture sector and 37.00 percent of women earned annual income of 22,000 and above. It was observed that status of tribal women was found to be lower than women who were well in terms of education, income, occupation, saving and employment patterns.

Gunasekaran (2016) conducted a study on a large sample of 3600 married women aged 15 – 49 years selected from both the rural and urban areas of three different districts of Tamil Nadu. The results showed that, empowerment level of women on various dimensions indicated that the women were relatively more empowered (around 60 – 70.00 percent) in socio-cultural, familial and psychological, it was moderate (around 45.00 percent) in economic empowerment and very poor (less than 25.00 percent) in legal and political. It was observed that, age of women, type of marriage, education of women and her husband, occupation of women and her husband, membership in SHG and exposure to mass media were the factors significantly associated with the better women empowerment.

Bhukya (2015) found the fact that, empowerment of tribal women for the accelerated socio-economic development of any community, the active participation of women is essential. Study revealed that in a social set up like India, their participation has to be ensured through tangible measures, taken at various levels, which results in their empowerment in the real sense and study identified that empowerment includes higher literacy levels, education,

better healthcare, equal ownership of productive resources, increased participation in economic and commercial sectors, awareness of rights and responsibilities, improved standards of living, self-reliance, self-esteem and self-confidence. Study concluded that empowerment for women in India require a crosscutting approach and one which addresses the diversity of social structures that govern women's lives.

The study conducted by Rashid and Gao (2014), assessed the empowerment status and decision-making ability of native and tribal women of Bangladesh. Women empowerment was conducted through interviews with tribal and native rural women residing in the coastal region of Bangladesh. For the study, 70 tribal women and 70 native women were randomly selected as sample. Structured interview schedules were used to collect data. The study found that majority of the tribal women had attained only a medium level of empowerment. The chi-square test revealed significant differences in the empowerment and decision-making abilities of native and tribal women. There was significant positive correlation with empowerment and family size, assets, personal income, media exposure and decision-making among tribal women as compared to native women. While half of the tribal women enjoyed better opportunities for taking decisions on family matters, more than half of the native women had significantly lesser opportunities. Both groups of women perceived poverty and lack of education as major impediments to empowerment.

Sundaram *et al.* (2014) aimed to create the awareness among the women about different empowerment and identifying the impact of education in women overall empowerment in Madurai district. Totally 455 women respondents between 20–50 years age group were selected for the study. Findings of the study showed that educational qualification played a significant role in women empowerment. The study concluded that if women's empowerment is to be improved, it can be carried out only through the medium of education. Hence, it is of foremost importance to raise the level of education amongst tribal women.

Kritz and Makinwa-Adebusoye (2014) examined the determinants of wife's decision-making authority in ethnic groups of Nigeria. Two-stage, stratified, cluster-sampling strategy was employed. Women from Hausa, Ibo, Yoruba, Kanuri and Yoruba ethnic communities were selected. Results indicated that household decisions related to family purchase, sell and spend money were done by husband alone and child related issues were decided by husband and wife together in Nigerian ethnic communities. Decision making score was higher among

women of Yoruba and Ebo communities. Higher education, age, type of work, income of the wife had positive and significant effects on women's decision making. Along with the ethnicity other covariates such as background characteristics, work and family related variables together contributed higher for women's decision-making authority.

Das (2012) examined the extent of decision-making role of tribal women on their socio - economic status and make a comparative note on decision making role of tribal and non-tribal women. The study was carried out in three tribal hamlets of Oraon and Munda tribes of Santoshpur village in Sundergargh district. The three hamlets having 225 households was taken into account. The study was based on primary data, collected from each household, relating to various parameters of socio-economic status and decision-making role through structured questionnaire and interviews. It was observed that, the women of the study area have high decision-making role in the house hold matter. They took independent decisions regarding their own expenditures, daily household expenditures, decisions pertaining to visiting kin and relatives, treatment of sick etc. They have equal decisive role with their male counterparts, regarding children's education. The finding showed that tribal women were passive participants in decision making at community level. The literacy rate among tribal women was very low. The empowerment among non-tribal women was high compared to tribal women. They have high socio-economic status which gives them an edge over tribal women.

Heggade and Heggade (2012) determined the constraints and factors influencing the tribal women's economic empowerment in Mysore and Chamarajanagar districts, Karnataka on total sample of 300 girls and women. Results indicated that education among studied population was very low. High level of malnutrition (65.07 %) and CED (Chronic energy deficiency) was noted among tribal women than the non-tribal women. Decision making and leadership qualities were very poor (20.00 %) among tribal women. High unemployment rate and lack of self-employment were found to be the factors that hindered progress of tribal women's economic empowerment.

Muniyandi and Singh (2012) analysed the tribal women's empowerment for health development in Indian perspective. The data was gathered by various published reports and documents on women empowerment. Results found that majority of tribal women were illiterate and were working in agriculture sector (80.00%). More than half of tribal women

were not exposed to any mass media (57.00%). Small proportion of violence was noted among them. Health and wealth status among studied tribal population was inadequate.

Oraw and Toppo (2012) investigated the economic empowerment and status of 200 tribal women in south Dinajpur district, West Benagal. Results revealed that majority of tribal women worked in agriculture sector as cultivators and agricultural labours. It was found that there was no savings and the dominate customary laws of the tribe endowed less discrimination between males and females. Women move freely without taking permission from male or other senior family members. It was noticed that tribal women took active part in religious and social ceremonies.

The study conducted by Acharya *et al.* (2010) explored the links between women's household position and their autonomy in decision making. Nepal Demographic Health Survey (NDHS) -2006 was used, which provided data on ever married women aged 15-49 years (n = 8257). The data consisted of women's four types of household decision making; own health care, making major household purchases, making purchase for daily household needs and visits to her family or relatives. Women's autonomy was positively associated with their age, employment and number of living children. Women from rural area and Terai region have less autonomy in all four types of outcome measures. Western women are more likely to make decision in own health care (1.2-1.6), while they are less likely to purchase daily household needs (0.6-0.9). Women's increased education was positively associated with autonomy in own health care decision making ($p < 0.01$), however their more schooling showed non-significance with other outcome measures. Interestingly, rich women were less likely to have autonomy to make decision in own healthcare.

Choudhari (2009) explored the possible determinants of women empowerment based on primary data from a district of Southern Punjab. Primary data was collected from Dera Ghazi Khan District of Southern Punjab. From Dera Ghazi Khan District, Dera Ghazi Khan Tehsil and Tribal area Tehsil were selected. From Dera Ghazi Khan Tehsil, 90 women each from rural and urban areas were selected. From Tribal area Tehsil, fifty women were selected. Stratified random sampling technique was used. Total 200 women were selected. Age of the sample was 14-65 years. Both married and unmarried women were included. Interview was conducted using structured information schedule. Study found that empowerment status of women was relatively poor in tribal area of Dera Ghazi Khan district

of Southern Punjab. Study indicated that, empowerment of women considerably was influenced by higher education, paid work, access to media, socio-cultural norms of the community and household participation rates.

Mitra (2007) analysed the status of women among schedule tribes in India with comparison to main stream Hindus, in term of social and cultural practices. The study shows that tribal women in their community has high status and absolutely no gender discrimination in tribal communities.

Bhasin (2007) carried out a study about tribal women in different geographic region i.e. Ladhak, North Eastern Region, Rajasthan and she found that tribal women possess a lot of importance in tribal communities. Author stated that, tribal communities do not look upon the birth of a girl child a curse. Dowry system is not there and girl possesses the right to choose her husband, divorce are easy and secured. Women play vital role in economic activities. They take joint decision along with the male counterparts. Women power is not extended to societal or political sphere. Their economic power is not translated in to corresponding community authority. Women supremacy is restricted with household domain and due credit and importance is not given at official level. Women have secondary importance in public affair and community decision making.

It can be concluded from the above studies that, educational attainment of tribal women was found to be very less. Women have low level of awareness and aspiration, moderately empowered, decision-making power was very less and status of women was not favourable. Higher education, age, type of work, family size, assets, personal income, media exposure were significantly correlated with empowerment status.

2.3 General health status and health care practices of tribal women

Chandana and Kumar (2020) conducted a study to identify health problems, assess the health services, make out any gaps in health service delivery and to inquire their health seeking behaviour towards common diseases or ailments in Integrated Tribal Development Agency, Bhadrachalam in Bhadrachalam district, Telangana. Cross sectional design was used. A sample of 120 tribal women aged 15-49 years were enrolled for the study. Self structured interview schedule, using questionnaire from WHO demographic health survey (DHS, 2018) was used. It was evident that majority (75.80%) of tribal women were not diagnosed of any chronic illness, 35.00 per cent women in the above age 40 had general

health issues. Age of the women significantly correlated with health complications where health problems increased with age. More than 70.00 per cent women had no knowledge on vector-borne diseases.

Borges *et al.* (2016) examined the prevalence of anaemia and associated factors using the data from the First National Survey of Indigenous People's Health and Nutrition in Brazil. Multistage sampling technique was used to select the villages. Women belonged to 14 to 49 years of age were selected. Questionnaire covered the information on socio-demographic conditions, sanitation, domestic economy, access to health services and maternal characteristics. Haemoglobin level and anthropometric measurements were assessed. Results indicated that prevalence of anaemia was 33.00 per cent in Brazil and showed pronounced disparities between regions, where the prevalence was more among Northern Brazil. Socioeconomic status, body mass index, food patterns and having been treated for malaria were associated with prevalence of anaemia and haemoglobin levels.

Bepari *et al.* (2015) investigated the nutritional and health status of Lodha tribal women and was compared to the women of the general population. Total of 240 women (Lodha-120; General community-120) having the age range of 18 to 45 years were randomly selected from different villages under Nayagram block in the district of Paschim Medinipur, West Bengal. The socioeconomic status was evaluated by questionnaire method. The body dimension, blood pressure and haematological parameters were measured by standard methods. The results indicated that the Lodha women belong to poor socioeconomic group. The prevalence of under nutrition among the Lodha women was very high (80.00%) and the risk of under nutrition among the Lodha women was significantly and approximately eleven times higher than the women of general communities. Similar trend also noted in case of blood pressure. About 31.68 per cent of Lodha women were hypotensive, anaemia prevalence was very high (91.67 %) and approximately five times higher than the women of general communities. Lodha women had significantly higher white blood cell count than the general community. Poor economic condition, dietary deficiency, poor dietary patterns, poor sanitary conditions and unequal food sharing in the families found to be the causative factors for under nutrition and anaemia in Lodha community.

Shrinivasa *et al.* (2014) estimated the prevalence of anaemia among tribal women of 15-45 years of age of Wayanad District. A cross-sectional survey was done among a sample

of 347 tribal non-pregnant, non-lactating women aged between 15-45 years in 10 clusters of Wayanad. It was found that the mean haemoglobin of the study group was 9.04 gm per cent. Prevalence of anaemia was found to be 96.50 per cent. Mild anaemia (Haemoglobin = 10-11.9 gm %) was found to be 30.50 per cent. About (55.90 %) had moderate degree anaemia (Hb 7-9.9 gm %) and severe anaemia (<7 gm %) was found to be 10.10 per cent. Prevalence of anaemia was substantially high among women of reproductive age group of Wayanad.

Booth and Carroll (2012) inspected the determinants of self-assessed health outcomes of Indigenous and non-Indigenous Australians. 'Australian Bureau of Statistics' 2011 National Health Survey (NHS) was conducted in Australia-wide between which gathered information on health status, use of health services, health-related aspects of respondents' lives, socio-economic factors and demographic attributes. Sampling was done at the household level and one person in the household, aged 18 years and over from each dwelling was selected and interviewed about their health. It was observed that, statistically significant gap in self-assessed health status between indigenous and non-indigenous Australians. Health gap was mediated by the factors such as differences in income, education and socio-economic status between indigenous and non-indigenous Australians where indigenous women had poor health compared to non-indigenous women.

Maiti *et al.* (2005) investigated the health care and health condition among the tribal women in comparison to the non-tribal women in Jharkhand by drawing upon data from the National Family Health Survey - 2. NFHS-2 had collected data of a representative probability sample of 1614 ever married women age 15-49 years residing in 1642 households in Jharkhand. The findings revealed that in each and every socio-economic, demographic as well as health parameters, the tribal women a very much poor than the non-tribal women. Malnutrition is pervasive among tribal women. There was also a high prevalence of anaemia among the tribal women in Jharkhand. The utilization of maternal health care and use of modern methods of contraception was also significantly less among the tribal women than the non-tribal women.

The findings mentioned above can be summarised by saying that age of the women and health issues are significantly associated. The prevalence of anaemia and haemoglobin levels were correlated with body mass index, dietary habits, and receiving malaria treatment. Undernutrition and anaemia were found to be caused by low economic circumstances, dietary

deficiencies, poor dietary patterns, poor sanitary conditions, and unequal food sharing in the households. Factors such variations in income, education, and socioeconomic status served as a mediating factor for the health gap.

2.4 Reproductive health status and health care practices of tribal women

Sahoo and Pradhan (2020) carried out a sequential explanatory study design to study the reproductive healthcare status of Chandaka-Dampara, and Achankamar tribal communities. A total of 194 tribal women within reproductive age group of 15–49 years were surveyed and focus group discussion was conducted. Women who had given birth in the last five years were selected using a purposive sampling method. Results showed that women lack awareness of child spacing capabilities (57.00 %) and the unmet need for family planning was comparatively higher. More than half of the women faced domestic violence that curtailed their capabilities to avail reproductive health care services and reduced the immediate wellbeing of their children. Women lacked control over the decision on reproductive healthcare which indicated lack of social and political freedom among women of tribal communities.

Udayar and Praveen (2019) studied on 288 tribal women in Kodagu, Karnataka It was observed that registration of pregnancy at first trimester was observed to be 66 per cent. About 64.00 per cent of tribal women consumed all iron and folic acid tablets given to them. Most of the mothers received TT immunization (71.00%) and advice on family planning (90.00%). Majority of deliveries took place at government or private health institutions (96.00%).

Chandraker *et al.* (2017) conducted a cross-sectional study to understand the pregnancy related women's reproductive health, infant and child morality, to assess the nutritional status of mother and under five children among Dhur Gond tribal community of Mahasamund district of Chhattisgarh, India. A total of 174 married women and 68 under five children were selected for the study. Pre-structured schedule was used to collect socio-economic, demographic, reproductive health including ante-natal care, delivery practices etc. Weight of under five children and height and weight of mother were measured by standard techniques. Results revealed that 47.12 percent of mothers were undernourished (BMI <18.5 kg/m). Poor health status during child bearing period, less ante-natal care, more number of deliveries at home along with high prevalence of under nutrition of under five children and

mothers were observed. Low socio-economic conditions, low literacy rate, lack of awareness were found to be negative correlates for reproductive health.

Hamid *et al.* (2017) collected data from 410 Bakkerwal and Gujarat tribal women of Kashmir, aged 18-45 years to assess reproductive health status. The results indicated that 84.00 per cent women were having regular periods and only 15.00 per cent were reported to have irregular periods. Dysmenorrheal was reported by 83.00 per cent and only 15.00 per cent reported amenorrhea. About 43.00 per cent of women had received antenatal care services (ANC). Half of the (55.80%) delivery among tribal mothers took place at hospital and 44.00 per cent birth among tribal women had been conducted by untrained Dai. More than 93.00 per cent women never used any method of contraceptive and only 3.00 per cent were used some method of contraception.

Gautam and Kshatriya (2017) determined the maternal health care utilization among 919 currently married tribal women age ranging from 15-31 years in rural Jharkhand. Results indicated that maternal health care utilization was higher among women, who had some education than the women with no educational status. Educated women were three times more likely to undergo institutional delivery and make use of antenatal care services than illiterate women. Education of women was found to be the most influential component associated with maternal health care utilization.

Kumar *et al.* (2016) conducted a qualitative study on maternal and child health practices among Bagia tribal women age ranging from 13-49 years. Data was collected by focused group interview method. Study revealed that few women disclosed their pregnancy status to their family members after first trimester. Women had wrong perception about safe delivery and abortion, they perceived that hard work is a factor for normal delivery and family members encouraged and forced pregnant women to do hard work for safe delivery.

Geetha *et al.* (2015) assessed the reproductive health status of Sugali tribal women in the Rayalaseema region of Andhra Pradesh. Total of 200 Sugali married women between the age group of 15-45 years were selected for the study. Data was collected from two mandals in the Kadapa district and two mandals in the Chittoor district. Cross Sectional design was employed. A house-to-house survey was carried out to recruit the sample. Structured interview schedules were administered. Thirty-six percent of the subjects opined that their self-reported health was poor. Illiterate women were 1.27 times at risk of developing

menstrual irregularity than educated women and the risk increased to 1.85 times when the spouse was illiterate too. Illiteracy was the risk factor for menstrual problems and abortions. Reproductive health risks were mediated by socio-economic conditions in tribal women.

A cross sectional study was conducted by Mutreja and Kumar (2015) to assess the knowledge and practices related to birth preparedness among 146 tribal women in Sukuma district, Chattisgarah. Data was collected through interview method. Results revealed that 82.90 per cent of respondents were aware about antenatal check-ups and 91.00 per cent had received antenatal care services that include 3 antenatal visits, minimum 90 iron folic acid tablets and two or more TT vaccinations. Regarding dangerous signs during pre-natal and postnatal period reporting was done by 30.00 per cent, 9.00 per cent and 4.00 per cent of respondents respectively. Only few respondents had knowledge on dangerous signs of pregnancy (21.20%).

The study on 100 tribal women in Thana district Maharashtra by Bhaisare and Rao (2015) depicted that 60 per cent of mothers were conscious about post natal care services. Majority of mothers did not utilize post natal care available at primary health centre (84.00%). Only few mothers received postnatal check-ups at Primary Health Centers (PHC) or sub centers. While 16 respondent's women utilized postnatal care services on their own and 54 mothers had received postnatal care services during Anganwadi visit by Auxiliary nurse midwives (ANM). Advice on family planning and contraception usage and breast feeding received by 16 and 37 respondents respectively. Lack of information and knowledge about antenatal care services and low socio-economic status were the factors impacting on utilization of post natal care services among studied population.

Sharma *et al.* (2014) conducted a cross sectional study to examine the utilization of post natal care practices among women in tribal areas of Madhya Pradesh. Majority of women (71.90%) received post natal check-up within 10 days of delivery. With respect to number of post-natal check-up, 36.60 per cent mothers received one postnatal check-up followed by two (18.50%) and three post-natal check-ups (14.70%) respectively. Only 1.90 per cent received four post natal check-ups during their pregnancy. The education and working status of mothers, place of delivery, person conducting delivery and level of knowledge of mother regarding the need of postnatal check-up were influencing on utilization of postnatal check-ups.

Gogoi *et al.* (2014) study the relationship between the use of maternal health care services and the frequency of reproductive health complications during pregnancy, pre and post natal period on 300 tribal women of Assam. More than half of (62.40%) women reported having complications during pregnancy and delivery. In Assam post-delivery complications are reported less by women as compared to pregnancy and delivery complications. It was also found statistically significant that women who received full antenatal care during pregnancy reported less complications during the delivery and post-partum period.

Mavelil and Srivastava (2014) conducted a study to know the gap by understanding the reproductive health of women in the matrilineal tribes in Meghalaya. Field-based quantitative study was carried out in Garo Hills division, multi stage sampling technique was employed. A total of 900 respondents (760 female heads of households and 140 ASHAs) of reproductive age group were included in the study. Findings revealed that reproductive health risks, anaemia and abnormal blood pressure were found among women in matrilineal tribes of Meghalaya. Majority (81.70%) of women got married at 13-18 years of age and 77 per cent of women had their first pregnancy before they were 18 years old. Abortion /still birth rate was 29.70 per cent in matrilineal tribal women of Meghalaya.

Jose *et al.* (2014) studied on 35 tribal mothers and 35 nontribal mothers (70) from community health centres, Thariode, Kerala, India. It was found that 85.70 per cent tribal women fully utilized maternal health care services and overall utilization of maternal health care services was 92.80 per cent, 82.90 per cent tribal women registered their pregnancy during first trimester, whereas non-tribal women had 97.10 per cent of registration. About 2.90 per cent tribal women had partial utilization of maternal care services and 11.40 per cent tribal women had home deliveries.

Bais (2014) conducted a cross sectional study to understand the reproductive behaviour among Pando tribal women, Chhattisgarh. The total sample comprised of 218 women aged 15-49 years. Study revealed that mean age at marriage of women was very low (15.1 years) and 48.60 per cent women did not go for antenatal check-ups during their pregnancy. It was observed that utilization of IFA tablets (4.00 %) and TT injection (43.20%) was very low. Majority of women delivered at home, only 1.00 per cent of women underwent institutional delivery. The case of still birth and abortion was high, whereas infant mortality rate was low among these tribal women.

Srivasan and Ilango (2014) explored on reproductive health care of tribal women in Kollo hills at Nammakal district, Tamilnadu. The results revealed that, 86.00 per cent deliveries were performed at their home and three fourth delivered by untrained Dai. Very few started breast feeding within one hour of birth. The complete immunization of children was only 10.30 per cent in these tribes.

Kabir and Khan (2013) conducted a cross sectional experiment among 200 married women in the age group range 15-49 years to know the impact of educational level on utilization of prenatal care services in Urban slums of Dhaka city, Bangladesh and the respondents were interviewed. Findings indicated that, antenatal care utilization among studied women was 64.30 per cent. Education and antenatal care (ANC) was significantly related and indicated that, higher the level of education, higher is the likelihood of receiving ANC during pregnancy because educated women were well aware of the importance of ANC. There was no association between the income of the respondent women and ANC received by the women; which clearly indicated that, poor level of income influenced poor health status. Knowledge about antenatal care was found to be better among women who had utilized antenatal care as compared to women who did not receive antenatal care.

Agrawal (2013) examined disadvantaged condition of tribal women and children of Orissa in terms of socio-demographic, health and nutritional status. Data for the study was extracted from the National Family Health Survey (NFHS-3, 2005-06). Multi-stage cluster sampling technique was used. NFHS-3 collected representative probability sample of 4,540 ever married women aged 15–49 years residing in 3,910 households for the state of Orissa. Sample consisted of 955 tribal women and 3,585 non-tribal women. Results implied that disadvantaged ratio of women's illiteracy, husband's illiteracy, belonging to lower wealth quintile was higher in tribal women compared to non-tribal women. In all the maternal health parameters such as age of first pregnancy, prenatal and post natal check-up, contraceptive use the disadvantage ratio of tribal women was higher compared to non-tribal women.

Rahman *et al.* (2012) explored the context, reasons, and choices in pattern of health care seeking behaviour of the hill tribal population of Bangladesh. The sample size comprised of totally 218 men, women, adolescents boys and girls belonging to nine different tribal groups. The results revealed that traditional medicine and healers still played an important role in maintenance of health and wellbeing among tribal communities. Age, gender and tribal affiliation also affected health care seeking behaviour among tribes.

Gogoi and Prusty (2011) evaluated the reproductive health complications among north-eastern tribal women. District Level Household of facility Survey (DLHS-2008) data was used, which collected data from tribal and non-tribal women from North-Eastern parts of India. Self-reported symptoms of gynaecological problems occurring in the three month prior to the survey was taken. The results from the study indicated that very high incidence of self-reported symptoms of gynaecological morbidity was in north-eastern states of India. Factors such as low level of education, work status, low wealth index and rural residence playing a highly significant role in prevalence of self-reporting gynaecological problems. Complications related to pregnancy, delivery and after delivery were also significant predictors of reproductive health problems in both tribal and non-tribal women.

Roy *et al.* (2010) examined the maternal and child health care aspects among Khairwars of Madhya Pradesh. The study covered 44 pregnant and lactating Khairwar women and the findings indicated that, Khairwas consider pregnancy as a natural phenomena and gift of god. Women did not go for antenatal check-ups, worked hard during pregnancy and did not consume any special food during pregnancy period. Traditional birth attendant conducted delivery at home, water and food was not given to recently delivered mothers for initial 3 days, breast feeding started from 3 days on words and colostrum was discarded.

A cross- sectional study was conducted by Chandrashekar *et al.* (2009) to know the reproductive health among Dhur Gond tribal community, Chhattisgarh on a sample of 174 married women. Findings clearly stated that 51.72 per cent of mothers had not received antenatal check-ups, tetanus injection (41.38%) and iron and folic acid tablets (56.32%) during their pregnancy. A very high percentage (94.83%) of mother's had home delivery. 47.12 per cent of mothers were having BMI less than 18.5 kg/m².

Deb (2008) studied utilization services related to safe motherhood among 35 tribal village populations of east Khasi hills Meghalaya. The results reported that 82.00 per cent women received antenatal checkups during pregnancy and only 0.30 percent women received antenatal check-ups from traditional birth attendants. Abdominal examinations were most frequently carried out antenatal checkups by 80.00 percent women and 79.00 per cent women had their blood pressure measured, 78.00 per cent women had their weight measured, 51.00 per cent women had undergone blood test and 77.00 per cent women received TT injection. About 23.00 percent women had their delivery in district hospital and 27.00 per cent women

had delivery in private hospitals. Majority (89.00%) women had successful delivery and only 2.00 per cent women reported that their babies died immediately after birth.

Susuman (2012) performed a study on factors associated with maternal health care utilization among total of 1569 tribal women in Chhattisgarh, India. Data was accumulated from district level house hold survey on reproductive and child health 2002. The findings disclosed that women with higher level of education were three times more likely to receive postnatal care than illiterate women. The odds of institutional deliveries were three or four times higher among educated women than the women with no educational status. Findings also showed that the chances of younger mothers to give birth in medical institution (68.00 %) was higher than the older mothers (>35). Mother's age had positive impact on the odds of institutional delivery; women who had delay in child bearing were more likely to deliver in medical institution.

Islam *et al.* (2009) explored antenatal and post natal care seeking behaviour among 223 married Garo tribal women having child less than five year of age. Information was gathered by administering interview method. The results revealed that, 83.40 per cent of women were aware about availability of health care services, education among studied tribal women was 88. 80 per cent. Antenatal and post natal care seeking behaviour was higher among tribal women belonging to higher socio-economic status and among educated tribal women.

Maiti *et al.* (2005) conducted a situational analysis on health care and health status of 469 tribal women and 1145 non-tribal women aged 15- 49 years in Jharkhand and data was gathered by National family health survey-2. The results showed that tribal women had low level of standard of living (75.00 %) compared to non-tribal women (49.00 %). The practice of smoking (4.00%), alcohol consumption (31.00 %), were more among tribal women than the non-tribal women. Tribal women had poor health, socio demographic parameters. Non-tribal women had better utilization of maternal health care services than the tribal women.

According to studies on women's reproductive health, women lacked autonomy over decisions regarding their own healthcare. Low socioeconomic status, low literacy rates, and a lack of knowledge were found to be detrimental associations for reproductive health. Mothers' educational background, employment situation, place of birth, the person who delivers the baby, and their level of understanding regarding the use of maternal health care were the

influencing parameters for reproductive health of the tribal women.

2.5 Nutritional status of tribal women

Rokade *et al.* (2020) conducted a study to know the prevalence and determinants of nutritional status among tribal women in Maharashtra. Data was taken from national representative sources of the National Family Health Survey-4 (2015–2016). Present study was based on 35 districts of Maharashtra and focused on tribal women on a total sample of 3923 women aged 15–49 years. Results showed that The BMI of tribal women in Maharashtra showed that 11.70 per cent of women were found obese and 37.40 per cent were found underweight. Fifty four per cent of tribal women were anaemic, 40.80 per cent were mild anaemic, 11.90 per cent were moderate and 1.30 per cent were severely anaemic. Age of women between 15-24 years, low education, lower wealth index and rural locality were the leading factors causing underweight and anaemia. The nutritional status of tribal women in Maharashtra clearly showed the prevalence of underweight and overweight throughout the districts. The underweight prevalence was highest in Nasik but obesity was highest in Pune district against other districts. Bi-variate and logistic regression was calculated using a statistical tool linked with nutritional status. The prevalence of underweight was lower among tribal women but more than half of the total women were found to be anaemic and less than 6.00 per cent of women were obese. In the spatial analysis, predominant results of anaemia of tribal women were found in the Northwest districts of Maharashtra. The highest (2.50–4.60 %) and the moderate percentage (1.50–2.50%) of severe anaemia, and obesity were found in almost all the districts located in western Maharashtra, whereas the prevalence of high (48.00–62.00%) and moderate (35.00–48.00%) and underweight women were found dispersedly throughout Maharashtra.

Mohandas *et al.* (2019) evaluated the nutritional status and its associated factors among tribal women in the reproductive age group at Wayanad. A hospital-based cross-sectional study was carried out during January 2017 at Amrita Kripa Charitable Hospital in Kainatty, Wayanad. Sample was selected using systematic random sampling method. Data was collected using semi-structured questionnaire and examined for height, weight, body mass index, and pallor from total of 223 study participants. Results revealed that, among them, 53.80 per cent were undernourished (<18.5 kg/m²) with 25.00 per cent were severe underweight and 3.10 per cent and 2.70 per cent preobese and obese women. Participants who

were less than 30 years of age (0.001), those who used smokeless tobacco (0.008), and women from the Paniya tribe (0.001) had significantly higher odds of under nutrition. Almost one-fourth of the study participants were severely undernourished and 5.80 per cent belonged to obese and preobese categories, thereby indicating the gravity of the nutritional difficulties among tribal women.

Monika *et al.* (2018) conducted comparative study to assess nutritional status of Saharia tribal and non-tribal women aged 18-35 years in Rajasthan. Dietary survey, anthropometric measurements was taken to assess nutritional status. The assessment results indicated that 3.00 per cent of tribal women were obese, and 4.00 per cent of non-tribal women were overweight. A very few (29.00%) Saharia tribal women had normal body mass index (BMI); whereas 18.20 per cent non-tribal women had normal BMI. Majority of tribal women were having BMI less than 18.50 and 24.00 per cent of non-tribal women were underweight.

Sartaz *et al.* (2017) assessed the prevalence of nutritional status of lactating (LW) and non-pregnant non-lactating women (NPNLW) and found impact of their present socio-economic condition and different nutritional factors on nutritional status of the two groups of reproductive women. Cross Sectional study was conducted in hilly districts of Chittagong Hill Tracts, a total of 85 lactating and 86 Non-pregnant non-lactating women aged between 15-40 years were enrolled for the study. Nutritional assessment, food security and nutritional knowledge measures and semi-structured questionnaire to gather socio-demographic variables were used. Results showed high literacy rate, occupancy in household chores, better income, food security recommended calorie intake level and better nutritional knowledge were the factors found to significantly influence better nutritional status of lactating (LW) and non-pregnant non-lactating women. Majority of the ethnic women of Chittagong Hill Tracts were in better nutritional status with normal BMI and daily calorie intake was according to Recommended Dietary Allowance (RDA). Most of them were food secured and had better nutritional knowledge. Better socio-economic condition, nutritional knowledge and accurate calorie intake played a vital role in achieving healthy nutritional status in both the women groups.

Nayak and Sreegiri (2016) assessed the nutritional status of tribal women in the tribal population of ITDA Paderu division in Visakhapatnam district. Cross-sectional study

conducted in Integrated Tribal Development Agency Paderu division of Visakhapatnam district on tribal women of reproductive age group (15-49 years). Study was conducted during April 2014 to October 2014. Multistage simple random sampling technique was applied in three stages. Semi-structured schedule was used to collect the information. Anthropometric measurements such as height and weight were measured and BMI was calculated according to the WHO classification. Pallor was observed by examining the conjunctiva of study on women in day light. Results showed that, one fifth of the study population were at risk of nutritional deficiency. Continuous earnings of families throughout the year and debt free condition influenced better nutritional status among women and they had BMI above 18.50. The prevalence of BMI less than 18.50 was more among women in the age group of 15-30 years. Pallor was observed among 61 per cent of study women.

Ghosh (2016) carried out a study to analyze the nutritional status among Santal-Munda tribal women residing at rural area of Amdanga block; North 24th Parganas district, West Bengal. Results showed that, most of the women were having normal BMI (76.27 %) but quite a few of them were found to be overweight (4.23 %) as well as under nutrition was also prevalent (19.49 %) among these tribal women with 6.80 per cent severity. The analyses indicated that the prevalence of under nutrition was still a major problem. In addition, there was also an emerging trend for overweight/obesity, thereby indicating a double burden of malnutrition as observed in other ethnic group of the country.

Ghosh (2016) assessed the nutritional status of 117 Santal Munda tribal women in West Bengal. Findings indicated that none of the tribal reproductive women were obese; Mean weight and mean height of women was 46 ± 7.708 kg and 150.07 ± 6.135 cm respectively. Most of the tribal women had normal BMI (76.27%). Prevalence of under nutrition was observed to be 19.49 per cent.

Nayak *et al.* (2016) conducted study on nutritional status of tribal women in Visakhapatnam district; Andhra Pradesh, India. A sample of 225 reproductive age group tribal women were elected and the study revealed that, mean height of study population was 147.95 ± 6.33 cm and mean weight was 45.01 ± 6.372 kg. Prevalence of thinness among the study population was 18.20 per cent followed by moderate thinness (15.15 %) and mild thinness (3.10%). Pallor was observed 61 per cent of study women. Women from families

with continuous earning and debt free condition had BMI above 18.5.

Kosariya and Chakravarty (2015) conducted a study on a total of 114 Bhunjia tribal women, (93 lactating women) and (21 pregnant women) to assess the maternal health status of women with special focus on nutritional status. Findings revealed that half of the lactating mothers were found to be undernourished (58.00 %) and only 29.00 per cent women possessed normal BMI while 4.30 per cent were overweight.

Raikwar and Sharma (2015) evaluated health profile of 207 Korku tribal women of Betul district, Madhya Pradesh. The assessment of body mass index of 200 women revealed that about 70.50 per cent women are normal, 26.55 per cent were underweight and only 3.00 per cent women were overweight whereas none of the women were found to be obese.

According to the studies mentioned above, more number of tribal women were in underweight category. Achieving a healthy nutritional status required improved socioeconomic level, nutritional understanding, and precise calorie intake. Women from families who were debt-free and had steady incomes had normal nutritional status.

2.6 Interrelationship between health status and empowerment status of tribal women

Sado *et al.* (2014) investigated the influence of women's empowerment within the household on antenatal and postnatal care utilization in tribes of Albania. Data was taken from the 2008–09 Albania Demographic and Health Survey (ADHS), a nationally representative survey based on 7,999 households in which all women between 15-49 years of age living in these households were interviewed and assessed for women empowerment, decision-making power, attitudes towards domestic violence. Total of 1303 tribal women of Albania aged between 15-49 years were selected for the study. Antenatal and postnatal care associated with the last live birth that occurred within the five-year period before the survey was assessed. Results found that, levels of antenatal care tended to be high among tribal women of Albania who were in richer households, better educated, employed for cash and to have fewer children. Women those who took two or more decisions in the family and having high self-esteem were more likely to have four or more antenatal visits. Women those who took two or more decisions in the family and women classified as having high self-esteem were more likely to have received post natal care within 24 hours after delivery. Number of decisions had a statistically significant association with the number of antenatal care visits, with the greater the numbers of decisions, the more likely that women have up to four or more ante natal care

(ANC) visits. Women with higher self-esteem had significantly higher odds of using four or more ANC visits than women with lower self-esteem. Both indicators of women's empowerment emerged as positive and statistically significant on the odds of having had a postnatal care visit within 24 hours of delivery.

Khan *et al.* (2013) studied the levels of autonomy of women through various indicators in Astore district of Gilgit Baltistan, Pakistan by investigating the practices of prenatal care, postnatal care and care taken at the time of delivery and impact of women's autonomy on maternal health care utilization. Study was conducted in 211 Shina tribal women. Simple random sampling was employed. Interview schedule was designed and administered individually. The results indicated that majority of the tribal women reported that they have freedom of movement and consulted in household decisions. Majority of the respondents reported that prenatal and post natal check-ups were performed. There was a significant relationship between the maternal health care and the women's autonomy.

Studies showed that there was significant relationship observed between reproductive care and the women's autonomy.

2.7 Role of Self Help Groups (SHGs) in tribal women empowerment

Sharma *et al.* (2020) studied the tribal women perception on various aspects of women empowerment in the study districts. All SHGs of the fifteen tribal district of Madhya Pradesh was selected as study area. Descriptive research design was employed. Study was conducted on the basis of non-participant observation and administering interview schedule. Non-probability sampling was used to collect the data. The study depended on both the primary and secondary data. Five tribal districts with highest tribal women population was purposively selected for the study. Study found that self-reliance and self-confidence in women had been increased after joining the self-help groups. They became more aware about them and also SHGs developed mutual help and cooperative nature among them. Awareness level regarding banking transaction, health and family welfare, legal aspects and political issues had increased after joining the SHGs. The credit facilities SHGs provided for their group members helped them to start their self-business and increase their physical assets. This also helped in increase of tribal women's monthly income and savings. Value of their assets had also increased and it showed the positive impact of SHGs on the economic empowerment. Persuasion of social responsibility, increase command of decision making and knowledge

about banking procedures were the social impact of joining the SHGs. Positive impact of the SHGS on political empowerment of the tribal women was also observed.

Rathod and Devi (2019) employed a study to understand about the SHGs in Dahod district of Gujarat. A multi-stage sampling design was adopted for the study. Total 60 SHG members from Bhills community were selected. Similar types of non-members who have same socio-economic status were also selected from the same villages to compare the socio-economic status of SHG members and non-members. Total 120 respondents (60 members and 60 non-members) were selected and the primary data were collected from each of the selected households by personal interview method. Study found that there was significant difference between SHG members and non-members with regard to economic empowerment index, social empowerment index and combined socio-economic index. Bhills tribal women who were members of SHG were better among all the three aspects namely, economic empowerment index, social empowerment index and combined socio-economic index. Micro-finance through self-help groups developed the entrepreneurial skills among rural women community and helped them to be self-employed. SHGs were responsible for significant positive change in the economic variables like income, employment generation, asset building, productive investment and savings.

Pathania and Rao (2018) analyzed the reasons for joining self-help group by tribal women and impact of SHGs on tribal women. Study was conducted in Visakhapatnam district of Andhra Pradesh. Primary and secondary data used. Field survey was conducted through interview schedule for Primary data collection. It was observed that SHGs helped to increase the family income and status of tribal women which reduces their poverty and financial dependency. More than half of the tribal women expressed that decision regarding responsibilities were taken by them. Tribal women gained several benefits conferred by different activities under the SHG schemes. Self-help groups effectively take care of the present need and requirement of the tribal women.

Satapathy (2017) conducted a study to know the role and performance of SHGs in promoting tribal Women's empowerment in Mayurbhanj district of Odisha. Five SHG group from four panchayats and from each SHG group three members were undertaken for the study. The sample size consisted of 60 tribal women belongs to SHGs. Probability sampling technique was used. From the study it was observed that, the women SHGs have enhanced the

status of women as participant decision makers and beneficiaries on the democratic, economic, social and cultural spheres of life and sensitized the women members to take active part in socioeconomic progress in the tribal areas of our country. In the study area, SHGs had not only produced the tangible assets but also helped in changing the social outlook and attitude of the tribal women.

Ravi and Raju (2016) examined the position of tribal women in Nilagiri hills and how they empowered themselves through self-help groups (SHG). Majority (16.00%) of tribal population worked in agriculture sector and only 5.00 per cent of tribal families worked as labourers. The study clearly indicated that after the formation of SHGs in tribal community there was a remarkable change in the economic and social status of tribal women. Post formation of SHG tribal women carried out many activities like tailoring, mushroom cultivation, bakery, constructing toilets etc.

The studies mentioned above showed that joining SHGs had a positive social impact by encouraging social responsibility, improving decision-making skills, and increasing understanding of banking practises. Positive effects of the SHGS on the political emancipation of tribal women were also noted. Following SHG membership, a considerable improvement in economic factors like income, employment creation, asset development, profitable investment, and savings was noted.

2.8 Intervention to improve empowerment status of women

Ismayilova *et al.* (2017) conducted an experimental study to test the effects of an economic intervention alone and in combination with a family focused component, on women's empowerment status and family violence in Burkina Faso. The 3-arm cluster randomized controlled trial with baseline and 1-year follow-up was included. The sample consisted 360 ultra-poor married women from 12 villages. Villages were randomized to the 3 study arms: economic intervention for women (Trickle Up/TU), a combination of economic intervention and family coaching (Trickle Up Plus), and waitlist (control arm). Analysis utilized repeated-measures mixed effects regressions. Results revealed that, compare with the control group, there was a significant improvement in both the TU arm and the TU Plus arm in women's financial autonomy and in quality of marital relationships. Women in both intervention arms reported a significant reduction in emotional spousal violence in the past year, with the effect size greater for the combined intervention (TU Group OR=0.28, 95% CI

[0.10, 0.82], $p=0.02$ and TU + Group OR=0.19, 95% CI [0.06, 0.64], $p =0.007$). Economic intervention showed benefits that go beyond changes in financial wellbeing and increased women's status as well as improved family relationships. Integrating psychosocial components with economic strategies may be more effective for improving women's empowerment status in West Africa.

Rani and Devi (2021) aimed to study the impact of intervention on enhancing status of empowerment through decision-making skills of tribal working women in Utnoor Mandal Adilabad district. The sample for the study comprised of 50 tribal working women between the age group of 25 to 45 years. The total sample population for the study was 50 tribal working women, and data was analysed using a paired t test. Results revealed that at pre-test, majority of the women were at average level of decision-making skills (78.00%), 12 per cent were at low level and only 10.00 per cent were at high level. After the intervention, post test results revealed that 74.00 per cent of the women were high in decision making skills and remaining 26.00 per cent were at average level. Interestingly, none of the respondents had low level of life skills. Thus, intervention found to be effective among women respondents to develop and enhance their empowerment status through decision-making skills.

Lyngdoh and Pati (2013) evaluated the impact of microfinance on women empowerment in the matrilineal tribal society of India. It covered a period of five years, where in, data was compiled for 300 microfinance women (experimental group [EG]) and 150 non-microfinance women (control group [CG]). For impact evaluation, Propensity Score Matching (PSM) and Difference-in-Difference (DinD) techniques were applied. The study highlighted that microfinance had a positive impact on income, expenditure and savings. It led to an improvement in asset structure, increased access to livestock, micro machines, family wealth and family savings, education decision-making, improved mobility, communication skills, voicing of concerns, self-confidence, increased political participation to promote gender equality, etc. Results concluded that, Microfinance was a potent tool of women empowerment even in matrilineal tribal settings.

2.9 Intervention to improve health status of women

Akhouri *et al.* (2017) assessed the impact of a reproductive health education intervention package on reproductive health practice in rural literate Sarna tribal women in Jharkhand. Study was conducted in Kanke district of Jharkhand on 180 literate Sarna tribal

women. Stratified random sampling technique was employed. Stratification was based on age. Socio-demographic and personal data sheet and Reproductive Health Practice Scale by P.G. Department of Psychology Ranchi University, Hassan MK-2002 was used. Results indicated that, educational intervention improved reproductive health practice of tribal women. Reproductive health education based on discussion as compared to reproductive health education without such discussion was more effective for the improvement in reproductive health practice. Greater the frequency of intervention stronger the effects on reproductive health practices was observed. Age did not influence the reproductive health practice of the respondents.

Sengupta et al. (2020) conducted a study to find the gaps in the existing system and promote health literacy and health-seeking behaviour. Community-based, exploratory, cross-sectional, contextually designed study was employed. Covered tribal population of Bastar, Chhattisgarh and study was conducted between 5 years from 2012 to 2017. Study found that factors such as regular home visits, point of care diagnostics, and identification of high-risk mothers and their timely referral, and behavioural change communication increased trust of the community. Intervention was effective in improving the reproductive health care related practices in tribal women. Mean age at first pregnancy increased to 22 years (2017) from 17 years (2012). The adolescent pregnancy rate (<19 years) reduced to 6.80 per cent (2017) from 13.50 per cent (2012). Supervised births and high-risk referrals increased from 19.5 per cent (2014) to 58.00 per cent (2017) and 8.50 per cent (2014) to 13.10 per cent (2017), respectively.

Health and empowerment as intervention categories were both shown to be successful. They raised the situation of women.

3. MATERIAL AND METHODS

The research study on “Empowerment and health Status of Halakki Vokkaliga and Kunbi tribal women: A study in Uttara Kannada district of Karnataka ” was conducted during the period of 2019-2022 in Halakki Vokkaliga and Kunbi communities residing areas of Uttara Kannada district.

The materials and method used in the study are presented under the following headings.

- 3.1 Research method and design
- 3.2 Population and sample selection for the study
- 3.3 Variables selected for the study
- 3.4 Tools used for the study
- 3.5 Data collection procedures
- 3.6 Statistical analysis
- 3.7 Intervention
- 3.8 Operational definitions
- 3.9 Hypothesis set for the study

3.1 Research method and Design:

The study aimed to assess the empowerment and health status of women of two tribal communities namely, Halakki Vokkaliga and Kunbi in Uttara Kannada district. A **QUAN-qual mixed research method** (sequential design) was employed wherein QUAN–quantitative research method remains a dominant research method followed by a less dominant qual–qualitative research method to understand and explore the empowerment and health status among Halakki Vokkaliga and Kunbi women.

Under Quantitative research method, differential design was employed to study the difference between Halakki Vokkaliga and Kunbi women on dependent variables such as empowerment and health status (general and reproductive health and nutritional status).

Correlational design was used to study the relationship between independent variable and dependent variables.

Experimental research design was used to study the efficacy of the intervention program in improving the empowerment knowledge in Kunbi women who underwent intervention for being low on empowerment status. A time series design including one pretest and two post-tests with an interval of seven sessions between the two posttests were used to measure the change in empowerment knowledge. An experimental design between experimental and control group was carried out to study the efficacy of intervention package.

In qualitative research method ethnographic case study was used in order to explore cultural influences over time and have in depth- knowledge on status of both Halakki Vokkaliga and Kunbi women. Ethnographic case studies helped to explore further and to answer the “how” and “why” arising from quantitative research results. It further helped to have an in-depth understanding of the subjective experiences of both Halakki Vokkaliga and Kunbi women with respect to their knowledge, attitude and practices regarding empowerment and health aspects through the lens of culture.

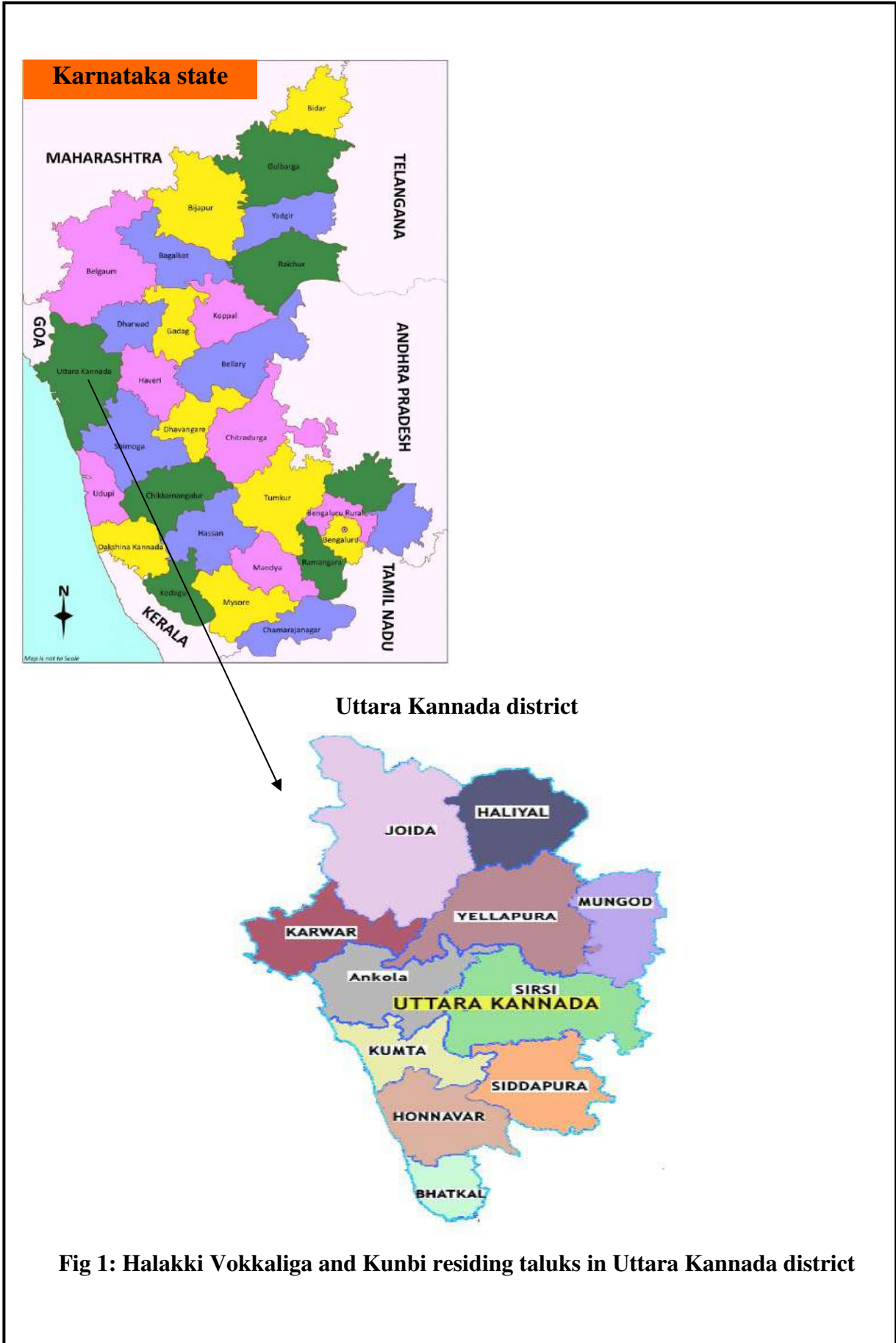
3.2 Population and sample selection for the study

3.2.1 Population of the study

The target population of the study was Halakki Vokkaliga and Kunbi community women. Halakki Vokkaliga community spreads in Karwar, Ankola, Kumta and Honnavar taluks. Kunbi community can be seen in Joida and Yellapur taluks of Uttara Kannada district. (Fig 1)

3.2.2 Sample of the study

The target sample of the study was Halakki Vokkaliga and Kunbi community women in the age group between 20-50 years, who were married, non-pregnant and non-lactating. The respondents were drawn randomly (in four different directions so as to represent entire district) from the villages where Halakki Vokkaliga and Kunbi communities resided in Uttara Kannada district. About 3-4 per cent of the population from Kunbi community and 2-3 per cent from Halakki Vokkaliga community formed the sample of the study. The Halakki Vokkaliga sample comprised of 230 women from fourteen villages. The Kunbi sample comprised of 230 women from twenty two villages. The total sample included 460 women from both the communities.



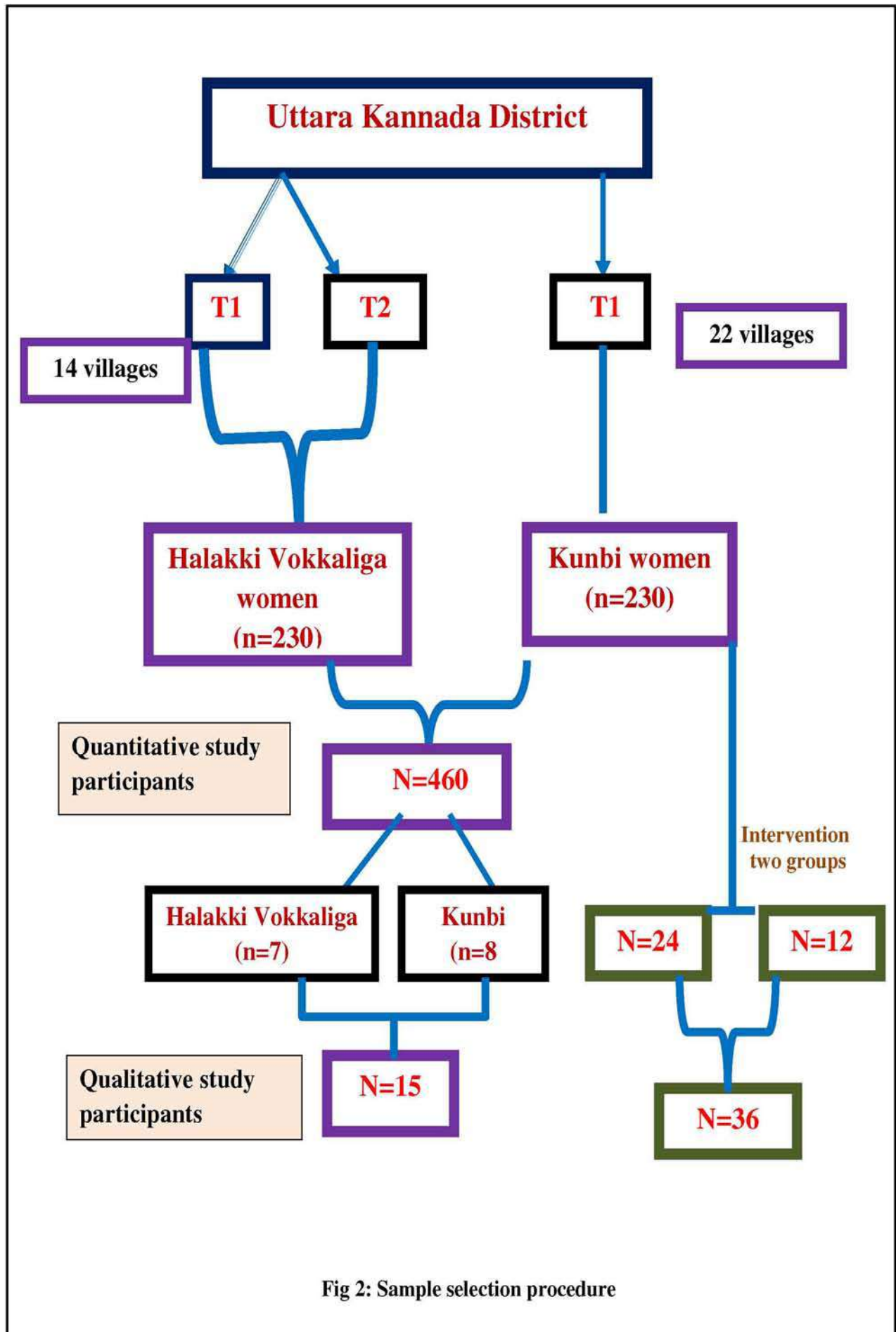


Fig 2: Sample selection procedure

3.3 Variables selected for the study:

Dependent variables:

- Empowerment status
- Health Status -General health, Reproductive health and Nutritional status

Independent variables: The independent variables were categorized as following:

a) Individual characteristics:

- Age of the respondent
- Education of the respondent
- Occupation of the respondent

Other individual variables considered: These variables were used for selected analysis purpose.

b) Reproductive health related characteristics

- Age at marriage
- Type of marriage
- Age at first pregnancy
- Age at menarche
- Type of delivery
- Place of delivery

These variables were analyzed only with health status of the respondents.

c) Social characteristics

- SHG enrollment
- Govt. schemes enrollment
- Media usage
- Mobile phone usage
- Frequency of mobile phone usage

These variables were analyzed only with empowerment status of the respondents.

d) Familial characteristics:

- Type of family
- No. of family members
- Socio-economic status
- Education of the husband
- Occupation of the husband

3.4 Tools used for the study

The tools used for the study are enumerated as follows.

- 1) General information schedule
- 2) Empowerment status questionnaire by Rashid and Gao (2014)
- 3) PGI-2 health questionnaire by Wig *et al.* (1978)
- 4) Reproductive health practice scale by Hassan MK (2002)
- 5) Nutritional status assessment
- 6) Socio-economic status (SES) scale (Aggrawal *et al.*, 2005)

Description of research tools are as follows:

1) General information schedule: The general information schedule was used to gather respondents' individual characteristics such as age, education, occupation; familial characteristics such as type of family, no. of family members, education and occupation of the husband; reproductive health related characteristics such as age at marriage, type of marriage, no. of children, age at first pregnancy, type of delivery, place of delivery and social characteristics such as SHG enrollment, govt. schemes enrollment, media usage frequency of mobile phone usage, mobile phone usage and its frequency. (Appendix - I).

The quantification of these selected variables is presented below:

i) Age: The chronological age of the respondent in completed years at the time of investigation was considered and categorized as below:

Categories Age (years)	Code
20-30	1
30-40	2
40-50	3

ii) Education: Education of the respondent and her husband was quantified separately by using weightages as per Aggarwal's socio - economic status scale (2005).

Categories	Code
Professional qualification (technical degrees or diplomas, Doctor, Engineer, C.A., MBA etc.)	8
Post-graduation (non-technical incl. Ph.D)	7
Graduation	6
10 th class pass but < graduation	5
Primary pass but < 10 th	4
< Primary but attended school for at least one year	3
Just literate but no schooling	2
Illiterate	1

iii) Occupation: Occupation of the respondent and her husband was quantified separately by using weightages as per Aggarwal *et al.*'s Socio economic scale (2005).

Categories	Code
Service in Central/State/Public undertakings or owner of a company employing > 20 persons or self-employed professional viz. Doctors, CA, Engineer, etc.	5
Service in private sector or independent business employing 2-20 Persons	4
Service at shops, home, transport, own cultivation of land	3
Self-employed e.g. shops, petty business with income > 5000	2
Self-employed with income < 5000 (labourer, house wife)	1

iv) Age at marriage: The chronological age of women at marriage in completed years was considered and categorized as below.

Categories Age (in years)	Code
16-20	1
21-25	2
26-30	3

v) **Type of marriage:** Type of marriage of the respondent was grouped as below:

Categories	Code
Consanguineous	1
Non-consanguineous	2

vi) **Age at menarche:** The chronological age of women when she attained menstrual cycle was considered and categorized as below.

Categories Age (in years)	Code
10-12	1
13-14	2
> 15	3

vii) **Age at first pregnancy:** The chronological age of women at first pregnancy in completed years was considered as below.

Categories Age (in years)	Code
18-22	1
23-25	2
≥ 26	3

viii) **Type of delivery:** The preceding delivery undergone by women was noted and classified as follows:

Categories	Code
Normal	1
Caesarean	2

ix) **Place of delivery:** The place of preceding delivery undergone by women was noted and grouped as follows:

Categories	Code
Home	1
Hospital	2

x) Self Help Group (SHG) enrollment: Joining of women to the any one of the self-help groups was considered and coded as follows:

Categories	Code
Yes	1
No	2

xi) Govt. schemes enrollment: Women taking/taken the benefit of any of the government schemes for employment, girl/ women welfare schemes were considered.

Categories	Code
Yes	1
No	2

xii) Media usage: Frequency of use of any of the media such as newspaper, television, radio etc. is considered.

Categories	Code
Regular	1
In consistent	2

xiii) Mobile phone usage: Use of mobile phone by the respondent for the minimum two functions such as receiving/dialling call, read/send messages etc. are considered and coded as follows:

Categories	Code
Use independently	3
Assistance of others	2
Do not use	1

xiv) Frequency of mobile phone usage: Frequency of use of mobile phone by the respondent is noted and coded as below:

Categories	Code
Use regularly	3
Use irregularly	2
Do not use	1

xv) Type of family: Type of family was classified into three groups:

- a) Nuclear family: consisting of a single married couple living with unmarried children
- b) Joint family: consisting of more than one married couple of either same generation / older and living together with or without children.
- c) Extended family: consisting of more than the nuclear family, that includes one or other relatives.

Type of family	Code
Nuclear	1
Joint	2
Extended	3

xvi) No. of family members: On the basis of family members living together, family size was classified as below.

No. of members	Code
1-5	1
6-10	2
More than 10	3

2) Empowerment status questionnaire by Rashid and Gao (2014)

The empowerment of the women was assessed using empowerment status questionnaire by Rashid and Gao (2014) using four indicators viz, autonomy, participation in development activities, political and legal awareness, and participation in decision-making. The scoring of each indicator is shown in the following table.

Indicators	Scoring			Total No. of Questions	Possible Range
	Alone (2)	Jointly (1)	Husband (0)		
Autonomy (AUT)	Alone (2)	Jointly (1)	Husband (0)	12	0-24
Participation in social and development activities (PSDA)	Yes (1)	No (0)	-	5	0-5
Awareness about political and legal issues (APLT)	Yes (1)	No (0)	-	8	0-8
Participation in decision making (PIDM)	Alone (2)	Jointly (1)	Husband (0)	9	0-18

The score for Women Empower Status (WEST) was calculated on the basis of the following formula: WEST = AUT + PSDA + APLT + PIDM

Classification of empowerment status

Empowerment status	Category
High	> 38
Medium	19-37
Low	<18

Classification of empowerment status dimensions:		
Dimensions	Classification	Scoring
Autonomy	Low	6-12
	Medium	13-16
	High	19-24
Participation in developmental activities	No Participation	0
	Less Participation	1-3
	More Participation	>4
Political awareness	Low	2-5
	Medium	6-7
	High	>7
Participation in Decision making	Less Participation	7-10
	Medium participation	11-14
	More participation	>14

The reliability of the tool was measured using Guttman Split half coefficient and it was found to be 0.75.

3) PGI-2 health questionnaire by Wig *et al.* (1978)

To know the general health status of the respondents PGI scale was used. It assessed the general health in five areas namely, eye related problems, abdominal related problems, physical problems, and head related problems and psychological problems.

This questionnaire has 50 statements scored on 4-point Likert scale, which ranges from 1 to 4, where 1 is given for never and 4 given for too often. Higher the score indicates more the health problems. The respondents were grouped based on the score as follows:

Sl. No	Categories of health problem	Score
1	Mildly affected	50-99
2	Moderately affected	100-149
3	Severely affected	150-200

4) Reproductive health practice scale by Hassan MK (2002)

Reproductive health practice scale by P.G. Department of Psychology Ranchi Hassan MK (2002) consisted of 24 items. It covers the questions related to conception and child birth, safe motherhood, fertility regulation method and sexually transmitted diseases (STD) / acquired immune deficiency syndrome (AIDS).

Each question has three alternative responses: Always, Never and Sometimes. It is 3 point likert scale with both positive and negative items. Score ranges from 24-72. High scores indicated better reproductive health.

Reproductive health	Category
Poor	24-40
Average	41-56
High	57-72

The reliability of the tool was measured using Guttman Split half coefficient and it was found to be 0.79.

5) Nutritional status: It was assessed by noting anthropometric measurement *viz.*, height, weight, waist circumference and hip circumference. Nutritional status of the respondents in terms of Body Mass Index (BMI), Waist to Hip Ratio, Lean Body Mass Index (LBMI) using following anthropometric measurements.

Height: Height being measured by using anthropometric rod.

Weight: Weight being taken by using digital weighing balance.

From the height and weight measurements the BMI was calculated using the formula and classified (NIN 2016).

$$\text{BMI} = \frac{\text{Weight in kg}}{\text{Height in m}^2}$$

Classification of BMI:

Sl. No.	BMI category	Range
1	Under weight	< 18.50
2	Normal	18.50-24.99
3	Over weight	25.00-30.00
4	Obese	≥ 30.00

Waist circumference and Hip circumference: The waist and hip circumference were measured by using the fiber glass measuring tape. From waist circumference and hip circumference the WHR will be calculated using the formula.

$$\text{WHR} = \frac{\text{Waist circumference}}{\text{Hip circumference}}$$

WHR ratio classification for women:

Categories	Ratio
Normal	<0.85
Abdominal adiposity	>0.85

Lean Body Mass Index (LBMI): From the height and weight measurements the LBMI was calculated using the Boer formula,

For females: $LBM = (0.252 \times W) + (0.473 \times H) - 48.3$

Where “W” is body weight in kilograms and “H” is height in centimetres.

Status	Range
Underweight	<70 %
Normal	70-90 %
Obese	>90 %

Waist to hip ratio and lean body mass index were analyzed only to know the difference between Halakki Vokkaliga and Kunbi women. For further analysis, these variables were not considered.

7) Socio-Economic Status (SES) Scale (Aggrawal *et al.*, 2005)

The scale consists of 22 statements which was used to collect information education, occupation, monthly per capital income from all sources, family possessions, number of children, number of earning members in family, education of children, domestic servants in home, possession of agricultural land and non-agricultural land along with animals and social status of the family. The respondents will be classified based on the following classification

Classification of Socio-economic status

Sl. No.	SES of the family	Scores
1	Upper High	≥ 76
2	High	61-75
3	Upper Middle	46-60
4	Lower Middle	31-45
5	Poor	16-30
6	Very Poor (Below Poverty Line)	<15

3.5 Data Collection Procedure:

Phase 1: The information on the population of the communities was obtained from District office for Backward Classes and Minorities, Uttara Kannada district. In the first phase, the villages where Halakki Vokkaliga and Kunbi community women resided were identified in the Uttara Kannada district.



Collecting preliminary information from Anganwadi teachers



Plate 1: Data collection from the Halakki Vokkaliga and Kunbi women



Plate 2: Collecting information from respondents



Measuring weight and height of the respondents



Measuring mid upper arm circumference of the respondents

Plate 3: Anthropometric measurements of the respondents



Home garden and home grown vegetables of Halakki Vokkaliga women



Selling vegetables in the market by Halakki Vokkaliga women

Plate 4: Major occupation of the Halakki Vokkaliga women



Mahamane –The place where Kunbi people of Deriya village celebrate festivals together



Paddy fields of Kunbi community village



Outlook of the Kunbi community village



Plate 5: Pictures of Kunbi people residing village



Growing variety of tubers at home garden by Kunbi women



Selling tubers by Kunbi women at Tuber's Mela



Value added products of tubers by Kunbi women

Plate 6: Tubers: staple food in the Kunbi people's diet

Phase 2: The community heads of both the communities were initially contacted and they were briefed about the research work. After gaining their trust, the researcher was given permission to carry out the research in both Halakki Vokkaliga and Kunbi communities.

a) Halakki Vokkaliga community: Halakki Vokkaligas spreads in four taluks of Uttara Kannada district namely, Kumta, Karwar, Ankola and Honnavar. But the villages from all the four taluks are clustered into seven Koppas. Out of seven Koppas four Koppas were randomly selected from two taluks to have representative sample from all the directions. Finally, 230 women from 14 villages formed the sample of the study.

b) Kunbi community: The preliminary information indicated the Kunbi tribes residing in Joida and Yellapur taluks of Uttara Kannada district. Since Kunbi population is highly concentrated in Joida taluk, this taluk was selected for the study. The Kunbi tribes were found in 53 villages in Joida taluk out of which 22 villages were randomly selected for the study covering all the four directions to get a representative sample.

Based on the population in the villages and selection criteria for the study women were selected. The final sample of Kunbi women in their reproductive age was 230.

Phase 3: After selecting the villages, Anganwadi teachers of that village were contacted to get the preliminary information about the population and number of households. Pilot study was done on a sample of 30 women from each community to test the reliability of the tools and to get acquaintance with the questionnaires. Later, these samples were not included in the main sample of the study. The reliability of the tools was tested using Guttman Split half method in Statistical Package for Social Science Software (SPSS-IBM version 21.0) and reliability was found to be above 0.70 for each measure.

After the pilot study, home visits were made to collect the research data of the Halakki Vokkaliga and Kunbi women. Women of reproductive age group were randomly selected and interviewed individually at the household level. Initially rapport was built and later, questionnaires were administered. General information schedule eliciting information on individual, familial, social and reproductive information were asked. Questionnaires on empowerment status, general health status, reproductive health and socio-economic status were administered on each women respondent. Anthropometric measurements such as height, weight, waist circumference and hip circumference were measured. The factors influencing empowerment status and health status was studied by employing the quantitative research

method. Along with quantitative research method, concurrently, a qualitative method was also employed where ethnographic case study were carried out to the situationally analyse the respondents. Qualitative data was collected on seven Halakki Vokkaliga and eight Kunbi women.

Phase 4: Statistical analysis of Empowerment and health status of Halakki Vokkaliga and Kunbi communities were done. Intervention package to improve knowledge on empowerment status was developed. Based on the analysis of the data, an educational intervention was provided to that community where status of women was low compared to their counterparts.

Phase 5: Intervention was provided in 15 sessions to two groups of women consisting of 36 (24 in one group and 12 in another group) participants taken as an experimental group. An equal number of women from the same community were selected as control group. Pre-test was conducted on both the groups using self-structured questionnaire on empowerment knowledge which consisted of 24 questions covering women's knowledge on educational, economic- social and political-legal empowerment and autonomy –decision making of the women. After 7th session of the intervention, the same questionnaire was administered on both control and experimental group, as Post-test-1. After completing the intervention programme, after 20 days post-test 2 was conducted on both the groups.

Qualitative Data Collection

Qualitative data was collected in the second phase of the study where in-depth interviews of the Halakki Vokkaliga and Kunbi women were conducted in their place where they felt comfortable and could speak up, narrate all the issues related to women empowerment and health aspects (their views, attitude, practices and experiences) without much hesitations. The interviews were conducted in their native language (Kannada and Konkani) with the help of key informants Anganwadi teacher and supervisors in National Rural Livelihood Mission (NRLM).

Prior to interview, each of the participants was briefed about the study and oral consent was taken before audio taping their interviews. The participants were ensured about the confidentiality that would be maintained with respect to their identity so that they could share and narrate their views without much hesitation.

The interview began with the introduction of the participant, a common question on what she thinks of empowerment and health aspects and later the interview followed varied directions depending on the narrations of the participants. Each interview had its own rhythm, pace and duration to which the researcher tuned to probe further, paraphrased the words, immersed in-depth to understand the intricacies of the experiences. The researcher stayed focused by not intruding oneself too much in the interview, without commenting on any of the issues, monitoring self-disclosure, being non-judgmental and tried to strike balance between general and specific issues to bring rigor to the study. However, the researcher was empathetic, alert and observant of the gestures along with the words, pauses, silence, tone, intonations and various feelings expressed throughout the interview sessions.

The interview was audio recorded and the observational notes were taken during the interview for qualitative analysis purpose, which included all the minute things which could add meaning and depth to the audio data being recorded. The duration of the interview ranged from 20 minutes to 40 minutes depending on the participants of which some were highly expressive; wanting to share whereas others who answered in monosyllables; impassively waiting for next question were transcribed for further analysis. Such in-depth interviews were conducted until saturation of data was observed (in case of qualitative data, saturation comes from depth and not from breadth). These audio recordings and observational notes were further used for thematic development.

To bring in rigor in qualitative research, strategies such as prolonged engagement with the interviewee, data triangulation wherein interviews were supported with observations and tools/scales (quantitative data), negative case analysis (negative case analysis puts the onus on the researcher to operate in a critically self-reflective way by enhancing fairness, giving equitable attention to differing viewpoints and avoiding favouritism as well as lopsided interpretations) and auditing (adopting a spirit of openness and documenting each step taken in data collection and analysis) were employed.

The qualitative data collection was highly challenging. There were many practical problems such as dealing with the participant's emotional outbursts. These challenging moments were handled with utmost care and a mutually beneficial encounter was established with interviewer to benefit with in-depth information and interviewees gratified by the experience of being respected and listened to.

3.6 Statistical analysis

3.6.1 Quantitative data analysis

The data was collected and analyzed using the following statistical techniques.

- a. Frequency and percentage:** frequency and percentage were calculated to interpret the individual, familial, reproductive related and social characteristics.
- b. Chi- Square test:** Non parametric test was find out the association between empowerment status, health status with individual and familial characteristics using the formula,

$$\chi^2 = \sum_{i=1} \sum_{j=1} (O_{ij} - E_{ij})^2 / E_{ij}$$

Where,

χ^2 values are compared with table values for (r-1)(c-1) degrees of freedom (df)

'r' denoting the number of rows,

'c' denotes number of columns in the contingency tendency

O_{ij} = Observed frequencies

E_{ij} = Expected frequencies

- c. Modified chi-square:** A non-parametric test of independence was applied wherever the frequency in each cell were less than five using the formula by Lawal and Upton (1984) test of independence.

$$\text{Modified } \chi^2 = \{1 - 1/n (1 - d^{1/2})\} \times \chi^2 d, 0.05 \text{ 5 \% level}$$

where,

$\chi^2 d$ = table χ^2 value at 'd' degrees of freedom for 5 % level of significance.

n = sample size

- d. t- test:** was used to compare the means of the two groups *i.e.*, children with cerebral palsy and typical children with the following formula.

$$t' = \frac{|\bar{X}_1 - X_2|}{\sqrt{Sp^2 (1/n_1 + 1/n_2)}}$$

$$Sp^2 = \frac{\{(n_1 - 1) S_1^2 + (n_2 - 1) S_2^2\}}{(n_1 + n_2 - 2)}$$

Where,

- X1 = Mean of the first group
- X2 = Mean of the second group
- n1 = No. of observations in the first group
- n2 = No. of observations in the second group
- S1² = Variance of first group
- S2² = Variance of second group
- Sp² = Pooled variance of two groups

e. Karl Pearson's Product Moment correlation coefficient: It was computed to measure the relationship between cerebral palsy and child, parental and familial characteristics using the formula:

$$r = \frac{n \sum xy - \sum x \sum y}{\sqrt{\{n \sum x^2 - (\sum x)^2\} \{n \sum y^2 - (\sum y)^2\}}}$$

Where,

- r = simple correlation coefficient
- x = Independent variable
- y = Dependent variable
- x = Sum of 'x' values
- y = Sum of 'y' values
- x² = Sum of squares of 'x' values
- y² = Sum of squares of 'y' values
- xy = Sum of product of 'xy' values
- n = Number of pairs of observations

f. One way ANOVA (Analysis of Variance): This technique was used to know the influence of child's characteristics such as age, ordinal position, use of parental characteristics such as parent's age, education, occupation, familial characteristics such as – type of the family, size of family, socio-economic status, . Critical difference was calculated using 't' test to test the significant difference between different level of main effect and interaction effects whatever was found significant.

$$CD = \sqrt{EMS (1/n_i + 1/n_j) \times t_c}$$

Where, EMS = Error mean sum of squares

t_c = table value of 't' for degree of freedom

g) Multiple regression was used to know the effect of independent variables on dependent variables with the help of the formula,

$$y = a + b_1 x_1 + b_2 x_2 + b_3 x_3 + \dots \dots \dots 65$$

Where,

y = dependent variable $x_1, x_2, x_3, x_4, \dots \dots \dots x_n$ = Independent variables

$b_1, b_2, b_3, b_4, \dots \dots \dots b_n$ = Regression coefficient

h) Step wise regression was used to identify the predictor variables and its effect on empowerment status and health status.

3.6.2 Qualitative data analysis

The ethnographic case study approach to elicit experiences from participants was adopted by follow the below procedure.

- Individual interview transcripts were made.
- The most commonly used analytical procedures like coding and thematic development were done based on repeated readings of transcript.
- Open codes and themes as well as in vivo codes emerged directly from participants words were identified from the transcript to find similarities as well as dissimilarities among the cases.
- Peer debriefing and member checking were used as strategies of rigor.

3.7 Intervention

The intervention package entitled "*A Guide for Improve Empowerment Knowledge of Kunbi Tribal Women*" consisted 15 sessions. The intervention was conducted by the researcher under the guidance of Major advisor Dr. Vinutha U. Muktamath who participated as resource person and also played a major role in conducting the programme.

The package divided according to dimensions of women empowerment and covered the information on introduction to women empowerment, gender equality and gender equity educational empowerment of women, political and legal empowerment of women, economic

empowerment of women, social empowerment, health and nutrition of women, decision making and building interpersonal skills among women. Inter-rater reliability of the package was tested by giving to three subject experts, before beginning the intervention programme.

The programme was designed for fifteen sessions, with each session focusing on one issue related to women empowerment. Each session was planned for duration of about two hours. Information was disseminated in the form of lectures, activities, games, role plays and discussion in order to convey the message effectively. The folders and handouts developed by the researcher and guide was also distributed to the participants for better take home message. The programme was delivered in the regional Kannada language. Participants consent to attend all the sessions was taken. The intervention was carried out for fifteen weeks from 13th June, 2022 to 23rd September 2022. Sessions were conducted for two groups on the same day in different locations. In one group 24 participants and in other 12 participants attended the intervention session. After 20 days on 13th October 2022 follow up was done.

The sessions and issues addressed in each session are as below:

Intervention Package

A. Introduction to women empowerment, Gender equality and gender equity

1. Women Empowerment: Meaning, dimensions and its need

In this session participants get to know each other, understand the objectives of the intervention programme and what are the things will be covered; the meaning of “Women Empowerment” and its dimensions, need of women empowerment.

2. Gender equality and gender equity

The session concentrated on meaning and importance of gender equity and gender equality; Sex ratio, literacy rate, child ratio and gender-based violence, share experiences and feelings in a confidential group environment; think about our own life experiences as women, and about ways in which society sometimes oppresses us.

B. Educational empowerment of women

3. Importance of girl’s Education

The session was on importance of educating the girls, Benefits of girl’s education

4. Schemes for girls Education

Different schemes to encourage Girl's education -Information on eligibility criteria, procedure and benefits of different central and state government schemes for promoting girl child education

C. Political-legal empowerment of women

5. Constitutional provision for women

The session dealt with importance to know about the constitutional provision for women, different constitutional provisions for women; Women rights and its significance

6. Women welfare schemes

The session educated women on different schemes by Govt. of India for the welfare of the women and enrolment procedure

D. Economic empowerment of women

7. Information about income –generating activities

The session dealt with preparation of Phenyl; Demonstration of Mushroom Cultivation; Information on value-addition of tubers

8. Schemes to improve women economic empowerment

This session highlighted the schemes implemented by Govt. of India to improve the participation of women in entrepreneurial activities; Detailed description about the schemes

9. Agriculture related schemes in India

The session concentrated on detailed information on different agriculture schemes by central and state governments for welfare of farmers; Eligibility criteria, benefits and enrolment procedure

E. Social-empowerment, health and nutrition of women

10. Social-empowerment of women: Role of SHG

The session included information on ways to improve social empowerment of women; Role of SHG in empowerment of women

11. Health and nutrition

This session educated the women on balanced diet; Importance of diet during different stages of life-; Body mass index.



Providing educational intervention to the participants



Plate 7: Educational intervention to Kunbi women



Providing lecture on “Role of SHG in Women Empowerment by Mrs. Nayana, Head of SHG in Joida taluk



Plate 8: Performing activities in intervention programme



**Providing empowerment education to Kunbi women by resource person
Dr. Vinutha U. Muktamath, Assistant Professor, CCSc, UAS Dharwad**



**Demonstrating Mushroom cultivation as an income generating activity during
intervention programme by resource person**

Plate 9: Demonstration of Mushroom cultivation to intervention participants

12. Under nutrition and over nutrition among Women

This session included the information on undernourishment among women; Obesity in women.

13. Health related schemes for women

This session dealt with detailed information on women health-related schemes; Strategic model of “Women Empowerment”; Winding up by revising the content

F. Decision making and building interpersonal skills in Women

14. Decision making in women at household level and society

The session concentrated on meaning of decision making and participation of women in decision making; ways to improve decision making among women

15. Promoting Confidence, Self-esteem and Leadership among women

The session focused on the meaning of confidence, self-esteem and leadership; ways to improve self-esteem and Leadership among women

ACTIVITY CHART: INTERVENTION PROGRAM

Sessions	Topic	Duration	Teaching aids used
A.	Introduction and gender equality and gender equity		
1	Women Empowerment: Meaning, Dimensions and its need	2hrs	Lecture and interaction
2	Gender Equality and Gender Equity	2hrs	Lecture and PPT, Video shows
B.	Educational empowerment		
3	Importance of girl's Education	2hrs	Lecture, ppt presentation
4	Schemes for Girls Education	2hrs	Lecture, PPT, role-play, video shows, group discussion
C.	Political and legal empowerment of women		
5	Constitutional provision for women	2hrs	Lecture, flash cards, PPT, video shows, group discussion
6	Women welfare schemes	2hrs	Lecture, group discussion
D.	Economic empowerment of women		
7	Demonstration of income –generating activities	2hrs	Lecture, Demonstration, video shows
8	Schemes to improve women economic empowerment	2hrs	Lecture and PPT
9	Agriculture related schemes in India	2hrs	Lecture, PPT, group discussion
E.	Social empowerment, health and nutrition of women		
10	Social empowerment of women: Role of SHG	2hrs	Lecture, PPT, role-play, video shows
11	Health and nutrition	2hrs	Lecture, flash cards, PPT, video shows, group discussion
12	Under nutrition and over nutrition among women	2hrs	Lecture, flash cards, PPT, video shows, group discussion
13	Health related schemes for women	2hrs	Lecture, PPT, group discussion
F.	Decision making and inter-personal skills among Women		
14	Decision making at household level and society	2hrs	Lecture and interaction Role plays
15	Promoting confidence, self-esteem and leadership among women	2hrs	Lecture and PPT Activities

3.8 Operational definitions

1. Empowerment status: The empowerment status of the respondent measured using four indicators namely, autonomy, and participation in developmental activities, political awareness and participation in decision making (Rashid and Gao, 2014).

2. Health status: The health status of the respondents assessed in terms of health problems present at the time of data collection like eye, head, and abdominal, physical and psychological problems using PGI Health Questionnaire (Wig *et al.*, 1978).

3. Nutritional status: It is the physiological state of an individual, which results from the relationship between nutrient intake and requirements and from the body's ability to digest, absorb and use the nutrients. For adults, general adequacy is assessed by measuring weight and height; the result is commonly expressed as the body mass index, the ratio of weight (kg) to height² (m) (FAO, 2017)

4) Reproductive health: It is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health of women assessed using conception and child birth, safe motherhood, fertility regulation method and sexually transmitted diseases (STD) and acquired immune deficiency syndrome (AIDS) (Akhouri *et al.*, 2017)

5) Lean body mass (LBM): It is a part of body composition that is defined as the difference between total body weight and body fat weight (Yu *et al.*, 2013)

6) Body mass index: Body mass index (BMI) is a measure of body fat based on height and weight that applies to adult men and women. Body Mass Index (BMI) is a person's weight in kilograms (or pounds) divided by the square of height in meters (or feet). A high BMI can indicate high body fatness (WHO, 2008)

7) Waist to Hip ratio: The waist-hip ratio or waist-to-hip ratio (WHR) is the dimensionless ratio of the circumference of the waist to that of the hips. This is calculated as waist measurement divided by hip measurement (W/H). (WHO, 2008)

8) Socio-economic status: Socioeconomic status is the position of an individual or group on the socioeconomic scale, which is determined by a combination of social and economic

factors such as income, amount and kind of education, type of occupation, place of residence and religious background etc. (Aggarwal, 2005).

3.9 Hypothesis set for the study

1. There is no significant difference between Halakki Vokkaliga and Kunbi women with respect to empowerment status.
2. There is no significant difference between Halakki Vokkaliga and Kunbi women with respect to health status.
3. There are no influence of individual and familial characteristics on empowerment status and health status of Halakki Vokkaliga and Kunbi women.
4. There is no relationship between empowerment status and health status of Halakki Vokkaliga and Kunbi women.
5. There is no influence of intervention on knowledge of tribal women.

4. RESULTS

The results of the study entitled “Empowerment and health status of Halakki Vokkaliga and Kunbi tribal women: A study in Uttara Kannada district of Karnataka” are presented under the following sub heads:

- 4.1 Socio-demographic characteristics of Halakki Vokkaliga and Kunbi women women selected for the study
- 4.2 Empowerment and health status of Halakki Vokkaliga and Kunbi women
- 4.3 Association and comparison of individual and familial characteristics on empowerment and health status of Halakki Vokkaliga and Kunbi women
- 4.4 Correlation between individual and familial characteristics and empowerment and health status of Halakki Vokkaliga and Kunbi women
- 4.5 Combined effects of selected factors on empowerment and health status of Halakki Vokkaliga and Kunbi women
- 4.6 Qualitative findings of Halakki Vokkaliga and Kunbi women focusing on empowerment and health aspects
- 4.7 Impact of intervention on empowerment knowledge of Kunbi women

4.1 Socio-demographic characteristics of Halakki Vokkaliga vokkaliga and Kunbi women selected for the study

The results of socio-demographic characteristics of Halakki Vokkaliga and Kunbi women selected for the study has been presented under following sub-headings from table 4.1.1 to 4.1.4.

- 4.1.1: Percentage distribution of individual characteristics of the respondents
- 4.1.2: Percentage distribution of familial characteristics of the respondents
- 4.1.3: Percentage distribution of reproductive health related characteristics of the respondents
- 4.1.4: Percentage distribution of social characteristics of the respondents

4.1.1: Percentage distribution of individual characteristics of the Halakki Vokkaliga and Kunbi women

Individual characteristics of the respondents such as age, education and occupation is represented in Table 4.1.1. With regard to the age characteristics, almost an equal number of participants were in the age group of 25-30 years, 30-40 years and 40-50 years. With regard to education, 35.65 per cent of the Halakki Vokkaliga women were primary pass less than 10th, 24.34 per cent were 10th pass but less than graduation, 19.13 per cent were less than primary but attended school for at least one year followed by 10.86 per cent were graduated, 6.62 per cent were just literate but no schooling, 2.60 per cent were illiterates and 0.86 per cent were post graduated. In Kunbi women, 42.60 per cent were primary pass but less than 10th, 27.39 per cent were less than primary but attended school for at least one year, 13.47 per cent were 10th class pass but less than graduation, 8.27 per cent were just literate but no schooling, 3.48 per cent were illiterates and 4.79 per cent were completed graduation. With respect to occupation of the respondents, in Halakki Vokkaliga women, majority (82.60 %) were self-employed with income less than 5000 rupees, 6.10 per cent were service in state govt. followed by 8.70 per cent service at own cultivation of land, 1.74 per cent were self-employed at shops and only 0.86 per cent had service in private sector. Among Kunbi women, vast majority (88.26 %) were self-employed with income less than 5000 rupees, 6.10 per cent were service in state govt. followed by 4.34 per cent service at own cultivation of land, 0.86 per cent were self-employed at shops and only 0.44 per cent service had in private sector.

4.1.2: Percentage distribution of familial characteristics of Halakki Vokkaliga and Kunbi women

Table 4.1.2 provides the percentage distribution of the respondents by their familial characteristics. With regard to type of family of Halakki Vokkaliga women, more than sixty per cent (60.43 %) belonged to nuclear family, 22.17 per cent belonged to extended family and 17.40 per cent belonged to joint family. In Kunbi community, 53.48 per cent of the women belonged to nuclear family, 26.08 per cent belonged to extended family.

Table 4.1.1: Percentage distribution of individual characteristics of Halakki Vokkaliga and Kunbi women**N = 460**

Variables	Halakki Vokkaliga vokkaliga women (n = 230)	Kunbi women (n=230)
Age (years)		
20-30 years	72 (31.30)	78 (33.90)
31-40 years	80 (34.78)	83 (36.08)
41-50 years	78 (33.92)	69 (30.00)
Education		
Professional qualification with technical degrees or diploma e.g. Doctor, Eng. CA, MBA, etc.	-	-
Post-graduation (non-technical incl. Ph.D)	2 (0.86)	-
Graduation	25 (10.86)	11 (4.79)
10 th class pass but <Graduation	56 (24.34)	31 (13.47)
Primary pass< 10 th	82 (35.65)	98 (42.60)
<primary but attended school for at least one year	44 (19.13)	63 (27.39)
Just literate but no schooling	15 (6.52)	19 (8.27)
Illiterate	6 (2.60)	8 (3.48)
Occupation		
Service in central/state/public undertakings or owner of a company employing>20 persons or self-employed professional viz. Doctors, CAs, Eng. Etc.	14 (6.10)	10 (4.34)
Service in Private sector or independent business employing 2-20 persons	2 (0.86)	2 (0.86)
Service at shops, home, transport, own cultivation of land	20 (8.70)	14 (6.10)
Self-employed e.g. shops, Rehdies or petty business with income >5000	4 (1.74)	1 (0.44)
Self-employed with income <5000 (labourer, house wife)	190 (82.60)	203 (88.26)
None of the family member is employed	-	-

Figure in the parenthesis indicates percentage

Table 4.1.2: Percentage distribution of Halakki Vokkaliga and Kunbi women by familial characteristics**N = 460**

Variables	Halakki Vokkaliga women (n = 230)	Kunbi women (n=230)
Type of family		
Nuclear	139 (60.43)	123 (53.48)
Joint	40 (17.40)	47 (20.44)
Extended	51 (22.17)	60 (26.08)
Socio-economic status		
Upper High	-	-
High	9 (3.92)	-
Upper middle	21 (9.14)	13 (5.66)
Lower middle	86 (37.39)	69 (30.00)
Poor	94 (40.86)	102 (44.34)
Very poor	20 (8.69)	46 (20.00)
No. of family members		
1-5	114 (49.56)	86 (37.39)
6- 10	93 (40.44)	114 (49.56)
More than 10	23 (10.00)	30 (13.04)
Husband's education		
Professional qualification with technical degrees or diploma e.g. Doctor, Eng. CA, MBA, etc.	-	-
Post-graduation (non-technical incl. Ph.D)	7 (3.04)	2 (0.86)
Graduation	35 (15.21)	13 (5.65)
10 th class pass but <Graduation	55 (23.92)	55 (23.91)
Primary pass< 10 th	87 (37.82)	91 (39.56)
<primary but attended school for at least one year	32 (13.92)	43 (18.69)
Just literate but no schooling	9 (3.92)	20 (8.69)
Illiterate	5 (2.17)	6(2.60)
Husband's occupation		
Service in central/state/public undertakings or owner of a company employing>20 persons or self-employed professional viz. Doctors, CAs, Eng. Etc.	23 (10.00)	16 (6.95)
Service in Private sector or independent business employing 2-20 persons	10 (4.35)	13 (5.65)
Service at shops, home, transport, own cultivation of land	23 (10.00)	12 (5.22)
Self-employed e.g. shops, Rehdies or petty business with income >5000	18 (7.83)	15 (6.52)
Self-employed with income <5000 (labourer, house wife)	156 (67.82)	174 (75.66)
None of the family member is employed	-	-

Figure in the parenthesis indicates percentage

The distribution based on socio-economic status of the family in Halakki Vokkaliga women indicates that 40.86 per cent of women belonged to poor SES family, followed by 37.39 per cent lower middle, 9.14 per cent upper middle, 8.69 per cent very poor and 3.92 per cent high SES. Among Kunbi women, 44.34 per cent were into poor SES, followed by 30 per cent lower SES, 20 per cent very poor and 5.66 per cent upper middle. However, none of them belonged to upper high SES family.

With respect to number of family members, in Halakki Vokkaliga women nearly fifty (49.56 %) were having 1-5 members, 40.44 per cent of women were having 6-10 members and 10 per cent of were having more than 10 family members. In Kunbi community, nearly half of women (49.56 %) were having 6-10 family members, 37.39 per cent were having 1-5 family members and 13.04 per cent were having more than 10 family members.

Regarding husband's education, in Halakki Vokkaliga community, about 37.82 per cent were primary pass less than 10th, followed by 23.92 per cent who had passed 10th class, 15.21 per cent were graduated, 13.92 per cent were less than primary, 3.92 per cent were just literates, 3.04 per cent were post graduated and 2.17 per cent were illiterates. In Kunbi women, about 39.56 per cent were primary pass less than 10th followed by 23.92 per cent were 10th class pass, 18.69 per cent were less than primary, 8.69 per cent were just literates, 5.65 per cent were graduated, 2.69 per cent were illiterates and only 0.86 per cent were post graduates.

With reference to husband's occupation, in Halakki Vokkaliga, more than sixty per cent (67.82 %) were self-employed with income less than 5000 rupees, service in state government (10.00 %) and 10 per cent service at own cultivation of land, 7.83 per cent were self-employed at shops and only 4.35 per cent were in private sector service . Consider to Kunbi, majority (75.66 %) were self-employed with income less than 5000 rupees, 6.95 per cent were in state govt service. followed by 6.52 per cent were self-employed at shops, 5.65 per cent service at service in private sector and 5.22 per cent were worked in own cultivation of land.

4.1.3 Percentage distribution of reproductive health related characteristics of Halakki Vokkaliga and Kunbi women

Reproductive health related characteristics of the respondents shown in table 4.1.3. With regard to age at menarche, in Halakki Vokkaliga women, more than sixty per cent

Table 4.1.3: Percentage distribution of reproductive health related characteristics of Halakki Vokkaliga and Kunbi women**N = 460**

Variables	Halakki Vokkaliga women (n = 230)	Kunbi women (n=230)
Age at menarche		
10-12	69 (30.00)	76 (33.04)
13-14	141 (61.30)	135 (58.70)
>15	20 (8.70)	19 (8.26)
Age at marriage		
<20 years	63 (27.40)	72 (31.30)
21-25 years	137 (59.56)	134 (58.26)
>25 years	30 (13.04)	24 (10.44)
Type of marriage		
Consanguineous	20 (8.70)	27 (11.73)
Non-consanguineous	210 (91.30)	203 (88.27)
Age at first pregnancy		
<20	49 (23.90)	52 (24.88)
21-25	144 (70.24)	133 (63.64)
>25	37 (18.04)	24 (11.48)
Type of delivery		
Normal	153 (74.63)	165 (78.95)
Caesarean	52 (25.37)	44 (21.05)
Place of delivery		
Home	26 (12.68)	39 (19.02)
Hospital	179 (87.32)	170 (81.33)

Figure in the parenthesis indicates percentage

attained menarche at the age of 13-14 years, 30 per cent were at 10-12 years and remaining 8.70 per cent were above 15 years. The distribution of Kunbi women depicts that 58.70 per cent attained menarche at 13-14 years followed by 10-12 years (33.04 %) and 8.26 per cent were above 15 years. Relating to age at marriage, 59.56 per cent of Halakki Vokkaliga women married between the age of 21-25 years, 27.40 per cent were at below 20 years and 13.04 per cent were at above 25 years. Among Kunbi women, 58.26 per cent married between the age of 21-25 years, 31.30 per cent below 20 years and 10.44 per cent were married after 25 years. Pertaining to type of marriage, in Halakki Vokkaliga women, most of the respondents (91.30 %) marriages were non-consanguineous and only 8.70 per cent had consanguineous marriages. In Kunbi women, most of the (88.27 %) marriages were non-consanguineous and 11.73 per cent were consanguineous marriages.

In connection to age at first pregnancy of the respondents, in Halakki Vokkaliga women, majority (70.24 %) had first child at 21-25 years, 23.90 per cent had below 20 years and 18.04 per cent above 25 years. Among Kunbi women, more than sixty per cent (63.04 %) had first child at 21-25 years, 24.88 per cent had below 20 years and 11.48 per cent above 25 years. Regarding type of delivery, nearly 74.63 per cent had normal delivery and remaining 25.37 per cent had caesarean delivery. In Kunbi women, 78.95 per cent had normal delivery and 21.05 per cent had caesarean delivery. Pertaining to place of delivery, a large number (87.32 %) of Halakki Vokkaliga women had delivery at hospital and 12.68 per cent had at home. Among Kunbi women, 81.33 per cent of women had delivery at hospital and 19.02 per cent delivered at home.

4.1.4: Percentage distribution of social characteristics of Halakki Vokkaliga and Kunbi women

Table 4.1.4 represents percentage distribution of social characteristics of the respondents. With regard to SHG enrollment, sixty per cent of Halakki Vokkaliga women enrolled for SHG and remaining 39.14 per cent were not enrolled. Among Kunbi women, majority (68.70 %) enrolled for SHG and remaining 31.30 per cent were not enrolled. With reference to govt scheme enrollment, in Halakki Vokkaliga women, 48.70 per cent were found to be enrolled for govt scheme and 51.30 per cent were not enrolled. Among Kunbi women, 42.60 per cent were enrolled and more than fifty per cent (57.40 %) were not enrolled. When media usage was considered, among Halakki Vokkaliga women, nearly sixty

Table 4.1.4: Percentage distribution of social characteristics of Halakki Vokkaliga and Kunbi women**N = 460**

Variables	Halakki Vokkaliga women (n = 230)	Kunbi women (n=230)
SHG enrollment		
Yes	140 (60.86)	158 (68.70)
No	90 (39.14)	72 (31.30)
Govt schemes enrolment		
Yes	112 (48.70)	98 (42.60)
No	118 (51.30)	132 (57.40)
Media usage		
Regular	94 (40.86)	70 (30.44)
In consistent	136 (59.14)	160 (69.56)
Mobile usage frequency		
Daily	69 (30.00)	36 (15.65)
Occasionally	93 (40.44)	105 (45.65)
Do not use	68 (29.56)	89 (38.70)
Mobile usage		
Independently	103 (44.78)	62 (26.96)
With the assistance of others	59 (25.65)	79 (34.34)
Do not use mobile	63 (27.40)	89 (38.70)

Figure in the parenthesis indicates percentage

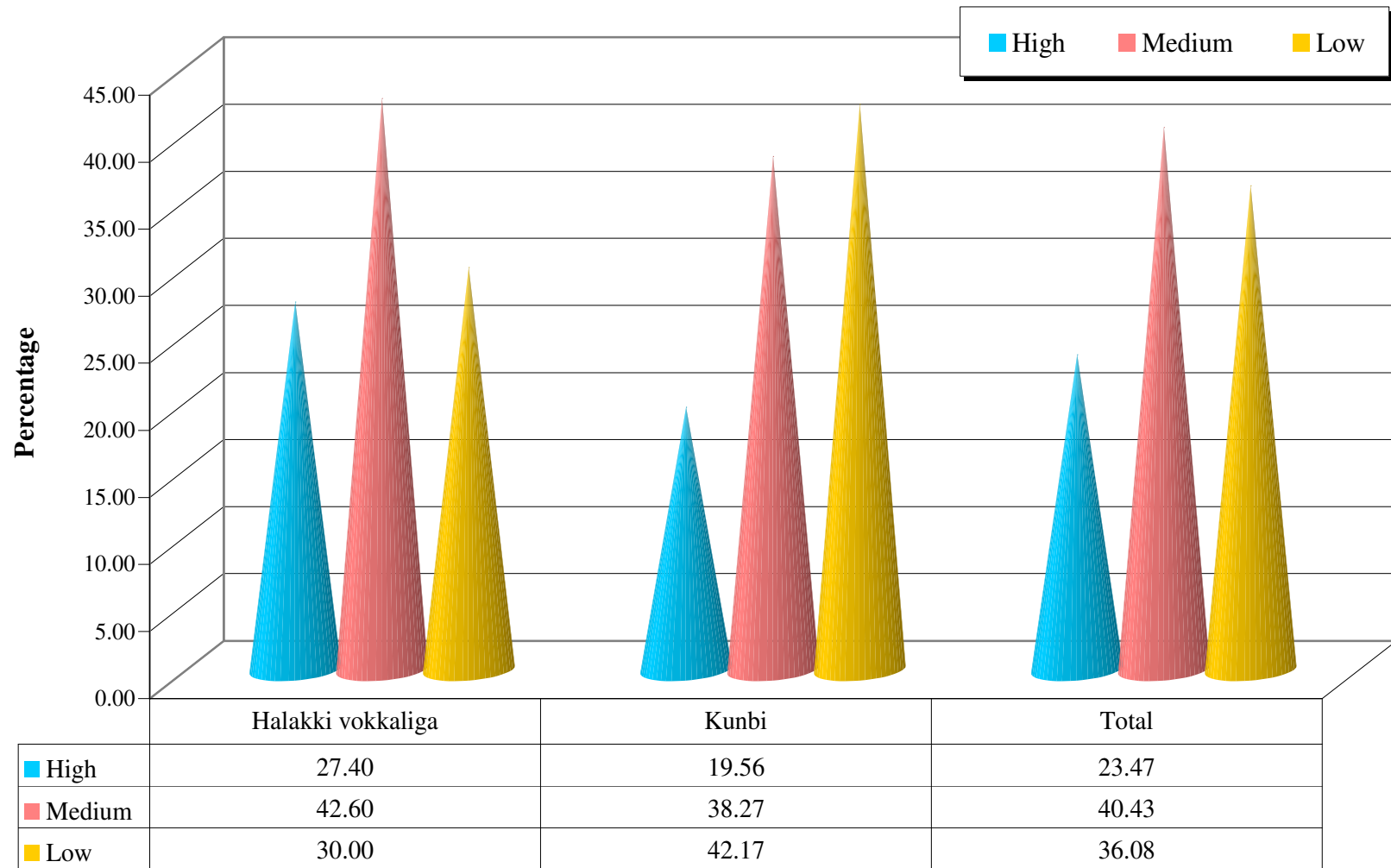


Fig. 1: Percentage distribution of empowerment status of Halakki vokkaliga and Kunbi women in Uttara Kannada district

per cent (59.14 %) were using media in consistently and 40.86 per cent per cent used regularly. In Kunbi women, majority (69.56 %) used in consistently, only 30.44 per cent used regularly. Pertaining to mobile usage frequency, among Halakki Vokkaliga women, 40.44 per cent used occasionally followed by 30.00 per cent used daily and 29.56 per cent were not using the mobile at all. In Kunbi women, 45.65 per cent used occasionally followed by 38.70 per cent did not use mobile at all and only 15.50 per cent used daily. Relating to mobile usage, 44.78 per cent used independently followed by 29.56 did not use the mobile and 25.65 per cent used it with the assistance of others. In Kunbi women, 38.70 did not use the mobile followed by 34.34 per cent used with the assistance of others and 26.96 per cent used independently.

4.2 Empowerment and health status of Halakki Vokkaliga and Kunbi women

Percentage distribution of empowerment status and comparison of empowerment status, health status (general health, reproductive health and nutritional status) are presented in fig 1.2 and 3 and table 4.2.1 to 4.2.6.

Percentage distribution of empowerment status of Halakki Vokkaliga and Kunbi women in Uttara Kannada district is showed in Fig 1. Among Halakki Vokkaliga women, 42.60 per cent were in medium level of empowerment status followed by 27.40 per cent were in high level and 30 per cent were in low level of empowerment. In Kunbi women, more than forty per cent (42.17 %) were in low level of empowerment followed by 38.27 per cent in medium level and less than twenty per cent (19.56 %) were in low level of empowerment.

Percentage distribution of dimensions of empowerment status namely autonomy, participation in developmental activities, political awareness and participation in decision making of Halakki Vokkaliga and Kunbi women in Uttara Kannada district is presented in table 4.2.1. With regard to autonomy, among Halakki Vokkaliga women, 43.92 per cent were in medium level followed by 31.30 per cent were in high level and 24.78 per cent were in low level of autonomy. Among Kunbi women, 40 per cent were in low level, 39.56 per cent were in medium level and only 20.43 per cent were in high level. Pertaining to participation in developmental activities, among Halakki Vokkaliga women, 41.30 per cent participated less followed by 39.14 per cent who had no participation and in high participation category (19.6 %). Among Kunbi women, more than fifty per cent (56.52 %) exhibited less participation followed by no participation (31.30 %) and more participation (12.18 %). when political

Table 4.2.1: Percentage distribution of dimensions of empowerment status of Halakki Vokkaliga and Kunbi women in Uttara Kannada district

N=460

Levels dimensions of empowerment	Halakki Vokkaliga women (n=230)	Kunbi women (n=230)	Total (n=460)
Autonomy			
Low (6-12)	57 (24.78)	92 (40.00)	149 (32.40)
Medium (13-16)	101 (43.92)	91 (39.56)	192 (41.74)
High (19-24)	72 (31.30)	47 (20.43)	119 (25.86)
Participation in developmental activities			
No Participation (0)	90 (39.14)	72 (31.30)	162 (35.22)
Less Participation (1-3)	95 (41.30)	130 (56.52)	225 (48.92)
More Participation (<4)	45 (19.56)	28 (12.18)	73 (15.86)
Political awareness			
Low (2-5)	73 (31.74)	98 (42.60)	171 (37.17)
Medium (6-7)	108 (46.94)	87 (37.82)	195 (42.40)
High (<7)	49 (21.30)	45 (19.56)	94 (20.43)
Participation in decision making			
Less Participation (7-10)	58 (25.22)	95 (41.30)	153 (33.27)
Medium participation(11-14)	103 (44.78)	85 (36.96)	188 (40.86)
More participation (< 14)	69 (30.00)	50 (21.74)	119 (25.87)

Figure in the parenthesis indicates percentage

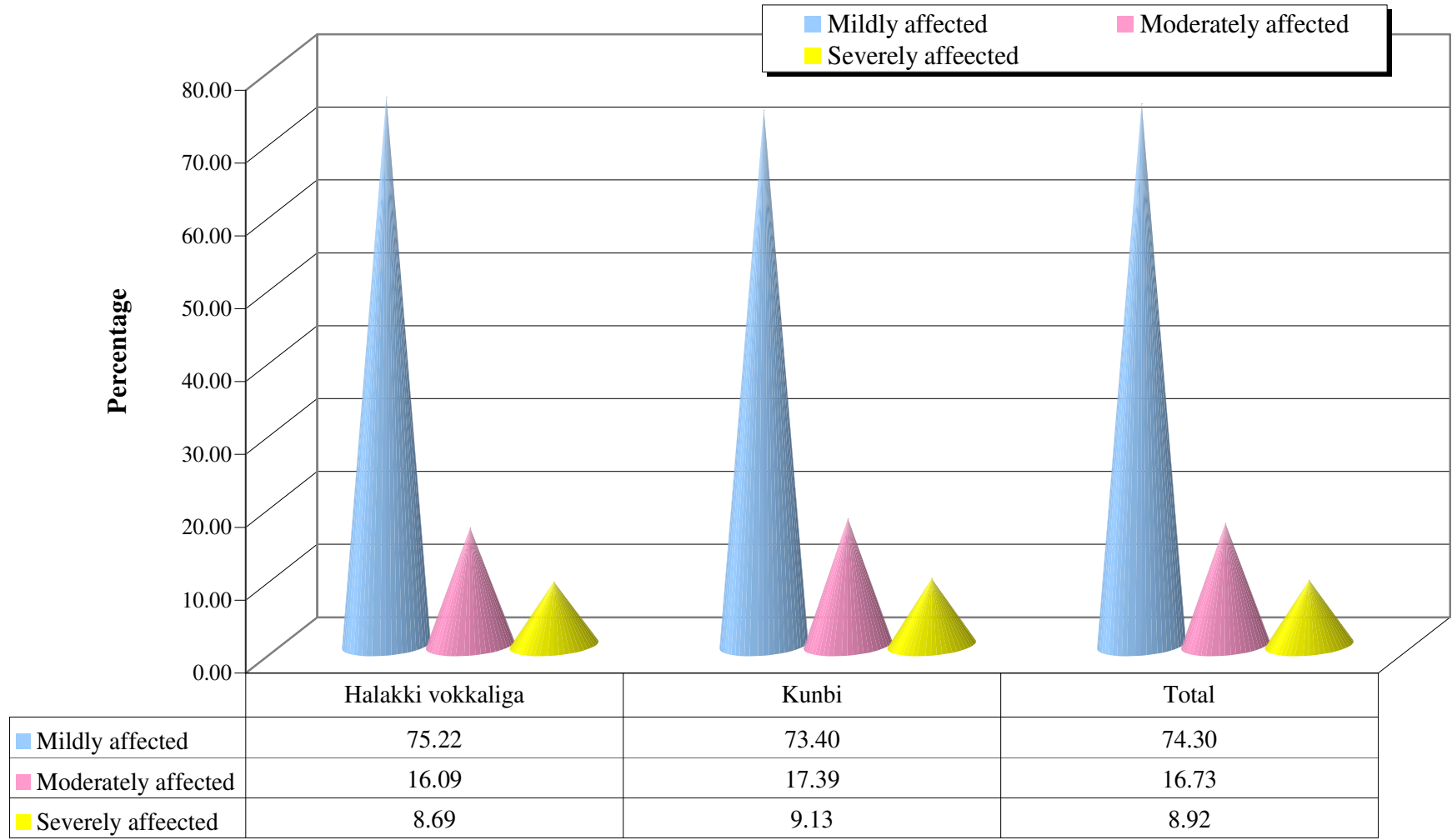


Fig. 2: Percentage distribution of health status of Halakki vokkaliga and Kunbi women in Uttara Kannada district

awareness was considered, among Halakki Vokkaliga women, 46.94 per cent were in medium level followed by 31.74 per cent in low and 21.30 per cent in high level. In Kunbi women, 42.60 per cent were in low level, 37.80 had medium level political awareness, 2 per cent were in medium level and 19.56 per cent were in high level of political awareness. With reference to participation in decision making, 44.78 per cent were in medium participation category followed more participation (30.00 %) and less participation (25.22 %). In Kunbi women the criteria was quite different where 41.30 per cent were in less participation category followed by 36.96 per cent in medium participation and 21.74 per cent exhibited more participation.

The results from table 4.2.2 describes the comparison of mean scores of empowerment status of Halakki Vokkaliga and Kunbi women. A significant difference (t value =5.99, $p < 0.01$) was observed between mean scores of empowerment status of Halakki Vokkaliga and Kunbi women, implying better empowerment status of Halakki Vokkaliga (29.53) women compared to Kunbi women (22.54).

Hence, the hypothesis stating that there is no significant difference between Halakki Vokkaliga and Kunbi women with respect to empowerment status is rejected.

Percentage distribution of general health status of Halakki Vokkaliga and Kunbi women is depicted in Fig 2. Among Halakki Vokkaliga women, majority (75.22 %) were mildly affected followed by moderately affected (16.09 %) and only 8.69 per cent were severely affected. Similar trend was observed in Kunbi women where, 73.40 per cent were mildly affected followed by moderately affected (17.39 %) and severely affected (9.13 %).

The findings from table 4.2.3 highlighted the results of comparison of mean scores of general health status of Halakki Vokkaliga and Kunbi women. There was no significant difference (t value= 0.67) observed between mean scores of health status however, mean scores of Halakki Vokkaliga (84.15) women was slightly high compared to Kunbi women (82.08) indicating slightly better health status among Halakki Vokkaliga women.

Consequently, the hypothesis stating that there is no significant difference between Halakki Vokkaliga and Kunbi women with respect to general status is accepted.

Fig 3 illustrates percentage distribution of reproductive health status among Halakki and Kunabi women. In Halakki Vokkaliga women, nearly sixty per cent (58.69 %) were having good reproductive health status followed by average level (25.66 %) and poor level

Table 4.2.2: Comparison of mean scores of empowerment status of Halakki Vokkaliga and Kunbi women in Uttara Kannada district

N=460

Empowerment Status	Halakki Vokkaliga women (n=230)		Kunbi women (n=230)		t-value
	Mean	SD	Mean	SD	
	29.53	11.07	22.54	10.60	

**Significant at 0.01 level

Table 4 2.3: Comparison of mean scores of health status of Halakki Vokkaliga and Kunbi women in Uttara Kannada district

N=460

Health status	Halakki Vokkaliga women (n=230)		Kunbi women (n=230)		t-value
	Mean	SD	Mean	SD	
	84.15	33.01	82.08	33.01	

NS-Non Significant

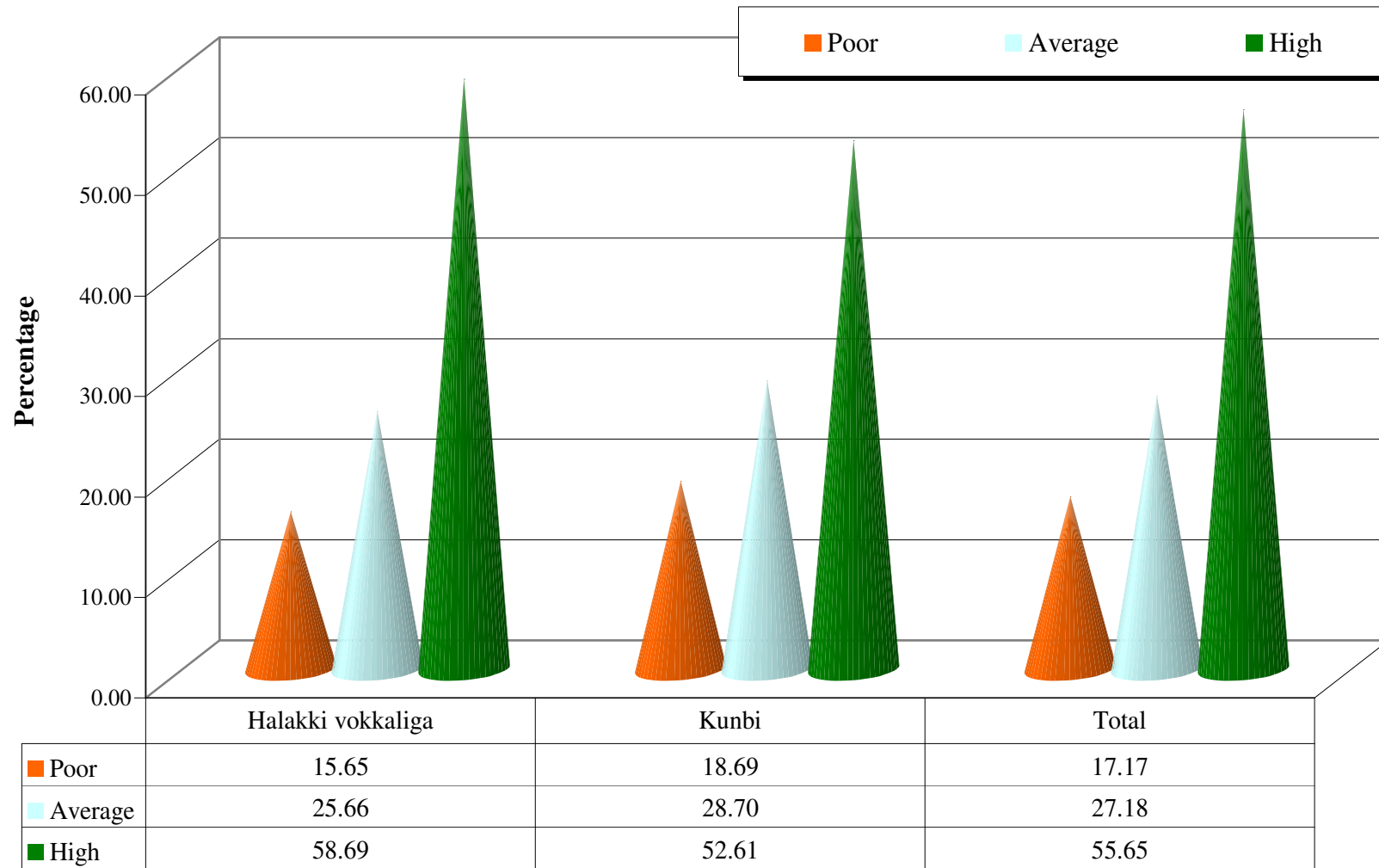


Fig. 3: Percentage distribution of reproductive health status of Halakki vokkaliga and Kunbi women in Uttara Kannada district

(15.65 %). Similar result trend was observed among Kunbi women where 52.61 per cent were having good reproductive health status followed by average level (28.70 %) and poor level (18.69 %).

Table 4.2.4 denoted the comparison of mean scores of reproductive health status of Halakki Vokkaliga and Kunbi women. Significant difference (t- value, $p < 0.05 = 2.48$) was observed between mean scores of reproductive health status of Halakki Vokkaliga and Kunbi women where reproductive health of Halakki Vokkaliga women (55.01) was better compared to Kunbi women (52.32).

Therefore, the hypothesis stating that there is no significant difference between Halakki Vokkaliga and Kunbi women with respect to reproductive status is rejected.

Percentage distribution of nutritional status of Halakki Vokkaliga and Kunbi women is represented in Table 4.2.5. Similar kind of results was observed with respect to body mass index (BMI) of Halakki Vokkaliga and Kunbi women. In Halakki Vokkaliga women, more than sixty per cent (63.05 %) were having ideal weight followed by underweight (22.60 %) and 14.35 per cent were found to be overweight. Among Kunbi women, 59.14 per cent were having ideal weight, 29.13 per cent were under weight and only 11.73 per cent were overweight. However, none of them were obese in both the communities. With regard to lean body mass index, among Halakki Vokkaliga women, more number (62.18 %) were in normal group followed by 25.22 per cent were underweight and 12.60 per cent were obese. In Kunbi women, 57.40 per cent had normal followed by underweight (32.60 %) and obese (10.00 %). Pertaining to waist to hip ratio, in Halakki Vokkaliga women more number (83.92 %) were normal and 16.08 per cent were having abdominal obesity. In Kunbi women also similar results was observed where, highest number (88.70 %) of women were normal and only 11.30 per cent were having abdominal obesity.

The comparison of mean scores of nutritional status of Halakki Vokkaliga and Kunbi women is presented in Table 4.2.6. Non-significant difference (t-value =1,73) was observed between Halakki Vokkaliga and Kunbi women with regard to body mass index where mean value of Halakki Vokkaliga women (21.55 kg/m^2) was slightly high in comparison with Kunbi women (20.01 kg/m^2). With reference to lean body mass index and waist to hip ratio also nosignificant difference (t-value=1.08 and t-value=1.39 respectively) was observed between Halakki Vokkaliga and Kunbi women.

Table 4.2.4: Comparison of mean scores of reproductive health status of Halakki Vokkaliga and Kunbi women in Uttara Kannada district

N=460

Reproductive Health status	Halakki Vokkaliga women n=230		Kunbi women n=230		t-value
	Mean	SD	Mean	SD	
		55.01	10.99	52.32	12.38

*Significant at 0.05 level

Table 4.2.5: Percentage distribution of nutritional status of Halakki Vokkaliga and Kunbi women in Uttara Kannada district

N=460

Nutritional status	Halakki Vokkaliga women (n=230)	Kunbi women (n=230)	Total (n=460)
Body Mass Index (BMI)			
Under weight (<18.5)	52 (22.60)	67 (29.13)	119 (25.87)
Ideal weight (18.5 -24.9)	145 (63.05)	136 (59.14)	281 (61.08)
Over weight (25-29.9)	33 (14.35)	27 (11.73)	60 (13.05)
Obese (>30)	-	-	-
Lean body mass index			
Underweight (>70 %)	58 (25.22)	75 (32.60)	133 (28.92)
Normal (70-90 %)	143 (62.18)	132 (57.40)	275 (59.78)
Obese (< 90 %)	29 (12.60)	23 (10.00)	52 (11.30)
Waist to Hip ratio			
Normal (<0.85)	193 (83.92)	204 (88.70)	397 (86.30)
Abdominal obesity (>0.85)	37 (16.08)	26 (11.30)	63 (13.70)

Figure in the parenthesis indicates percentage

Table 4.2.6: Comparison of mean scores of nutritional status of Halakki Vokkaliga and Kunbi women in Uttara Kannada district

N=460

Nutritional status	Halakki Vokkaliga women n=(230)		Kunbi women n=(230)		t-value
	Mean	SD	Mean	SD	
Body Mass Index (BMI)	21.55	2.94	20.01	2.76	1.73 ^{NS}
Lean body mass index	76.10	4.96	75.04	3.92	1.08 ^{NS}
Wait Hip ratio	0.76	0.61	0.75	0.44	1.39 ^{NS}

NS-Non significant

Thus, the hypothesis stating that there is no significant difference between Halakki Vokkaliga and Kunbi women with respect to nutritional status is accepted.

4.3 Association and comparison of individual and familial characteristics on empowerment and health status of Halakki Vokkaliga and Kunbi women

Results on association and comparison of individual and familial characteristics on empowerment and health status of Halakki Vokkaliga and Kunbi women was presented from table 4.3.1a to 4.3.4h.

4.3.1: Association and comparison of individual and familial variables on empowerment status of Halakki Vokkaliga and Kunbi women

Results of association and comparison of empowerment status and age of Halakki Vokkaliga and Kunbi women is presented in Table 4.3.1a. Among Halakki Vokkaliga women, there no significant association ($\chi^2=0.81$) was found between age and empowerment status of the respondents. In all the age groups i.e., 20-30 years, 30-40 years and 40-50 years more than forty per cent of the women were in medium level of empowerment status. With regard to difference between the mean scores, empowerment scores of 20-30 years was slightly higher compared to 30-40 years and 40-50 years. However, statistically no significant difference was found (F- value=1.58) implying similar empowerment status in both the communities with regard to age was observed.

In Kunbi women, in all the three age groups i.e., 20-30 years, 30-40 years and 40-50 years a greater number of women were found in low and medium level of empowerment status. In the age group of 40-50 years women, 44.90 per cent were in low empowerment status and less than twenty per cent (17.40 %) were in high empowerment status. However, both the association ($\chi^2=0.61$) and comparison (F value=0.39) of age with empowerment status was found non-significant.

Accordingly, the hypothesis stating that there is no influence of age on empowerment status of Halakki Vokkaliga and Kunbi women is accepted.

Table 4.3.1a: Association and comparison of empowerment status and age of Halakki Vokkaliga and Kunbi women

N=460

	Age (years)	Empowerment status			Total	χ^2	Mean \pm SD	F-value
		High	Medium	Low				
Halakki Vokkaliga Women (n=230)	20-30	20 (27.80)	33 (45.80)	19 (26.40)	72 (100.00)	0.81 ^{NS}	29.87 \pm 10.22	1.58 ^{NS}
	30-40	22 (27.50)	32 (40.00)	26 (32.50)	80 (100.00)		28.63 \pm 11.23	
	40-50	21 (26.90)	33 (42.30)	24 (30.80)	78 (100.00)		26.69 \pm 11.65	
	Total	63 (27.40)	98 (42.60)	69 (30.00)	230 (100.00)			
Kunbi Women (n=230)	20-30	17 (21.80)	30 (38.50)	31 (39.70)	78 (100.00)	0.61 ^{NS}	22.98 \pm 10.86	0.39 ^{NS}
	30-40	16 (19.30)	32 (38.60)	35 (42.20)	83 (100.00)		22.25 \pm 10.89	
	40-50	12 (17.40)	26 (37.70)	31 (44.90)	69 (100.00)		21.39 \pm 10.80	

Figure in the parenthesis indicates percentage

NS-Non Significant

Table 4.3.1b denotes the results of association and comparison of empowerment status and education of Halakki Vokkaliga and Kunbi women. Significant association ($\chi^2=14.33$) was observed between education and empowerment status of Halakki Vokkaliga women.

Among Halakki Vokkaliga women, more number of women with 10th class pass and more education were in high and medium level (more than 40 per cent) of empowerment status and women with less than 10th education and no schooling were higher in low empowerment status. However, none of the women with graduation level of education were in low empowerment status and none of women with no schooling were having high empowerment status. Comparison of mean scores of empowerment status and education was found to be significant (F value=7.51). Mean scores of women with more education had higher empowerment status compared to their counterparts. Women who were having less education and no schooling scored less. The post hoc (Tukey's HSD) shows, significant difference between the levels of education.

In Kunbi women more number of women with 10th class pass and more education were in high and medium level of empowerment status and women with less than 10th education and no schooling were higher in low empowerment status. However, none of the women with graduation level of education were in low empowerment status and none of the women with no schooling were having high empowerment status. Comparison of mean scores of empowerment status and education was found to be significant (F-value=9.65). Mean scores of women with more education was higher compared to their corresponding women. Women who were having less education and no schooling scored less. The post hoc (Tukey's HSD) value indicates significant difference between all the levels of education.

Hence, the hypothesis stating that there is no influence of education on empowerment status of Halakki Vokkaliga and Kunbi women is rejected.

Association and comparison of empowerment status and occupation of Halakki Vokkaliga and Kunbi women is illustrated in table 4.3.1c. Occupation categories were merged for the statistical analysis purpose and categorized as working and agriculture labourer/housewife. Chi square test revealed that there was significant association ($\chi^2=16.22$)

Table 4.3.1b: Association and comparison of empowerment status and education of Halakki Vokkaliga and Kunbi women

N=460

	Education	Empowerment status			Total	Modified χ^2	Mean \pm SD	F-value
		High	Medium	Low				
Halakki Vokkaliga Women (n=230)	Graduation	22 (81.48)	5 (18.52)	-	27 (100.00)	14.33**	29.41 \pm 10.21 ^a	7.51**
	10th class pass but <Graduation	23 (41.07)	23 (41.07)	10 (17.85)	56 (100.00)		26.54 \pm 11.24 ^b	
	Less than 10th	18 (14.28)	66 (52.38)	42 (33.32)	126 (100.00)		23.56 \pm 11.47 ^c	
		-	4 (19.05)	17 (80.95)	21 (100.00)		16.50 \pm 10.55 ^e	
	Total	63 (27.40)	98 (42.60)	69 (30.00)	230 (100.00)			
Kunbi Women (n=230)	Graduation	9 (81.82)	2 (18.18)	-	11 (100.00)	17.54**	29.11 \pm 10.01 ^{ab}	9.65**
	10th class pass but <Graduation	18 (58.06)	9 (29.04)	4 (12.90)	31 (100.00)		27.04 \pm 11.04 ^{ba}	
	Less than 10th	18 (11.18)	67 (41.62)	76 (47.20)	161 (100.00)		23.06 \pm 10.54 ^c	
	No schooling	-	10 (37.04)	17 (62.96)	27 (100.00)		16.71 \pm 10.40 ^d	
	Total	45 (19.60)	88 (38.30)	97 (42.20)	230 (100.00)			

Figure in the parenthesis indicates percentage

**Significant at 0.01 level

Table 4.3.1c: Association and comparison of empowerment status and occupation of Halakki Vokkaliga and Kunbi women

N=460

	Occupation	Empowerment status			Total	χ^2	Mean±SD	t-value
		High	Medium	Low				
Halakki Vokkaliga Women (n=230)	Working	26 (65.00)	14 (35.00)	-	40 (100.00)	16.22**	34.75±6.22	7.24**
	Agriculture labourer/housewife	37 (19.50)	84 (44.20)	69 (36.30)	190 (100.00)		25.96±10.40	
	Total	63 (27.40)	98 (42.60)	69 (30.00)	230 (100.00)			
Kunbi Women (n=230)	Working	19 (70.40)	8 (29.60)	-	27 (100.00)	13.85**	32.48±4.53	5.01**
	Agriculture labourer/housewife	26 (12.80)	80 (39.40)	97 (47.80)	203 (100.00)		21.95±9.23	
	Total	45 (19.60)	88 (38.30)	97 (42.20)	230 (100.00)			

Figure in the parenthesis indicates percentage

**Significant at 0.01 level

observed between working and agriculture labourer/housewife Halakki Vokkaliga women, in that, none of the working women were in low empowerment status. t-test also revealed highly significant (t value=7.24) difference between working and agriculture labourer/housewife related to empowerment scores. Mean empowerment scores of working women (34.75 ± 6.22) was higher compared to non- working women (25.96 ± 10.40).

Similar findings were also obtained in Kunbi women, where majority of the working women were in high empowerment status and no one in low empowerment status. Association was found to be highly significant ($\chi^2=13.85$). Comparison of mean scores was also highly significant (t value=5.01), where working women scores was significantly higher (32.48 ± 4.53) compared to agriculture labourer/housewife women (21.95 ± 9.23) implying high empowerment among working women.

Hence, the hypothesis stating that there is no influence of occupation on empowerment status of Halakki Vokkaliga and Kunbi women is rejected.

Association and comparison empowerment status and type of family of Halakki Vokkaliga and Kunbi women is presented table 4.1.3d. Among Halakki Vokkaliga women, more percentage of women belonged to nuclear type of families, were more in high and medium (more than thirty per cent) empowerment status but in joint and extended families, women were found in lesser percentage (less than 20 per cent) in high empowerment status category. However, the result was found to be non-significant for type of family and empowerment status. Conversely, the result was found to be significant (F value=3.79) for comparison of mean scores of types of family and empowerment status. Empowerment mean scores of nuclear family women was high compared to joint and extended families. The post hoc (Tukey's HSD) value implies that, there was significant difference observed between nuclear, joint and extended families.

In Kunbi women, with respect to nuclear families, a greater number of women belonged to high and low empowerment status. With regard to joint and extended families, percentage of women with high empowerment status was low. The result were found to be non- significant for association between type of family and empowerment status, on the other hand, comparison of mean scores showed significant results (F value=2.78). Empowerment mean scores of women from nuclear families was high and the post hoc (Tukey's HSD) value also indicates significant difference between nuclear with joint and extended families in both

Table 4.3.1d: Association and comparison of empowerment status and type of family of Halakki Vokkaliga and Kunbi women

N=460

	Type of family	Empowerment status			Total	χ^2	Mean±SD	F-value
		High	Medium	Low				
Halakki Vokkaliga Women (n=230)	Nuclear	48 (34.50)	54 (38.80)	37 (26.60)	139 (100.00)	6.14 ^{NS}	28.92±11.27 ^a	3.79 ^{**}
	Joint	6 (15.00)	20 (50.00)	14 (35.00)	40 (100.00)		23.98±10.44 ^{bc}	
	Extended	9 (17.60)	24 (47.10)	18 (35.30)	51 (100.00)		23.33±11.93 ^{cb}	
	Total	63 (27.40)	98 (42.60)	69 (30.00)	230 (100.00)			
Kunbi Women (n=230)	Nuclear	29 (23.60)	49 (39.80)	45 (36.60)	123 (100.00)	6.03 ^{NS}	23.57±11.02 ^a	2.78 ^{**}
	Joint	6 (12.80)	14 (29.80)	27 (57.40)	47 (100.00)		20.06±10.33 ^{bc}	
	Extended	10 (16.70)	25 (41.70)	25 (41.70)	60 (100.00)		21.21±10.58 ^{cb}	
	Total	45 (19.60)	88 (38.30)	97 (42.20)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

^{**}Significant at 0.01 level

the communities. No difference was observed between joint and extended families depicting better empowerment status among women in nuclear families.

Therefore, the hypothesis stating that there is no influence of type of family on empowerment status of Halakki Vokkaliga and Kunbi women is rejected.

Table 4.3.1e characterizes the association and comparison of empowerment status and socio-economic status of Halakki Vokkaliga and Kunbi women. Among Halakki Vokkaliga women, those who were from upper middle and lower middle SES families were more number in high and medium empowerment status and poor and very poor SES families were in low empowerment status. Significant association found between SES and empowerment status ($\chi^2=17.24$). The comparison of mean scores between social economic status and empowerment status showed significant (F value=5.52) results where the women from upper middle socioeconomic status scored higher compared to the women from poor and very poor socio economic status. The post hoc (Tukey's HSD) value also showed significant difference between upper middle lower middle, poor and very poor socio-economic status.

With regard to Kunbi women, there were more number of women belonged to the middle and upper middle socio economic status were in high and medium empowerment status compared to poor and very poor socio economics status. Comparatively higher percentage of poor and very poor socio economic status women were in low empowerment status. Association found to be significant for socio economic status and empowerment status ($\chi^2=18.56$). The comparison of mean scores also showed significant result where women from upper middle social economic status where better were scored higher compared to women from poor and very poor socio-economic status. The same trend has been observed for Kunbi women also where the post hoc (Tukey's HSD) value showed significant difference between upper middle, lower middle, poor and very poor socio-economic status with empowerment status.

As a result, the hypothesis stating that there is no influence of socio-economic status on empowerment status of Halakki Vokkaliga and Kunbi women is rejected.

Association and comparison of empowerment status and number of family members of Halakki Vokkaliga and Kunbi women is shown in table 4.3.1f. Among Halakki Vokkaliga women there was no significant result found between type of family and empowerment status. The chi-square result was found to be non-significant ($\chi^2=7.60$). Whereas the difference

Table 4.3.1e: Association and comparison of empowerment status and socio-economic status of Halakki Vokkaliga and Kunbi women

N=460								
	Socio-economic status	Empowerment status			Total	Modified χ^2	Mean±SD	F-value
		High	Medium	Low				
Halakki Vokkaliga Women (n=230)	Upper middle	20 (66.67)	8 (26.66)	2 (6.67)	30 (100.00)	17.24 **	32.21±10.01 ^a	5.52**
	Lower middle	35 (40.69)	34 (39.53)	17 (19.76)	86 (100.00)		28.01±9.22 ^b	
	Poor	8 (8.51)	50 (5.30)	36 (38.29)	94 (100.00)		24.13±7.24 ^c	
	Very poor	-	6 (30.00)	14 (70.00)	20 (100.00)		21.52±12.94 ^d	
	Total	63 (27.40)	98 (42.60)	69 (30.00)	230 (100.00)			
Kunbi Women (n=230)	Upper middle	9 (69.24)	4 (30.76)	-	13 (5.66)	18.56**	33.21±10.31 ^a	6.11**
	Lower middle	30 (43.48)	14 (20.28)	25 (36.24)	69 (100.00)		26.01±9.22 ^b	
	Poor	6 (5.90)	48 (47.05)	48 (47.05)	102 (100.00)		24.18±9.24 ^{cd}	
	Very poor	-	22 (47.82)	24 (52.18)	46 (100.00)		22.26±12.49 ^{dc}	
	Total	45 (19.60)	88 (38.30)	97 (42.20)	230 (100.00)			

Figure in the parenthesis indicates percentage

**Significant at 0.01 level

Table 4.3.1f: Association and comparison of empowerment status and number of family members of Halakki Vokkaliga and Kunbi women

N=460

	No. of family members	Empowerment status			Total	χ^2	Mean±SD	F-value
		High	Medium	Low				
Halakki Vokkaliga Women (n=230)	1-5	31 (27.20)	47 (41.20)	36 (31.60)	114 (100.00)	7.60 ^{NS}	28.92±11.27 ^{ac}	2.79*
	6-10	26 (28.30)	45 (48.90)	21 (22.80)	92 (100.00)		28.98±10.44 ^{bc}	
	More than 10	6 (25.00)	6 (25.00)	12 (50.00)	24 (100.00)		23.33±11.93 ^c	
	Total	63 (27.40)	98 (42.60)	69 (30.00)	230 (100.00)			
Kunbi Women (n=230)	1-5	20 (23.30)	30 (34.90)	36 (41.90)	86 (100.00)	5.05 ^{NS}	23.06±10.83	1.37 ^{NS}
	6-10	20 (17.50)	50 (43.90)	44 (38.60)	114 (100.00)		22.39±10.57	
	More than 10	5 (16.70)	8 (26.70)	17 (56.70)	30 (100.00)		19.30±11.61	
	Total	45 (19.60)	88 (38.30)	97 (42.20)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

*Significant at 0.05 level

between the means scores showed significant difference (F value=2.79) where women having 1 to 5 family members and 6 to 10 family members were better compared to the women who are having more than 10 family members. The post hoc (Tukey's HSD) value also showed significant difference between 1 to 5 and 6 to 10 with more than 10 family members. This implies that women with less number of family members scored better compared to more number of family members.

Among Kunbi women, there was no significant association ($\chi^2=5.05$) and difference found between empowerment status and number of family members.

As a result, the hypothesis stating that there is no influence of number of family members on empowerment status of Halakki Vokkaliga is rejected however it is accepted for Kunbi women.

Table 4.3.1g describes the association and comparison of empowerment status and husband's education of Halakki Vokkaliga and Kunbi women. With respect to Halakki Vokkaliga, women whose husband's had higher education i.e., 10th class pass and more were in high and medium level of empowerment status and women whose husbands were having lower education i.e., less than 10th were in low empowerment status. There was significant association ($\chi^2=13.21$) between husband's education and empowerment status. Comparison of mean score also showed significant difference (F-value= 3.56) where those women husband's having higher education were scored more compare to their counterparts. Tukey's value showed significant difference between education levels of the husband and women empowerment status.

In terms of Kunbi women who were having husbands with higher education—those who had completed at least the 10th grade - were in high and medium levels of empowerment, while those whose husbands had less education i.e. less than 10th and no schooling were in low levels. The empowerment status and the husband's education were found to be significantly associated ($\chi^2=15.46$). Comparison of the means also revealed a significant difference (F-value= 3.87), with better scores for the women whose husbands have more education. Significant differences between the husband's educational level and the wife's level of empowerment were revealed by the Post hoc (Tukey's HSD) test.

As a result, the hypothesis stating that there is no influence of husband's education on empowerment status of Halakki Vokkaliga and Kunbi women is rejected.

Table 4.3.1g: Association and comparison of empowerment status and husband's education of Halakki Vokkaliga and Kunbi women

N=460

	Husband's education	Empowerment status			Total	Modified χ^2	Mean \pm SD	F-value
		High	Medium	Low				
Halakki Vokkaliga Women (n=230)	Graduation	25 (59.52)	13 (30.95)	4 (9.53)	42 (100.00)	13.21*	30.33 \pm 13.33 ^a	3.56*
	10th class pass but <Graduation	18 (32.72)	28 (50.90)	9 (16.36)	55 (100.00)		28.54 \pm 10.22 ^b	
	Less than 10th	18 (15.12)	51 (42.85)	50 (42.01)	119 (100.00)		25.51 \pm 10.10 ^c	
	No schooling	2 (14.28)	6 (42.86)	6 (42.86)	14 (100.00)		20.11 \pm 12.54 ^d	
	Total	63 (27.40)	98 (42.60)	69 (30.00)	230 (100.00)			
Kunbi Women (n=230)	Graduation	8 (53.33)	5 (33.33)	2 (13.34)	15 (100.00)	15.46*	30.43 \pm 12.36 ^a	3.87*
	10th class pass but <Graduation	13 (23.63)	26 (47.27)	14 (25.45)	55 (100.00)		28.14 \pm 10.23 ^b	
	Less than 10th	23 (17.16)	43 (32.08)	68 (50.74)	134 (100.00)		25.79 \pm 10.04 ^c	
	No schooling	1 (3.84)	13 (50.00)	12 (46.16)	26 (100.00)		21.25 \pm 10.07 ^d	
	Total	45 (19.60)	88 (38.30)	97 (42.20)	230 (100.00)			

Figure in the parenthesis indicates percentage

*Significant at 0.05 level

Table 4.3.1h denotes association and comparison of empowerment status and husband's occupation of Halakki Vokkaliga and Kunbi women. Among Halakki Vokkaliga women, women whose husbands were working were higher number in high and medium empowerment status and women whose husbands were non-working were higher percentage in low and medium empowerment status. There was significant association ($\chi^2=21.14$) found between empowerment status and husband's occupation. Difference between the mean scores also found to be significant (t-value=6.52) in that, mean scores of women whose husbands were working was high compare to other groups.

Consider to Kunbi women, women with working husbands were more prevalent in the high and medium levels of empowerment, whereas those with non-working husbands were more prevalent in the low and medium levels. The husband's work and empowerment status were found to be significantly associated ($\chi^2=19.24$). The difference in the mean scores was also significant (t-value=5.54) in that the mean scores of women whose husbands worked were higher than those of other groups.

As a result, the hypothesis stating that there is no influence of husband's occupation on empowerment status of Halakki Vokkaliga and Kunbi women is rejected.

4.3.2: Association and comparison of individual and familial variables on general health status of Halakki Vokkaliga and Kunbi women

Results of association and comparison of general health status and age of Halakki Vokkaliga and Kunbi women is presented in Table 4.3.2a. Among Halakki Vokkaliga women, there was no significant association ($\chi^2=0.81$) was found between age and health status of the respondents. In all the age groups i.e., 20-30 years, 30-40 years and 40-50 years more than seventy per cent of the women were in mildly affected health status. With regard to difference between the mean scores, health scores of 20-30 years was better compared to 30-40 years and 40-50 years. However, the difference was not found significant (F value=1.41).

In Kunbi women, in all the three age groups i.e., 20-30 years, 30-40 years and 40-50 years majority of women were found in mildly affected health status. The association ($\chi^2=1.93$) and comparison of mean scores of the age with general health status were found non-significant (F value=1.08) indicating no influence of age on health status of women.

Thus, the hypothesis stating that there is no influence of age on general health status of Halakki Vokkaliga and Kunbi women is accepted.

Table 4.3.1h: Association and comparison of empowerment status and husband's occupation of Halakki Vokkaliga and Kunbi women**N=460**

	Husband's occupation	Empowerment status			Total	χ^2	Mean±SD	t-value
		High	Medium	Low				
Halakki Vokkaliga Women (n=230)	Working	24 (32.43)	34 (45.94)	16 (21.62)	74 (100.00)	21.14**	31.11±12.35	6.52**
	Non-working	39 (25.00)	64 (41.02)	53 (33.97)	156 (100.00)		23.17±14.25	
	Total	63 (27.40)	98 (42.60)	69 (30.00)	230 (100.00)			
Kunbi Women (n=230)	Working	34 (60.71)	16 (28.57)	6 (10.71)	56 (100.00)	19.24**	29.51±12.67	5.54*
	Non-working	11 (6.33)	72 (41.37)	91 (52.30)	174 (100.00)		22.17±15.25	
	Total	45 (19.60)	88 (38.30)	97 (42.20)	230 (100.00)			

Figure in the parenthesis indicates percentage

**Significant at 0.01 level

Table 4.3.2a: Association and comparison of general health status and age of Halakki Vokkaliga and Kunbi women**N=460**

	Age (years)	Health status			Total	χ^2	Mean \pm SD	F-value
		Mildly affected	Moderately affected	Severely affected				
Halakki Vokkaliga Women (n=230)	20-30	58 (80.60)	9 (12.50)	5 (6.90)	72 (100.00)	2.87 ^{NS}	76.68 \pm 30.68	1.41 ^{NS}
	31-40	58 (72.50)	16 (20.00)	6 (7.50)	80 (100.00)		84.41 \pm 32.72	
	41-50	57 (73.10)	12 (15.40)	9 (11.50)	78 (100.00)		84.69 \pm 35.14	
	Total	173 (75.20)	37 (16.10)	20 (8.70)	230 (100.00)			
Kunbi Women (n=230)	20-30	60 (76.90)	11 (14.10)	7 (9.00)	78 (100.00)	1.93 ^{NS}	80.20 \pm 33.17	1.08 ^{NS}
	31-40	60 (72.30)	17 (20.50)	6 (7.20)	83 (100.00)		84.43 \pm 32.81	
	41-50	49 (71.00)	12 (17.40)	8 (11.60)	69 (100.00)		88.27 \pm 34.04	
	Total	169 (73.50)	40 (17.40)	21 (9.10)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

Table 4.3.2b symbolizes the results of association and comparison of general health status and education of Halakki Vokkaliga and Kunbi women. Significant association ($\chi^2=16.42$) was observed between education and health status of Halakki Vokkaliga women. Among Halakki Vokkaliga women a higher number of women with 10th class pass and more education were in mildly and moderately affected health status and women with less than 10th education and no schooling. Comparison of mean scores of health status and education found to be significant (F -value= 4.51). Mean health scores of women with more education was better compared to their counterparts. Women who were having less than 10th education and no schooling scored less. The post hoc (Tukey's HSD) value implies significant difference between all the levels of education.

In Kunbi women majority of women with 10th class pass and more education were in mildly and moderately affected health status and women with less than 10th education and no schooling were higher in severely affected health status. Comparison of mean scores of health status and education were found to be significant (F-value=5.01). Women with higher education scored better in health, compared to their counterparts. Women who were having less than 10th education and no schooling were not good in health status. The post hoc (Tukey's HSD) value indicates significant difference between the levels of education.

As a result, the hypothesis stating that there is no influence of education on general health status of Halakki Vokkaliga and Kunbi women is rejected.

Association and comparison of general health and occupation of Halakki Vokkaliga and Kunbi women is illustrated in table 4.3.2c. Occupation categories were merged for the statistical analysis purpose and categorized as working and agriculture labourer/housewife. Chi square test revealed that there was significant association ($\chi^2=15.95$) observed between working and agriculture laborer/housewife Halakki Vokkaliga women and .t-test also revealed highly significant (t value=9.18) difference between working and agriculture labourer/housewife related to health scores. Mean health scores of working women (86.64 ± 34.39) was higher compared to agriculture laborer/housewife women (72.45 ± 39.34). Similar findings also obtained in Kunbi women, association found to be highly significant ($\chi^2=11.04$). Comparison of mean scores was also highly significant (t value=8.92), where working women scores was significantly higher (86.21 ± 34.63) compared to agriculture labourer/housewife women (71.62 ± 32.80).

Table 4.3.2b: Association and comparison of general health status and education of Halakki Vokkaliga and Kunbi women**N=460**

	Education	Health status			Total	Modified χ^2	Mean \pm SD	F-value
		Mildly affected	Moderately affected	Severely Affected				
Halakki Vokkaliga Women (n=230)	Graduation	16 (59.26)	6 (22.22)	5 (18.52)	27 (100.00)	6.42 ^{NS}	81.68 \pm 30.68 ^a	4.51*
	10 th class pass but <Graduation	43 (76.79)	8 (14.29)	5 (8.92)	56 (100.00)		91.20 \pm 33.17 ^b	
	Less than 10 th	110 (87.30)	12 (9.52)	4 (3.18)	126 (100.00)		102.20 \pm 33.17 ^c	
	No schooling	4 (19.04)	11 (52.38)	6 (28.57)	21 (100.00)		122.24 \pm 32.14 ^d	
	Total	173 (75.20)	37 (16.10)	20 (8.70)	230 (100.00)			
Kunbi Women (n=230)	Graduation	4 (36.36)	3 (27.28)	4 (36.36)	11 (100.00)	7.5 ^{NS}	.88 \pm 31.68 ^a	5.01*
	10 th class pass but <Graduation	14 (45.16)	13 (41.94)	4 (12.90)	31 (100.00)		72.20 \pm 32.17 ^b	
	Less than 10 th	143 (88.82)	12 (7.46)	6 (3.72)	161 (100.00)		80.875 \pm 30.25 ^{cd}	
	No schooling	8 (29.63)	12 (44.44)	7 (25.93)	27 (100.00)		88.54 \pm 34.14 ^d	
	Total	169 (73.50)	40 (17.40)	21 (9.10)	230 (100.00)			

Figure in the parenthesis indicates percentage

*Significant at 0.05 level

**Significant at 0.01 level

Table 4.3.2c: Association and comparison of general health status and occupation of Halakki Vokkaliga and Kunbi women**N=460**

	Occupation	Health status			Total	Modified χ^2	Mean \pm SD	t-value
		Mildly affected	Moderately affected	Severely affected				
Halakki Vokkaliga Women (n=230)	Working	30 (75.00)	5 (12.50)	5 (12.50)	40 (100.0)	15.95**	86.64 \pm 34.39	9.18**
	Agriculture laborer/housewife	143 (75.26)	32 (16.84)	15 (7.90)	190 (100.00)		72.45 \pm 39.34	
	Total	173 (75.20)	37 (16.10)	20 (8.70)	230 (100.00)			
Kunbi Women (n=230)	Working	20 (74.07)	5 (18.52)	2 (7.41)	27 (100.00)	11.04**	86.21 \pm 34.63	8.92**
	Agriculture laborer/housewife	149 (73.40)	35 (17.25)	19 (9.35)	203 (100.00)		71.62 \pm 32.80	
	Total	169 (73.50)	40 (17.40)	21 (9.10)	230 (100.00)			

Figure in the parenthesis indicates percentage

**Significant at 0.01 level

Consequently, the hypothesis stating that there is no influence of occupation on general health status of Halakki Vokkaliga and Kunbi women is rejected.

Association and comparison of general health status and type of family of Halakki Vokkaliga and Kunbi women is presented table 4.3.2d. Among Halakki Vokkaliga women, result found to be non-significant for type of family and health status and the comparison of mean scores also non-significant. In Kunbi women also the same trend was followed where non-significant association and difference found between type of family and health status was observed.

Therefore, the hypothesis stating that there is no influence of type of family on general health status of Halakki Vokkaliga and Kunbi women is accepted.

Table 4.3.2e characterizes the association and comparison of general health status and socio-economic status of Halakki Vokkaliga and Kunbi women. Among Halakki Vokkaliga women, those who were from upper middle and lower middle SES families were observed more in mildly affected and moderately affected health status whereas poor and very poor SES families were in severely affected health status. Significant association was found between SES and health status ($\chi^2=18.22$). The comparison of mean scores between social economic status and health status showed significant (t-value=4.84) where the women from upper middle socioeconomic status scored were having better health score compared to the women from poor and very poor socio-economic status. The post hoc (Tukey's HSD) value also showed significant difference between upper middle poor and very poor socio-economic status.

With regard to Kunbi women, high number of women belonged to the middle and upper middle socio-economic status were in mildly affected and moderately affected health status compared to poor and very poor socio economics status. Higher percentage of poor and very poor socio-economic status women were severely affected. Association was found to be significant for socio-economic status and health status ($\chi^2=18.56$). The comparison of mean scores also showed significant result where women from upper middle social economic status where better scored higher compared to women from poor and very poor socio-economic status. The same trend has been observed for Kunbi women also where the post hoc (Tukey's HSD) value showed significant difference between upper middle, poor and very poor socio-economic status with general health status.

Table 4.3.2d: Association and comparison of general health status and type of family of Halakki Vokkaliga and Kunbi women

N=460

	Type of family	Health status			Total	χ^2	Mean \pm SD	F-value
		Mildly affected	Moderately affected	Severely Affected				
Halakki Vokkaliga Women (n=230)	Nuclear	110 (79.10)	21 (15.10)	8 (5.80)	139 (100.00)	4.99 ^{NS}	80.74 \pm 30.59	2.29 ^{NS}
	Joint	28 (70.00)	6 (15.00)	6 (15.00)	40 (100.00)		77.90 \pm 31.78	
	Extended	35 (68.60)	10 (19.60)	6 (11.80)	51 (100.00)		79.75 \pm 43.15	
	Total	173 (75.20)	37 (16.10)	20 (8.70)	230 (100.00)			
Kunbi Women (n=230)	Nuclear	96 (78.00)	20 (16.30)	7 (5.70)	123 (100.00)	5.98 ^{NS}	88.83 \pm 28.83	2.10 ^{NS}
	Joint	31 (66.00)	8 (17.00)	8 (17.00)	47 (100.00)		85.15 \pm 33.30	
	Extended	42 (70.00)	12 (20.00)	6 (10.00)	60 (100.00)		83.98 \pm 31.30	
	Total	169 (73.50)	40 (17.40)	21 (9.10)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

Table 4.3.2e: Association and comparison of general health status and socio-economic status of Halakki Vokkaliga and Kunbi women

N=460

	Socio-economic status	Health status			Total	Modified χ^2	Mean \pm SD	F-value
		Mildly affected	Moderately affected	Severely Affected				
Halakki Vokkaliga Women (n=230)	Upper middle	21 (70.00)	7 (23.34)	2 (6.67)	30 (100.00)	18.22**	72.45 \pm 19.34 ^{acd}	4.84*
	Lower middle	73 (84.88)	9 (10.46)	4 (4.66)	86 (100.00)		76.64 \pm 30.59 ^{bd}	
	Poor	72 (76.60)	11 (11.70)	11 (11.70)	94 (100.00)		82.98 \pm 31.54 ^{ca}	
	Very poor	7 (35.00)	10 (50.00)	3 (15.00)	20 (100.00)		93.15 \pm 33.80 ^{da}	
	Total	173 (75.20)	37 (16.10)	20 (8.70)	230 (100.00)			
Kunbi Women (n=230)	Upper middle	9 (69.23)	2 (15.38)	1 (7.69)	13 (100.00)	18.56**	71.58 \pm 25.78 ^{acd}	4.36*
	Lower middle	55 (79.72)	10 (14.49)	4 (5.79)	69 (100.00)		75.98 \pm 32.87 ^{bd}	
	Poor	69 (67.64)	19 (18.63)	14 (13.73)	102 (100.00)		81.25 \pm 30.28 ^{ca}	
	Very poor	35 (76.09)	9 (19.56)	2 (4.35)	46 (100.00)		93.25 \pm 32.14 ^{dba}	
	Total	169 (73.50)	40 (17.40)	21 (9.10)	230 (100.00)			

Figure in the parenthesis indicates percentage

*Significant at 0.05 level

**Significant at 0.01 level

Hence, the hypothesis stating that there is no influence of socio-economic status and general health status of Halakki Vokkaliga and Kunbi women is rejected.

Association and comparison of general health status and number of family members of Halakki Vokkaliga and Kunbi women shown in table 4.3.2f. Among Halakki Vokkaliga women there was significant association ($\chi^2=9.74$) found between type of family and general health status. The difference between the means scores also showed significant result (F value=4.29) where women having 1 to 5 family members had better health status compared to the women who were having more than 10 family members. The post hoc (Tukey's HSD) value also showed significant difference between 1 to 5 family members and more than 10 family members. Among Kunbi women, there was no significant association found whereas the difference between health status and number of family members was found significant (F-value=4.09) at all levels indicating smaller the family size better the health status.

So, the hypothesis stating that there is no influence of number of family members on general health status of Halakki Vokkaliga and Kunbi women is rejected.

Table 4.3.2g describes the association and comparison of general health status and husband's education of Halakki Vokkaliga and Kunbi women. With respect to Halakki Vokkaliga, women whose husband's had higher education i.e., 10th class pass and more were in mildly and moderately affect general health status and women whose husbands were having lower education i.e., less than 10th were in severely affected general health status. There was si no significant association ($\chi^2=6.42$) between husband's education and general health status. However, comparison of mean scores showed significant difference (F-value= 4.51) where those women husband's having higher education were scored more compare to their counterparts. Post hoc values (Tukey's HSD) value showed significant difference between education levels of the husband and women general health status. This implies husband's higher education level linked with better health status of women participants.

In terms of Kunbi women who were having husbands with higher education—those who had completed at least the 10th grade—were in mildly affected and moderately affected general health, while those whose husbands had less education i.e. less than 10th and no schooling were in severely affected level. The general health status and the husband's education were not significantly associated ($\chi^2=5.71$). Comparison of the means revealed a significant difference (F-value= 5.01), with better health for the women whose husbands have

Table 4.3.2f: Association and comparison of health status and number of family members of Halakki Vokkaliga and Kunbi women

N=460

	No. of family members	Health status			Total	Modified χ^2	Mean \pm SD	F-value
		Mildly affected	Moderately affected	Severely affected				
Halakki Vokkaliga Women (n=230)	1-5	85 (74.60)	21 (18.40)	8 (7.00)	114 (100.00)	9.74*	77.90 \pm 31.78 ^a	4.29**
	6-10	75 (81.50)	9 (9.80)	8 (8.70)	92 (100.00)		81.74 \pm 30.59 ^b	
	More than 10	13 (54.20)	7 (29.20)	4 (16.70)	24 (100.00)		89.75 \pm 34.15 ^c	
	Total	173 (75.20)	37 (16.10)	20 (8.70)	230 (100.00)			
Kunbi Women (n=230)	1-5	59 (68.60)	17 (19.80)	10 (11.60)	86 (100.00)	7.73 ^{NS}	76.40 \pm 34.42 ^a	4.09*
	6-10	92 (80.70)	14 (12.30)	8 (7.00)	114 (100.00)		82.20 \pm 29.91 ^b	
	More than 10	18 (60.00)	9 (30.00)	3 (10.00)	30 (100.00)		85.56 \pm 38.62 ^c	
	Total	169 (73.50)	40 (17.40)	21 (9.10)	230 (100.00)			

Figure in the parenthesis indicates percentage

*Significant at 0.05 level

**Significant at 0.01 level

NS-Non Significant

Table 4.3.2g: Association and comparison of general health status and husband's education of Halakki Vokkaliga and Kunbi women

N=460

	Husband's education	Health status			Total	Modified χ^2	Mean±SD	F-value
		Mildly affected	Moderately affected	Severely Affected				
Halakki Vokkaliga Women (n=230)	Graduation	22 (52.38)	15 (35.72)	5 (11.90)	42 (100.00)	6.42 ^{NS}	86.68±50.68 ^a	4.51*
	10 th class pass but <Graduation	44 (80.00)	7 (12.72)	4 (7.28)	55 (100.00)		92.20 ±43.17 ^b	
	Less than 10 th	103 (86.56)	9 (7.56)	7 (5.88)	119 (100.00)		100.20±3.17 ^c	
	No schooling	4 (28.57)	6 (42.86)	4 (27.57)	14 (100.00)		114.24±32.14 ^d	
	Total	173 (75.20)	37 (16.10)	20 (8.70)	230 (100.00)			
Kunbi Women (n=230)	Graduation	8 (53.33)	4 (26.67)	3 (20.00)	15 (100.00)	5.71 ^{NS}	87.88±31.68 ^a	5.01*
	10 th class pass but <Graduation	37 (67.27)	14 (25.46)	4 (7.27)	55 (100.00)		92.38 ±32.16 ^b	
	Less than 10 th	111 (82.83)	15 (11.19)	8 (5.97)	134 (100.00)		100.87±30.25 ^c	
	No schooling	13 (50.00)	7 (26.92)	6 (23.08)	26 (100.00)		116.54±34.14 ^d	
	Total	169 (73.50)	40 (17.40)	21 (9.10)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

*Significant at 0.05 level

more education. Significant differences between the husband's educational level and the wife's level of empowerment were revealed by the Post hoc (Tukey's HSD) test.

Table 4.3.2h denotes association and comparison of general health status and husband's occupation of Halakki Vokkaliga and Kunbi women. Among Halakki Vokkaliga women, there was no significant association ($\chi^2=5.95$) found between general health status and husband's occupation. Difference between the mean scores also found to be significant (t-value=9.18) in that, mean scores of women whose husbands were working was having less scores implies better health status compare to other group. Consider to Kunbi women, association found ($\chi^2=4.01$). The difference in the mean scores was also significant (t-value=8.92) in that the mean scores of women whose husbands worked were higher than those of other groups. As a result, the hypothesis stating that there is no influence of husband's occupation on general health status of Halakki Vokkaliga and Kunbi women is rejected.

4.3.3: Association and comparison of individual and familial variables on reproductive health status of Halakki Vokkaliga and Kunbi women

Results of association and comparison of reproductive health status and age of Halakki Vokkaliga and Kunbi women was presented in Table 4.3.3a. Among Halakki Vokkaliga women, there was no significant association ($\chi^2=0.60$) found between age and reproductive health of the respondents. In all the age groups i.e. 20-30 years, 30-40 years and 40-50 years more than fifty per cent of the women were in good reproductive health status. With regard to mean scores comparison, there was no significant difference observed between the groups (F value=0.35). It implies there was no influence of age on reproductive health status of Halakki Vokkaliga women.

Similar type of results was observed in Kunbi women in all the three age groups i.e. 20-30 years, 30-40 years and 40-50 years more than fifty per cent of women were found in good reproductive health status. The result found to be non-significant ($\chi^2=0.88$). Comparison of mean scores of age with reproductive health status also showed non-significant (F value=0.57). It suggests, there was no influence of age on reproductive health status of Kunbi women.

So, the hypothesis stating that there is no influence of age on reproductive health status of Halakki Vokkaliga and Kunbi women is accepted.

Table 4.3.2h: Association and comparison of general health status and husband's occupation of Halakki Vokkaliga and Kunbi women**N=460**

	Husband's occupation	Health status			Total	Modified χ^2	Mean \pm SD	t-value
		Mildly affected	Moderately affected	Severely Affected				
Halakki Vokkaliga Women (n=230)	Working	48 (64.86)	22 (29.72)	4 (5.42)	74 (100.00)	5.95 ^{NS}	86.64 \pm 44.39	9.18**
	Agriculture laborer/housewife	125 (80.12)	15 (9.61)	16 (10.25)	156 (100.00)		100.45 \pm 54.34	
	Total	173 (75.20)	37 (16.10)	20 (8.70)	230 (100.00)			
Kunbi Women (n=230)	Working	37 (66.07)	16 (28.57)	3 (5.36)	56 (100.00)	4.01 ^{NS}	86.21 \pm 44.53	8.92**
	Agriculture laborer/housewife	132 (75.86)	24 (13.79)	18 (10.35)	174 (100.00)		101.62 \pm 52.80	
	Total	169 (73.50)	40 (17.40)	21 (9.10)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

**Significant at 0.01 level

Table 4.3.3a: Association and comparison of reproductive health status and age of Halakki Vokkaliga and Kunbi women

N=460

	Age (years)	Reproductive health status				χ^2	Mean \pm SD	F-value
		Poor	Average	Good	Total			
Halakki Vokkaliga Women (n=230)	20-30	12 (16.70)	20 (27.80)	40 (55.60)	72 (100.00)	0.60 ^{NS}	54.16 \pm 10.77	0.35 ^{NS}
	31-40	13 (16.30)	20 (25.00)	47 (58.80)	80 (100.00)		55.17 \pm 11.03	
	41-50	11 (14.10)	19 (24.40)	48 (61.50)	78 (100.00)		55.64 \pm 11.25	
	Total	36 (15.70)	59 (25.70)	135 (58.70)	230 (100.00)			
Kunbi Women (n=230)	20-30	16 (20.50)	22 (28.20)	40 (51.30)	78 (100.0)	0.88 ^{NS}	51.34 \pm 12.58	0.57 ^{NS}
	31-40	15 (18.10)	26 (31.30)	42 (50.60)	83 (100.00)		52.21 \pm 12.28	
	41-50	12 (17.40)	18 (26.10)	39 (56.50)	69 (100.00)		53.53 \pm 12.35	
	Total	43 (18.70)	66 (28.70)	121 (52.60)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

Table 4.3.1b denotes the results of association and comparison of reproductive health status and education of Halakki Vokkaliga and Kunbi women. Among Halakki Vokkaliga women a greater number of women with 10th class pass and more education were in average and good level of reproductive health status. However, none of the women with graduation level of education were in poor reproductive health status. Non-significant association observed between education and reproductive health status of Halakki Vokkaliga women. Comparison of mean scores of reproductive health and education also indicated non-significant (F-value=2.35) results.

In Kunbi women a greater number of women with 10th class pass and more education were in average and good category of reproductive health status, none of the women with graduation level of education were in poor reproductive health status. Comparison of mean scores of reproductive health status and education was also found to be non-significant (F-value =2.18).

Subsequently, the hypothesis stating that there is no influence of education on reproductive health status of Halakki Vokkaliga and Kunbi women is accepted.

Association and comparison of status and occupation of Halakki Vokkaliga and Kunbi women is illustrated in table 4.3.3c. Occupation categories were merged for the statistical analysis purpose and categorized as working and agriculture labourer/housewife. Chi-square test revealed that there was significant association ($\chi^2=19.94$) observed between working and agriculture labourer/housewife Halakki Vokkaliga women, in that a high number of working women were in average and good reproductive health status. Comparison of mean scores also revealed highly significant (t-value=5.67) difference between working and agriculture labourer/housewife related to reproductive health scores. Mean reproductive health scores of working women (57.43 ± 9.31) was higher compared to non- working women (53.52 ± 11.22).

Similar findings were also obtained in Kunbi women, where majority of the working women were in good reproductive health status and no one in poor reproductive health status. Association found to be highly significant ($\chi^2=21.79$). Comparison of mean scores was also highly significant (t-value=4.29), where working women's reproductive health score was significantly better (56.61 ± 10.88) compared to agriculture labourer/housewife women (51.07 ± 9.00).

Table 4.3.3b: Association and comparison of reproductive health status and education of Halakki Vokkaliga and Kunbi women**N=460**

	Education	Reproductive health status			Total	Modified χ^2	Mean \pm SD	F-value
		Poor	Average	Good				
Halakki Vokkaliga Women (n=230)	Graduation	-	5 (18.52)	22 (81.48)	27 (100.00)	4.52 ^{NS}	56.35 \pm 9.37	2.35 ^{NS}
	10th class pass but <Graduation	10 (17.85)	13 (41.07)	33 (41.07)	56 (100.00)		54.57 \pm 12.22	
	Less than 10th	23 (18.26)	35 (27.77)	67 (53.17)	126 (100.00)		53.78 \pm 10.87	
	No schooling	-	4 (26.66)	11 (73.34)	15 (100.00)		51.05 \pm 10.28	
	Total	36 (15.70)	59 (25.70)	135 (58.70)	230 (100.00)			
Kunbi Women (n=230)	Graduation	-	2 (18.18)	9 (81.82)	11 (4.79)	5.10 ^{NS}	56.45 \pm 10.37	2.18 ^{NS}
	10th class pass but <Graduation	4 (12.90)	9 (29.04)	18 (58.06)	31 (100.00)		55.75 \pm 12.30	
	Less than 10th	18 (11.18)	67 (41.61)	76 (47.20)	161 (100.00)		53.98 \pm 11.87	
	No schooling	-	10 (37.03)	17 (62.96)	27 (100.00)		51.34 \pm 9.56	
	Total	43 (18.70)	66 (28.70)	121 (52.60)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

Table 4.3.3c: Association and comparison of reproductive health status and occupation of Halakki Vokkaliga and Kunbi women

N=460

	Occupation	Reproductive health status			Total	χ^2	Mean \pm SD	t-value
		Poor	Average	Good				
Halakki Vokkaliga Women (n=230)	Working	4 (10.00)	16 (40.00)	20 (50.00)	40 (100.00)	19.94**	57.43 \pm 9.31	5.67*
	Agriculture labourer/ Housewife	32 (16.85)	43 (22.63)	115 (60.52)	190 (100.00)		53.52 \pm 11.22	
	Total	36 (15.70)	59 (25.70)	135 (58.70)	230 (100.00)			
Kunbi Women (n=230)	Working	-	8 (29.60)	19 (70.40)	27 (100.00)	21.79**	56.61 \pm 10.88	4.29**
	Agriculture labourer/ housewife	43 (21.18)	58 (28.58)	102 (50.24)	203 (100.00)		51.07 \pm 9.00	
	Total	43 (18.70)	66 (28.70)	121 (52.60)	230 (100.00)			

Figure in the parenthesis indicates percentage

*Significant at 0.05 level

**Significant at 0.01 level

NS-Non Significant

Consequently, the hypothesis stating that there is no influence of occupation on reproductive health status of Halakki Vokkaliga and Kunbi women is rejected.

Association and comparison reproductive health status and type of family of Halakki Vokkaliga and Kunbi women is presented table 4.3.3d Among Halakki Vokkaliga women, non-significant association for type of family and reproductive health status. Comparison of mean scores of types of family and reproductive health status also found non-significant. In Kunbi women also similar result was observed. Association and comparison of mean scores showed non-significant result.

Therefore, the hypothesis stating that there is no influence of type of family on reproductive health status of Halakki Vokkaliga and Kunbi women is accepted.

Association and comparison of reproductive health status and number of family members of Halakki Vokkaliga and Kunbi women shown in table 4.3.3e Among Halakki Vokkaliga women there was no significant result found between type of family and reproductive health status. The chi-square result found to be non-significant ($\chi^2=2.18$) and the difference between the means scores also showed non-significant difference (F value=0.23). Among Kunbi women, there was no significant association ($\chi^2=2.11$) and difference found between reproductive health status and number of family members.

Therefore, the hypothesis stating that there is no influence of number of family members on reproductive health status of Halakki Vokkaliga and Kunbi women is accepted.

Table 4.3.3e characterizes the association and comparison of reproductive health status and socio- economic status of Halakki Vokkaliga and Kunbi women. Among Halakki Vokkaliga women, those who were from upper middle and lower middle SES families were observed more in average and good reproductive health status whereas poor SES families were in poor reproductive health status. Association was found non-significant between SES and reproductive health status. The comparison of mean scores between social economic status and reproductive health status showed significant (t- value=4.89) where the women from upper middle socioeconomic status scored were having better reproductive health score compared to the women from poor and very poor socio- economic status. The post hoc (Tukey's HSD) value also showed significant difference between upper middle, lower middle and poor, very poor socio-economic status.

Table 4.3.3d: Association and comparison of reproductive health status and type of family of Halakki Vokkaliga and Kunbi women

N=460

	Type of family	Reproductive health status			Total	χ^2	Mean \pm SD	F-value
		Poor	Average	Good				
Halakki Vokkaliga Women (n=230)	Nuclear	24 (17.30)	40 (28.80)	75 (54.00)	139 (100.00)	3.63 ^{NS}	55.32 \pm 10.74	0.23 ^{NS}
	Joint	6 (15.00)	9 (22.50)	25 (62.50)	40 (100.00)		53.43 \pm 11.28	
	Extended	6 (11.80)	10 (19.60)	35 (68.60)	51 (100.00)		53.79 \pm 11.45	
	Total	36 (15.70)	59 (25.70)	135 (58.70)	230 (100.00)			
Kunbi Women (n=230)	Nuclear	27 (22.00)	36 (29.30)	60 (48.80)	123 (100.00)	3.01 ^{NS}	54.26 \pm 12.74	0.44 ^{NS}
	Joint	6 (12.80)	12 (25.50)	29 (61.70)	47 (100.00)		52.17 \pm 12.16	
	Extended	10 (16.70)	18 (30.00)	32 (53.30)	60 (100.00)		52.26 \pm 12.42	
	Total	43 (18.70)	66 (28.70)	121 (52.60)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

Table 4.3.3e: Association and comparison of reproductive health status and socio-economic status of Halakki Vokkaliga and Kunbi women**N=460**

	Socio-economic status	Reproductive health status			Total	Modified χ^2	Mean \pm SD	F-value
		Poor	Average	Good				
Halakki Vokkaliga Women (n=230)	Upper middle	4 (13.34)	11 (36.66)	15 (50.00)	30 (100.00)	6.22 ^{NS}	56.15 \pm 10.57 ^{ab}	4.89*
	Lower middle	7 (8.13)	26 (30.23)	53 (61.62)	86 (100.00)		54.65 \pm 11.30 ^{ba}	
	Poor	13 (13.82)	18 (19.14)	63 (67.02)	94 (100.00)		53.89 \pm 11.44 ^{cd}	
	Very poor	12 (60.00)	4 (20.00)	4 (20.00)	20 (100.00)		51.44 \pm 10.52 ^{dc}	
	Total	36 (15.70)	59 (25.70)	135 (58.70)	230 (100.00)			
Kunbi Women (n=230)	Upper middle	-	4 (30.76)	9 (69.24)	13 (100.00)	6.55 ^{NS}	57.11 \pm 10.72 ^{ab}	5.75*
	Lower middle	12 (17.39)	27 (39.13)	30 (43.48)	69 (100.00)		55.55 \pm 12.43 ^{ba}	
	Poor	13 (12.74)	17 (16.66)	72 (70.58)	102 (100.00)		53.78 \pm 10.66 ^{cd}	
	Very poor	18 (39.13)	18 (39.13)	10 (21.74)	46 (100.00)		51.22 \pm 9.58 ^{dc}	
	Total	43 (18.70)	66 (28.70)	121 (52.60)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

**Significant at 0.05 level

With regard to Kunbi women, high number of women belonged to the middle and upper middle socio-economic status were in mildly good and average reproductive health status compared to poor and very poor socio economics status. None of the women from upper middle SES were in poor reproductive health status. Association was found to be non-significant for socio-economic status and reproductive health status. The comparison of mean scores also showed significant result where women from upper middle social economic status where better scored higher compared to women from poor and very poor socio-economic status. The same trend has been observed for Kunbi women also where the post hoc (Tukey's HSD) value showed significant difference between upper middle, poor and very poor socio-economic status with reproductive health status.

Hence, the hypothesis stating that there is no influence of socio-economic status and reproductive health status of Halakki Vokkaliga and Kunbi women is rejected.

Table 4.3.3g describes the association and comparison of reproductive health status and husband's education of Halakki Vokkaliga and Kunbi women. With respect to Halakki Vokkaliga, women whose husband's had higher education i.e., 10th class pass and more were in good (61.90 % and 47.28 %) reproductive health status and women whose husbands were having lower education i.e., less than 10th and no schooling (39.49 % and 50 % respectively) were in poor reproductive health status. There was significant association ($\chi^2=9.43$) between husband's education and reproductive health status. However, comparison of mean scores showed significant difference (F-value=3.56) where those women husband's having higher education were scored more compare to their counterparts. Post hoc values (Tukey's HSD) value showed significant difference between education levels of the husband and women reproductive health status. This implies husband's higher education level linked with better reproductive health status of women participants.

In terms of Kunbi women who were having husbands with higher education—those who had completed graduation and at least the 10th grade—were in good (46.67 % 50.90 %) and while those whose husbands had less education i.e. less than 10th and no schooling were in poor reproductive health status. The reproductive health status and the husband's education were significantly associated ($\chi^2=11.43$). Comparison of the means revealed a significant difference (F-value=3.87), with better reproductive health for the women whose husbands have more education. Significant differences between the husband's educational level and the wife's level of reproductive health were revealed by the Post hoc (Tukey's HSD) test.

Thus, the hypothesis stating that there is no influence of husband's education on reproductive health status of Halakki Vokkaliga and Kunbi women is rejected.

Table 4.3.3f: Association and comparison of reproductive health status and number of family members of Halakki Vokkaliga and Kunbi women

N=460

	No. of family members	Reproductive health status			Total	Modified χ^2	Mean \pm SD	F-value
		Poor	Average	Good				
Halakki Vokkaliga Women (n=230)	1-5	15 (13.20)	32 (28.10)	67 (58.80)	114 (100.00)	2.18 ^{NS}	55.79 \pm 10.74	0.23 ^{NS}
	6-10	16 (17.40)	24 (26.10)	52 (56.50)	92 (100.00)		54.43 \pm 11.28	
	More than 10	5 (20.80)	3 (12.50)	16 (66.70)	24 (100.00)		55.32 \pm 11.45	
	Total	36 (15.70)	59 (25.70)	135 (58.70)	230 (100.00)			
Kunbi Women (n=230)	1-5	18 (20.90)	25 (29.10)	43 (50.00)	86 (100.00)	2.11 ^{NS}	54.26 \pm 12.74	0.44 ^{NS}
	6-10	20 (17.50)	35 (30.70)	59 (51.80)	114 (100.00)		52.17 \pm 12.16	
	More than 10	5 (16.70)	6 (20.00)	19 (63.30)	30 (100.00)		51.82 \pm 12.74	
	Total	43 (18.70)	66 (28.70)	121 (52.60)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

Table 4.3.3g: Association and comparison of reproductive health status and husband's education of Halakki Vokkaliga and Kunbi women

N=460

	Education	Reproductive health status			Total	Modified χ^2	Mean \pm SD	F-value
		Poor	Average	Good				
Halakki Vokkaliga Women (n=230)	Graduation	2 (4.76)	14 (33.34)	26 (61.90)	42 (100.00)	9.43*	58.51 \pm 9.67 ^a	3.56*
	10th class pass but <Graduation	7 (12.72)	22 (40.00)	26 (47.28)	55 (100.00)		55.85 \pm 11.23 ^b	
	Less than 10th	47 (39.49)	58 (48.73)	14 (11.76)	119 (100.00)		52.75 \pm 11.13 ^c	
	No schooling	7 (50.00)	4 (28.57)	3 (21.42)	14 (100.00)		50.69 \pm 10.53 ^d	
	Total	63 (27.40)	98 (42.60)	69 (30.00)	230 (100.00)			
Kunbi Women (n=230)	Graduation	2 (13.33)	5 (33.33)	7 (46.67)	15 (100.00)	11.43*	58.32 \pm 9.43 ^a	3.87*
	10th class pass but <Graduation	7 (12.73)	20 (36.37)	28 (50.90)	55 (100.00)		55.61 \pm 11.30 ^b	
	Less than 10th	23 (17.16)	55 (41.04)	57 (42.53)	134 (100.00)		52.82 \pm 11.47 ^c	
	No schooling	13 (50.00)	8 (30.76)	5 (19.24)	26 (100.00)		50.04 \pm 10.25 ^d	
	Total	45 (19.60)	88 (38.30)	97 (42.20)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

**Significant at 0.01 level

Table 4.3.3h denotes association and comparison of reproductive health status and husband's occupation of Halakki Vokkaliga and Kunbi women. Among Halakki Vokkaliga women, there was no significant association ($\chi^2=4.14$) found between reproductive health status and husband's occupation. Difference between the mean scores also found to be significant (t-value=6.52) in that, mean scores of women whose husbands were working (56.52 ± 10.42) was having good scores implies better reproductive health status compare to non-working (51.61 ± 10.88). Consider to Kunbi women, association found ($\chi^2=5.24$). The difference in the mean scores was also significant (t-value=5.54) in that the mean scores of women whose husbands worked (56.21 ± 10.54) were higher than those of other group (50.17 ± 10.50).

As a result, the hypothesis stating that there is no influence of husband's occupation on reproductive health status of Halakki Vokkaliga and Kunbi women is rejected.

4.3.4: Association and comparison of nutritional status and individual and familial characteristics of Halakki Vokkaliga and Kunbi women

Results of association and comparison of nutritional status and age of Halakki Vokkaliga and Kunbi women is presented in Table 4.3.4a. Among Halakki Vokkaliga women, there no significant association ($\chi^2=4.78$) was found between age and nutritional status of the respondents. In all the age groups i.e., 20-30 years, 30-40 years and 40-50 years more than sixty per cent of the women had ideal weight. Statistically no significant difference was found (F- value=1.58) implying similar nutritional status in both the communities with regard to age was observed.

In Kunbi women, in all the three age groups i.e., 20-30 years, 30-40 years and 40-50 years a greater number of women had ideal weight. In both the association ($\chi^2=4.78$) and comparison (F value=1.32) of age with nutritional status was found non-significant.

Accordingly, the hypothesis stating that there is no influence of age on nutritional status of Halakki Vokkaliga and Kunbi women is accepted.

Table 4.3.4b denotes the results of association and comparison nutritional status and education of Halakki Vokkaliga and Kunbi women. No Significant association was observed between education and nutritional status of Halakki Vokkaliga ($\chi^2=3.65$) and Kunbi women ($\chi^2=4.04$).

Table 4.3.3h: Association and comparison of reproductive health status and husband's occupation of Halakki Vokkaliga and Kunbi women**N=460**

	Husband's occupation	Reproductive health status			Total	χ^2	Mean±SD	t-value
		Poor	Average	Good				
Halakki Vokkaliga Women (n=230)	Working	10 (13.52)	27 (36.48)	37 (50.00)	74 (100.00)	4.14 ^{NS}	56.52±10.42	6.52*
	Non-working	53 (33.98)	71 (45.51)	32 (20.51)	156 (100.00)		51.61±10.88	
	Total	63 (27.40)	98 (42.60)	69 (30.00)	230 (100.00)			
Kunbi Women (n=230)	Working	9 (16.07)	16 (28.57)	31 (55.36)	56 (100.00)	5.24 ^{NS}	56.21±10.54	5.54*
	Non-working	36 (20.68)	72 (41.38)	66 (37.94)	174 (100.00)		50.17±10.50	
	Total	45 (19.60)	88 (38.30)	97 (42.20)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

*Significant at 0.05 level

Table 4.3.4a: Association and comparison of nutritional status and age of Halakki Vokkaliga and Kunbi women**N=460**

	Age (years)	Nutritional status			Total	χ^2	Mean±SD	F-value
		Under weight	Ideal Weight	Over weight				
Halakki Vokkaliga Women (n=230)	20-30	30 (41.67)	37 (51.38)	5 (6.95)	72 (100.00)	4.43 ^{NS}	20.84±2.12	1.32 ^{NS}
	31-40	14 (17.50)	51 (63.75)	15 (18.75)	80 (100.00)		21.01±2.03	
	41-50	8 (10.26)	57 (73.07)	13 (16.67)	78 (100.00)		21.08±2.30	
	Total	52 (22.60)	145 (63.05)	33 (14.35)	230 (100.00)			
Kunbi Women (n=230)	20-30	36 (46.15)	36 (46.15)	6 (7.70)	78 (100.00)	4.78 ^{NS}	20.54±2.22	1.25 ^{NS}
	31-40	21 (25.30)	46 (55.45)	12 (14.45)	83 (100.00)		21.13±2.21	
	41-50	10 (14.50)	54 (78.26)	9 (13.04)	69 (100.00)		20.56±2.26	
	Total	67 (29.13)	136 (59.14)	27 (11.73)	72 (100.00)			

Figure in the parenthesis indicates percentage
 NS-Non Significant

Table 4.3.4b: Association and comparison of nutritional status and education of Halakki Vokkaliga and Kunbi women**N=460**

	Education	Nutritional status			Total	Modified χ^2	Mean \pm SD	F-value
		Under weight	Ideal Weight	Over weight				
Halakki Vokkaliga Women (n=230)	Graduation	6 (22.22)	19 (70.38)	2 (7.40)	27 (100.00)	3.65 ^{NS}	21.81 \pm 2.31	0.56 ^{NS}
	10 th class pass but <Graduation	6 (10.72)	45 (80.36)	5 (8.92)	56 (100.00)		21.33 \pm 2.23	
	Less than 10 th	30 (23.80)	76 (60.32)	20 (15.88)	126 (100.00)		20.50 \pm 2.17	
	No schooling	10 (47.61)	5 (23.80)	6 (28.57)	21 (100.00)		20.01 \pm 2.05	
	Total	52 (22.60)	145 (63.05)	33 (14.35)	230 (100.00)			
Kunbi Women (n=230)	Graduation	3 (27.28)	6 (54.54)	2 (18.18)	11 (100.00)	4.04 ^{NS}	21.84 \pm 2.32	0.78 ^{NS}
	10 th class pass but <Graduation	6 (19.36)	22 (70.96)	3 (9.68)	31 (100.00)		21.25 \pm 2.00	
	Less than 10 th	44 (27.32)	100 (62.12)	17 (10.56)	161 (100.00)		20.18 \pm 2.03	
	No schooling	14 (51.86)	8 (29.62)	5 (18.52)	27 (100.00)		20.03 \pm 2.13	
	Total	67 (29.13)	136 (59.14)	27 (11.73)	230 (100.00)			

Figure in the parenthesis indicates percentage
 NS-Non Significant

Comparison of mean scores of nutritional status and education was also not found to be significant for both Halakki Vokkaliga (F value=0.56) and Kunbi women (F value=0.78).

Hence, the hypothesis stating that there is no influence of education on nutritional status of Halakki Vokkaliga and Kunbi women is accepted.

Association and comparison of nutritional status and occupation of Halakki Vokkaliga and Kunbi women is illustrated in table 4.3.4c. No Significant association was observed between occupation and nutritional status of Halakki Vokkaliga ($\chi^2=4.76$) and Kunbi women ($\chi^2=4.82$).

Comparison of mean scores of nutritional status and education was also not found to be significant for both Halakki Vokkaliga (F value=0.59) and Kunbi women (F value=0.80).

Hence, the hypothesis stating that there is no influence of occupation on nutritional status of Halakki Vokkaliga and Kunbi women is accepted.

Association and comparison nutritional status and type of family of Halakki Vokkaliga and Kunbi women is presented table 4.3.4d. Among Halakki Vokkaliga women, more percentage of women belonged to nuclear type of families, were having ideal weight but in joint and extended families, more number of women were in underweight. The result was found to be significant for type of family and nutritional status. The result was also found to be significant (F value=2.94) for comparison of mean scores of types of family and nutritional status. Nutritional status mean scores of nuclear family women was high compared to joint and extended families. The post hoc (Tukey's HSD) value implies that, there was significant difference observed between nuclear, joint and extended families.

In Kunbi women, with respect to nuclear families, a greater number of women belonged to ideal weight category, With regard to joint and extended families, percentage of women with ideal weight was low. The result were found to be significant for association between type of family and nutritional status, comparison of mean scores showed significant results (F value=2.78). Nutritional status mean scores of women from nuclear families was high and the post hoc (Tukey's HSD) value also indicates significant difference between nuclear with joint and extended families in both the communities. No difference was observed between joint and extended families depicting better nutritional status among women in nuclear families.

Table 4.3.4c: Association and comparison of nutritional status and occupation of Halakki Vokkaliga and Kunbi women**N=460**

	Working status	Nutritional status			Total	χ^2	Mean±SD	F-value
		Under weight	Ideal Weight	Over weight				
Halakki Vokkaliga Women (n=230)	Working	13 (32.50)	11 (27.50)	16 (40.00)	40 (100.00)	4.76 ^{NS}	21.11±2.11	0.59 ^{NS}
	Non-working	39 (20.53)	134 (70.53)	17 (8.94)	190 (100.00)		20.32±2.43	
	Total	52 (22.60)	145 (63.05)	33 (14.35)	230 (100.00)			
Kunbi Women (n=230)	Working	10 (37.04)	7 (25.92)	10 (37.04)	27 (100.00)	4.82 ^{NS}	21.50±2.71	0.80 ^{NS}
	Non-working	57 (28.08)	129 (63.54)	17 (8.38)	203 (100.00)		20.67±2.50	
	Total	67 (29.13)	136 (59.14)	27 (11.73)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

Table 4.3.4d: Association and comparison of nutritional status and type of family of Halakki Vokkaliga and Kunbi women**N=460**

	Type of family	Nutritional status			Total	χ^2	Mean \pm SD	F-value
		Under weight	Ideal Weight	Over weight				
Halakki Vokkaliga Women (n=230)	Nuclear	10 (7.20)	122 (87.76)	7 (5.04)	139 (100.00)	15.43*	22.34 \pm 2.10 ^a	2.94*
	Joint	20 (50.00)	10 (25.00)	10 (25.00)	40 (100.00)		20.01 \pm 2.42 ^{bc}	
	Extended	22 (43.13)	13 (25.49)	16 (31.38)	51 (100.00)		20.04 \pm 2.43 ^{cb}	
	Total	52 (22.60)	145 (63.05)	33 (14.35)	230 (100.00)			
Kunbi Women (n=230)	Nuclear	16 (13.00)	100 (81.30)	7 (5.70)	123 (100.00)	17.82**	22.81 \pm 2.21 ^a	2.98*
	Joint	24 (51.06)	13 (27.66)	10 (21.28)	47 (100.00)		20.15 \pm 2.03 ^{bc}	
	Extended	27 (45.00)	23 (38.34)	10 (16.66)	60 (100.00)		20.11 \pm 2.06 ^{cb}	
	Total	67 (29.13)	136 (59.14)	27 (11.73)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

*Significant at 0.05 level

**Significant at 0.01 level

Therefore, the hypothesis stating that there is no influence of type of family on nutritional status of Halakki Vokkaliga and Kunbi women is rejected.

Table 4.3.4e characterizes the association and comparison of nutritional status and socio-economic status of Halakki Vokkaliga and Kunbi women. Among Halakki Vokkaliga women, those who were from upper middle and lower middle SES families were more number in ideal weight category, less percentage in underweight and overweight category. Whereas, women from very poor SES families were more number in underweight category. . Significant association found between SES and nutritional status ($\chi^2=9.65$). The comparison of mean scores between social economic status and nutritional status showed significant (F value=3.23) results where the women's from upper middle socioeconomic status BMI scores higher compared to the women from poor and very poor socio economic status. The post hoc (Tukey's HSD) value also showed significant difference between upper middle lower middle, poor and very poor socio-economic status.

With regard to Kunbi women, the same trend observed as that of Halakki Vokkaliga women. Kunbi women belonged to the middle and upper middle socio-economic condition were having ideal body weight. Association found to be significant for socio economic status and nutritional status ($\chi^2=10.66$). The comparison of mean scores also showed significant (F-value=3.85) result where women from upper middle social economic status were better were having better BMI scores compared to women from poor and very poor socio-economic status. Post hoc (Tukey's HSD) value showed significant difference between upper middle, lower middle, poor and very poor socio-economic status with empowerment status.

As a result, the hypothesis stating that there is no influence of socio-economic status on nutritional status of Halakki Vokkaliga and Kunbi women is rejected.

Association and comparison of nutritional status and number of family members of Halakki Vokkaliga and Kunbi women is shown in table 4.3.4f. Among Halakki Vokkaliga women there was significant result found between type of family and empowerment status women having 1-5 family members were more number in ideal weight category than other two groups.. The chi-square result was found to be significant ($\chi^2=11.45$). Whereas the difference between the means scores showed significant difference (F value=3.92) where women having 1 to 5 family members and 6 to 10 family members were better compared to

Table 4.3.4e: Association and comparison of nutritional status and socio-economic status of Halakki Vokkaliga and Kunbi women**N=460**

	Socio-economic status	Nutritional status			Total	χ^2	Mean±SD	F-value
		Under weight	Ideal Weight	Over weight				
Halakki Vokkaliga Women (n=230)	Upper middle	6 (20.00)	16 (53.33)	8 (26.67)	30 (100.00)	9.65*	22.56±2.34 ^{ab}	3.23*
	Lower middle	12 (13.96)	64 (74.42)	10 (11.62)	86 (100.00)		21.35±2.42 ^{ba}	
	Poor	24 (25.54)	60 (63.82)	10 (10.64)	94 (100.00)		20.03±2.33 ^{cd}	
	Very poor	10 (50.00)	5 (25.00)	5 (25.00)	20 (100.00)		20.02±2.02 ^{dc}	
	Total	52 (22.60)	145 (63.05)	33 (14.35)	230 (100.00)			
Kunbi Women (n=230)	Upper middle	2 (15.38)	6 (46.16)	5 (38.46)	13 (5.66)	10.66*	22.84±2.20 ^{ab}	3.85*
	Lower middle	17 (24.64)	48 (69.56)	4 (5.80)	69 (100.00)		20.01±2.42 ^{ba}	
	Poor	26 (25.50)	70 (68.62)	6 (5.88)	102 (100.00)		20.04±2.03 ^{cd}	
	Very poor	22 (47.82)	12 (26.09)	12 (26.09)	46 (100.00)		20.14±2.01 ^{dc}	
	Total	67 (29.13)	136 (59.14)	27 (11.73)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

*Significant at 0.05 level

Table 4.3.4f: Association and comparison of nutritional status and no. of family members of Halakki Vokkaliga and Kunbi women**N=460**

	No. of family members	Nutritional status			Total	Modified χ^2	Mean \pm SD	F-value
		Under weight	Ideal Weight	Over weight				
Halakki Vokkaliga Women (n=230)	1-5	10 (8.78)	92 (80.70)	12 (10.52)	114 (100.00)	11.45*	22.98 \pm 2.46 ^a	3.92*
	6-10	28 (30.43)	48 (52.17)	16 (17.40)	92 (100.00)		20.13 \pm 2.26 ^{bc}	
	More than 10	14 (58.32)	5 (20.84)	5 (20.84)	24 (100.00)		20.04 \pm 2.17 ^{cb}	
	Total	52 (22.60)	145 (63.05)	33 (14.35)	230 (100.00)			
Kunbi Women (n=230)	1-5	18 (20.94)	59 (68.60)	9 (10.46)	86 (100.00)	13.09*	22.82 \pm 2.42 ^a	4.01*
	6-10	35 (30.70)	63 (55.26)	16 (14.04)	114 (100.00)		20.15 \pm 2.33 ^{bc}	
	More than 10	14 (46.67)	14 (46.67)	2 (6.66)	30 (100.00)		20.02 \pm 2.19 ^{cb}	
	Total	67 (29.13)	136 (59.14)	27 (11.73)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

*Significant at 0.05 level

the women who are having more than 10 family members. The post hoc (Tukey's HSD) value also showed significant difference between 1 to 5 and 6 to 10 with more than 10 family members. This implies that women with less number of family members had better BMI scores compared to more number of family members.

Among Kunbi women, there was also similar results observed. Significant association ($\chi^2=13.09$) and difference (F-value=4.01) found between nutritional status and number of family members. The post hoc (Tukey's HSD) value also showed significant difference between 1 to 5 and 6 to 10 with more than 10 family members. This suggests that women with less number of family members had better nutritional status compared to more number of family members.

As a result, the hypothesis stating that there is no influence of number of family members on nutritional status of Halakki Vokkaliga and Kunbi women is rejected.

Table 4.3.4g describes the association and comparison of nutritional status and husband's education of Halakki Vokkaliga and Kunbi women. There was no significant association found with husband's education and nutritional status of Halakki Vokkaliga ($\chi^2=4.79$) and Kunbi women ($\chi^2=4.04$). Comparison of mean scores of nutritional status and education was also not found to be significant for both Halakki Vokkaliga (F value=1.54) and Kunbi women (F value=1.65).

Hence, the hypothesis stating that there is no influence of husband's education on nutritional status of Halakki Vokkaliga and Kunbi women is accepted.

Table 4.3.4h denotes association and comparison of empowerment status and husband's occupation of Halakki Vokkaliga and Kunbi women.

No Significant association was observed between husband's occupation and nutritional status of Halakki Vokkaliga ($\chi^2=5.98$) and Kunbi women ($\chi^2=5.19$). Comparison of mean scores of nutritional status and education was also not found to be significant for both Halakki Vokkaliga (F value=1.77) and Kunbi women (F value=1.65).

As a result, the hypothesis stating that there is no influence of husband's occupation on nutritional status of Halakki Vokkaliga and Kunbi women is rejected.

Table 4.3.4g: Association and comparison of nutritional status and husband's education Halakki Vokkaliga and Kunbi women**N=460**

	Husband's education	Nutritional status			Total	Modified χ^2	Mean \pm SD	F-value
		Under weight	Ideal Weight	Over weight				
Halakki Vokkaliga women (n=230)	Graduation	6 (14.29)	30 (71.42)	6 (14.29)	42 (100.00)	4.79 ^{NS}	21.61 \pm 2.41	1.54 ^{NS}
	10 th class pass but <Graduation	9 (16.36)	42 (76.36)	4 (7.28)	55 (100.00)		21.53 \pm 2.34	
	Less than 10 th	34 (28.58)	66 (55.46)	19 (15.96)	119 (100.00)		20.80 \pm 2.73	
	No schooling	3 (21.42)	7 (50.00)	4 (28.58)	14 (100.00)		20.11 \pm 2.14	
	Total	52 (22.60)	145 (63.05)	33 (14.35)	230 (100.00)			
Kunbi Women (n=230)	Graduation	2 (13.34)	11 (73.32)	2 (13.34)	15 (100.00)	6.51 ^{NS}	21.51 \pm 2.11	1.65 ^{NS}
	10 th class pass but <Graduation	12 (21.82)	33 (60.00)	10 (18.18)	55 (100.00)		21.65 \pm 2.14	
	Less than 10 th	47 (35.08)	76 (56.72)	11 (8.20)	134 (100.00)		20.13 \pm 2.43	
	No schooling	8 (30.76)	14 (53.84)	4 (15.40)	26 (100.00)		20.19 \pm 2.42	
	Total	67 (29.13)	136 (59.14)	27 (11.73)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

Table 4.3.4h: Association and comparison of nutritional status and husband's occupation of Halakki Vokkaliga and Kunbi women

N=460

	Husband's occupation	Nutritional status			Total	Modified χ^2	Mean \pm SD	F-value
		Under weight	Ideal Weight	Over weight				
Halakki Vokkaliga Women (n=230)	Working	25 (33.79)	27 (36.49)	22 (29.72)	74 (100.00)	5.98 ^{NS}	21.81 \pm 2.16	1.77 ^{NS}
	Non working	27 (17.30)	118 (75.65)	11 (7.05)	156 (100.00)		20.35 \pm 2.24	
	Total	52 (22.60)	145 (63.05)	33 (14.35)	230 (100.00)			
Kunbi Women (n=230)	Working	19 (33.93)	24 (42.85)	13 (23.22)	56 (100.00)	5.19 ^{NS}	21.76 \pm 2.34	1.65 ^{NS}
	Non working	48 (27.58)	112 (64.37)	14 (8.05)	174 (100.00)		20.51 \pm 2.25	
	Total	67 (29.13)	136 (59.14)	27 (11.73)	230 (100.00)			

Figure in the parenthesis indicates percentage

NS-Non Significant

4.4 Correlation between independent variables and empowerment and health status of Halakki Vokkaliga and Kunbi women

Table 4.4.1 describes the correlation between individual factors such as age, education, working status; familial factors such as type of family, no. of family members, socio-economic status, husband's education, husband's occupation with empowerment status and health status of Halakki Vokkaliga women. Age, type of family, no. of family members was negatively and significantly correlated with empowerment status. As age increased, empowerment level decreased. Empowerment level increased with small type of family and less no. of family members. Education, working status socio-economic status, husband's education and husband's occupation were positively and significantly correlated with empowerment status. Increase in these variables increased the empowerment status. With respect to health status, as age increased, general health status decreased. Education, working status, socio-economic status, husband's education, husband's occupation was negatively and significantly correlated with general health status. This indicated increase in these variables decrease the risk of health complications. Education, working status, husband's education and husband's occupation were positively and significantly correlated with reproductive health status of the respondents. Women with higher education, employment, husband's higher education and better employment possess good reproductive health. Socio-economic status of the family was positively and significantly correlated with nutritional status. Type of family members and no. of family members were negatively and significantly correlated with nutritional status. Women who were residing in small families and less no. of people possessed better nutritional status compared to women in large and more number no. of family members. Socio-economic status of the family was positively and significantly correlated with nutritional status where, increase in socio-economic status increased the nutritional status.

Hence, hypothesis stating that there is no individual and familial characteristics on empowerment status and health status of Halakki Vokkaliga women is rejected.

Table 4.4.2 describes the correlation between individual factors such as age, education, working status; familial factors such as type of family, no. of family members, socio-economic status, husband's education, husband's occupation with empowerment status and health status of Kunbi women. Age, type of family, no. of family members was negatively and significantly correlated with empowerment status. As age increased, empowerment level decreased. Empowerment level increased with small type of family and less no. of family members. Education, working status, socio-economic status, husband's education and husband's occupation were positively and significantly correlated with empowerment status. Increase in these variables increased the empowerment status. Age was

Table 4.4.1: Correlation matrix between individual, familial characteristics with empowerment status and health status of Halakki Vokkaliga women**N=230**

Variables	Empowerment status	General health status	Reproductive health status	Nutritional status
Age	-0.194*	0.235*	0.097	0.068
Education	0.311**	-0.189*	0.216*	0.145
Occupation	0.586**	-0.195*	0.235*	0.168
Type of Family	-0.174*	0.132	0.056	-0.214*
No. of family members	-0.215*	0.121	0.087	-0.205*
Socio-economic status	0.418**	-0.341**	0.145	0.281*
Husband's education	0.341*	-0.184*	0.189*	0.232*
Husband's occupation	0.325*	-0.222*	0.206*	0.166

*Significant at 0.05 level

**Significant at 0.01 level

Table 4.4.2: Correlation matrix between individual, familial characteristics with empowerment status and health status of Kunbi women

N=230

Variables	Empowerment status	General health status	Reproductive health status	Nutritional status
Age	-0.258*	0.201*	0.124	0.057
Education	0.412**	-0.219*	0.204*	0.154
Occupation	0.614**	-0.185*	0.243*	0.166
Type of family	-0.218*	0.143	0.044	-0.184*
No. of family members	-0.245*	0.126	0.064	-0.195*
Socio-economic status	0.505**	-0.241**	0.354*	0.261*
Husband's education	0.234*	0.153	0.265*	0.152
Husband's occupation	0.267*	0.162	0.196	0.148

*Significant at 0.05 level

**Significant at 0.01 level

positively correlated with general health status of the respondents. As age increased, health complications increased. Education, working status, socio-economic status, husband's education, husband's occupation were negatively and significantly correlated with general health status. Health problems increases with lower education, low level of employment, SES, lower education of the husband and low level of employment of the husband. Education, working status, husband's education and husband's occupation were positively and significantly correlated with reproductive health status of the respondents. Women with higher education, employment, husband's higher education and better employment possess good reproductive health. Education, working status and husband's occupation of the family was positively and significantly correlated with nutritional status where, higher education, better employment and better occupation of the husband increased the nutritional status.

Therefore, hypothesis stating that there is no individual and familial characteristics on empowerment status and health status of Kunbi women is rejected.

Table 4.4.3 signifies the interrelationship between general health status and empowerment status of Halakki Vokkaliga women. There was positive and highly significant correlation found between health status and empowerment status. Health status was positively and significantly correlated with nutritional status and reproductive health status.

Thus, hypothesis stating that there is no relationship between empowerment status and health status of Halakki Vokkaliga women is rejected.

Table 4.4.4 implies the interrelationship between empowerment status and health status of Kunbi women. There was positive and highly significant correlation between health status and empowerment status. Nutritional status and reproductive health status were positively and significantly linked with health status.

Thus, hypothesis stating that there is no relationship between empowerment status and health status of Kunbi women is rejected.

4.5: Combined effects of selected factors on empowerment and health status of Halakki and Kunbi women

In the table 4.5.1, predictor variables of empowerment status of Halakki Vokkaliga women was explained. In the first model, individual characteristics such as age, education and occupation were added. Education and occupation were found to be the positive and significant predictors and contributing 37 per cent of variance to the empowerment status. In the second model, along with individual characteristics, familial characteristics like type of family, no. of family members, socio-economic status, husband's education and husband's

Table 4.4.3: Interrelationship between empowerment status and health status of Halakki Vokkaliga women

N=230

Factors	Empowerment status	General health Status	Nutritional status	Reproductive health status
Empowerment status	1			
General health status	0.250*	1		
Nutritional status	0.189*	0.425**	1	
Reproductive health status	0.121	0.311**	0.191*	1

*Significant at 0.05 level

**Significant at 0.01 level

Table 4.4.4: Interrelationship between empowerment status and health status of Kunbi women

N=230

Factors	Empowerment status	General health status	Nutritional status	Reproductive health status
Empowerment status	1			
General health status	0.284*	1		
Nutritional status	0.076	0.236*	1	
Reproductive health status	0.084	0.194*	0.112	1

*Significant at 0.05 level

Table 4.5.1: Predictor variables of empowerment status of Halakki Vokkaliga women
N=230

Predictors	Model 1		Model 2		Model 3	
	B	SE	B	SE	B	SE
Individual characteristics						
Age	-0.705	0.188	-0.605	0.152	-0.542	0.040
Education	4.12**	1.478	5.63**	2.188	5.071**	2.464
Occupation	2.138**	1.145	2.067*	1.142	2.064*	1.450
Familial characteristics						
Type of family			-0.601	0.296	-0.627	0.294
No. of family members			-0.307	0.623	-0.546	0.612
Socio-economic status			3.074**	2.904	3.001**	2.877
Husband's education			2.181**	1.941	2.011*	1.840
Husband's occupation			0.301	0.540	0.907	0.943
Social characteristics						
SHG enrolment					1.01*	0.124
Govt. schemes enrolment					0.054	0.212
Media usage					1.045*	0.856
Mobile usage frequency					1.014*	0.947
Mobile usage					0.904	0.024
R square	0.393		0.431		0.475	
Adjusted R square	0.373		0.394		0.435	
Standard error of the estimate	0.630		0.613		0.611	
F value	13.959**		11.568**		9.041**	

*Significant at 0.05 level

**Significant at 0.01 level

occupation were added. In this, socio-economic status and husband's education were significantly predicting and contributing 39 per cent to the empowerment status. In the third model, along with individual characteristics and familial characteristics, social characteristics like SHG enrolment, govt scheme enrolment, media usage, mobile usage frequency and mobile usage were included. SHG enrolment, media usage and mobile usage frequency were the positive significant predictors and explains 43 per cent to the empowerment status. All the three models were statistically significant and together contributing 43 per cent to empowerment status of Halakki Vokkaliga women.

Table 4.5.2 describes the predictor variables of empowerment status of Kunbi women. In model I, individual characteristics like age, education and occupation were added. The empowerment status was found to be positively and significantly predicted by education and occupation, which contributed to 37 per cent of the variance. Along with individual characteristics, familial characteristics like type of family, no. of family members, socio-economic status, husband's education and husband's occupation were incorporated in the model II along with individual characteristics. In this, socioeconomic status, husband's level of education and husband's occupation were positive predictors, accounting for 40 per cent variance. In model III, SHG enrolment, govt scheme enrolment, media usage, mobile usage frequency and mobile usage were included with individual and familial characteristics. Along with individual characteristics and familial characteristics social characteristics like SHG enrolment, media usage, mobile usage and mobile usage frequency were the positive significant predictors and explains 44 per cent to the empowerment status. The three models collectively contributed 44 per cent to the empowerment status of Kunbi women, each of which was statistically significant.

Table 4.5.3 denotes the predictor variables of health status of Halakki Vokkaliga women. In model I, individual characteristics like age, education and occupation were added. The health status was found to be positively and significantly predicted by education which contributed 28 per cent of the variance. Along with individual characteristics, familial characteristics like type of family, no. of family members, socio-economic status, husband's education and husband's occupation were included in the model II. In this, socioeconomic status and husband's education were the positive predictors, and contributors to the health status, explaining for 33 per cent variance. In the model III, along with individual characteristics and familial characteristics reproductive health characteristics like age at

Table 4.5.2: Predictor variables of empowerment status of Kunbi women**N=230**

Predictors	Model 1		Model 2		Model 3	
	B	SE	B	SE	B	SE
Individual characteristics						
Age	-0.887	0.198	-0.715**	0.174	-0.625	0.172
Education	4.58**	1.749	6.62**	2.188	5.071**	2.464
Working status	2.352**	1.546	2.241*	1.184	2.144*	1.522
Familial characteristics						
Type of family			-0.710	0.244	-0.547	0.243
No. of family members			-0.808	0.723	-1.446**	0.922
Socio-economic status			3.512*	2.806	3.321**	2.783
Husband's education			2.567**	1.849	2.471*	1.840
Husband's occupation			2.101*	1.540	2.007*	1.434
Social characteristics						
SHG enrolment					2.113*	1.124
Govt. schemes usage					1.194	2.194
Media usage					1.147*	0.956
Mobile usage frequency					1.018*	0.910
Mobile usage					1.115*	0.940
R square	0.398		0.447		0.478	
Adjusted R square	0.378		0.409		0.441	
Standard error of the estimate	0.772		0.751		0.720	
F value	16.959**		15.568**		11.041**	

*Significant at 0.05 level

**Significant at 0.01 level

Table 4.5.3: Predictor variables of general health status of Halakki Vokkaliga women**N=230**

Predictors	Model 1		Model 2		Model 3	
	B	SE	B	SE	B	SE
Individual characteristics						
Age	2.391	2.023	1.314	2.642	1.554	2.401
Education	4.12**	1.478	-5.63**	2.188	-5.071**	2.464
Occupation	3.016	2.737	2.203	3.312	2.168	3.111
Familial characteristics						
Type of family			1.033	1.37	1.469	1.336
No. of family members			1.162	4.68	2.343	5.283
Socio-economic status			-3.216*	2.877	-3.213*	3.215
Husband's education			-3.891*	2.354	-3.745*	2.412
Husband's occupation			2.741	2.332	1.184	1.418
Reproductive health related characteristics						
Age at menarche					0.225	0.188
Age at marriage					4.439**	2.252
Type of marriage					0.295	0.177
Age at first pregnancy					3.208*	2.116
Type of delivery					-5.190*	4.154
Place of delivery					0.475	0.253
R square	0.302		0.354		0.384	
Adjusted R square	0.284		0.337		0.354	
Standard error of the estimate	0.984		0.874		0.841	
F value	18.939**		17.865**		13.411**	

Significant at 0.05 level

**Significant at 0.01 level

menarche, age at marriage, type of marriage, no. of children, age at first pregnancy, type of delivery, place of delivery were incorporated along with individual and familial characteristics. Age at marriage and age at first pregnancy were the significant positive contributors and type of delivery was a negative significant predictor, together this model explains around 35 per cent of variance. Together, the three models contributed 35 per cent to the health status of Halakki Vokkaliga women, making them all statistically significant.

The reproductive health status predictor variables for Halakki Vokkaliga women are represented in Table 4.5.5. The first model contained individual factors such as age, education, and occupation. Education was found to have a significant influence on reproductive health status, accounting for 32 per cent of the variance. The model II considered factors related to the family, along with individual characteristics such as the type of family, the number of family members, socio-economic status, husband's education and husband's occupation along with individual characteristics. The characteristics that positively predicted the health status were the socio-economic status and husband's education and accounted for 36 per cent of the variance. Age at menarche, age at marriage, type of marriage, number of children, age at first pregnancy, type of delivery and place of delivery were reproductive health parameters that were added to the model III along with individual and familial characteristics. Positive contributors were age at marriage and age at first pregnancy, whereas type of delivery was a negative predictor. This model accounts for about 38 per cent of the variance. The three models collectively explained the reproductive health status of Halakki Vokkaliga women by 38 per cent, making them statistically significant.

The reproductive health status predictor variables for Kunbi women are represented in Table 4.5.6. The first model included individual factors such as age, education, and occupation. Education was found to have a significant influence on health status, accounting for 30 per cent of the variance. The model-II contained familial characteristics along with individual characteristics such as type of family, number of family members, socio-economic status, husband's education and husband's occupation. The factors such as socio-economic status and husband's education were positively predicted the reproductive health status and accounted for 32 per cent of contribution. Model III included individual characteristics, familial characteristics and reproductive health characteristics such as age at menarche, age at marriage, type of marriage, number of children, age at first pregnancy, type of delivery and

Table 4.5.4: Predictor variables of general health status of Kunbi women**N=230**

Predictors	Model 1		Model 2		Model 3	
	B	SE	B	SE	B	SE
Individual characteristics						
Age	2.525	2.040	-2.603	2.021	-2.412	2.001
Education	2.956	3.668	2.701	2.703	2.643	2.647
Occupation	-3.105*	2.721	-3.679*	1.588	-3.566*	1.844
Familial characteristics						
Type of family			1.442	1.845	2.351	2.780
No. of family members			3.041*	1.841	3.123*	2.328
Socio-economic status			-4.575**	3.756	-4.652**	3.884
Husband's education			-3.907**	2.703	-3.852*	2.674
Husband's occupation			1.679	2.365	1.547	2.114
Reproductive health related characteristics						
Age at menarche					0.332	0.733
Age at marriage					-4.319*	2.157
Type of marriage					0.086	0.116
Age at first pregnancy					3.423	3.231
Type of delivery					4.846*	3.588
Place of delivery					0.328	0.577
R square	0.332		0.378		0.379	
Adjusted R square	0.304		0.341		0.342	
Standard error of the estimate	0.998		0.964		0.912	
F value	13.959**		11.568**		9.041**	

Significant at 0.05 level

**Significant at 0.01 level

Table 4.5.5: Predictor variables of reproductive health status of Halakki Vokkaliga women**N=230**

Predictors	Model 1		Model 2		Model 3	
	B	SE	B	SE	B	SE
Individual characteristics						
Age	-1.242	0.247	-1.114	0.214	-1.014	0.587
Education	2.036*	1.145	2.166*	1.110	2.654**	1.247
Occupation	0.165	0.040	0.236	0.006	0.108	0.025
Familial characteristics						
Type of family			1.654	1.254	1.547	1.741
No. of family members			1.743	1.236	1.365	1.123
Socio-economic status			3.547*	2.35	4.658**	2.145
Husband's education			5.647**	3.254	5.247*	3.325
Husband's occupation			0.254	0.111	0.559	0.278
Reproductive health related characteristics						
Age at menarche					1.147	1.224
Age at marriage					5.147**	4.224
Type of marriage					0.064	0.001
Age at first pregnancy					4.578**	3.998
Type of delivery					-3.256**	3.214
Place of delivery					1.345	1.023
R square	0.347		0.388		0.402	
Adjusted R square	0.324		0.367		0.385	
Standard error of the estimate	0.947		0.923		0.900	
F value	10.411**		16.255*		18.411**	

Significant at 0.05 level

**Significant at 0.01 level

Table 4.5.6: Predictor variables of reproductive health status of Kunbi women**N=230**

Predictors	Model 1		Model 2		Model 3	
	B	SE	B	SE	B	SE
Individual characteristics						
Age	-1.422	0.427	-1.411	0.365	-1.410	0.250
Education	2.630*	1.415	2.661*	1.011	2.456**	1.741
Occupation	0.561	0.400	0.632	0.604	0.801	0.520
Familial characteristics						
Type of family			1.564	1.452	1.745	1.147
No. of family members			1.347	1.032	1.565	1.321
Socio-economic status			3.745*	2.530	4.854**	2.547
Husband's education			5.746**	3.457	5.748*	3.523
Husband's occupation			0.458	0.110	0.665	0.548
Reproductive health related characteristics						
Age at menarche					1.741	1.422
Age at marriage					5.741**	4.422
Type of marriage					0.460	0.100
Age at first pregnancy					4.875**	3.899
Type of delivery					-3.564**	3.419
Place of delivery					1.125	0.254
R square	0.324		0.357		0.397	
Adjusted R square	0.301		0.324		0.364	
Standard error of the estimate	0.749		0.654		0.601	
F value	9.47**		13.58**		15.411**	

Significant at 0.05 level

**Significant at 0.01 level

place of delivery were incorporated. Positive contributors were age at marriage and age at first pregnancy, whereas type of delivery was a negative contributor. This model accounts for about 36 per cent of the variance. The three models jointly explained the reproductive health status of Kunbi women by 36 per cent, making them statistically significant.

Table 4.5.7 shows the predictor variables for Halakki Vokkaliga women's nutritional status. Individual characteristics including age, education, and occupation were part of the first model. Education was shown to account for 28 per cent of the variance and to have a significant impact on nutritional status. The family's socio-economic status, type of family, number of family members, husband's education and husband's occupation were all included in the model II with individual characteristics. Socio-economic position and the level of education of the husband were significant predictors of reproductive health status, accounting for 32 per cent of the variance. Age at menarche, age at marriage, kind of marriage, number of children, age at first pregnancy, type of birth, and place of delivery were among the reproductive health factors added into Model III with individual characteristics and familial characteristics. Age at marriage was positive contributor and, in this model, 30 per cent of the variance is explained. The three models were statistically significant because they together explained 30 per cent of the reproductive health status of Halakki Vokkaliga women.

Table 4.5.8 signifies the predictor variables for nutritional status among Kunbi women. Individual characteristics like age, education, and occupation were added in the first model. Education accounted 27 per cent of variance and to have a significant impact on nutritional status. The socio-economic status, type of family, number of family members, husband's education and husband's occupation were all included in the model II along with individual characteristics. Socio-economic status was a significant predictor of nutritional status, accounting for 28 per cent of variance. Age at menarche, age at marriage, type of marriage, number of children, age at first pregnancy, type of birth, and place of delivery were among the reproductive health factors added into Model III along with individual characteristics and familial characteristics. Age at marriage and age at first pregnancy were positive contributors and, in this model, 29 per cent of the variance is explained. The three models were statistically significant because they together explained 29 per cent of the nutritional status of Kunbi women.

Table 4.5.7: Predictor variables of nutritional status of Halakki Vokkaliga women
N=230

Predictors	Model 1		Model 2		Model 3	
	B	SE	B	SE	B	SE
Individual characteristics						
Age	1.80	0364	1.64	1.713	1.478	1.368
Education	2.135*	0.371	2.444*	0.913	2.668*	2.373
Occupation	2.02	0.37	2.001	0.358	2.00	0.321
Familial characteristics						
Type of family			3.074	2.904	3.001	2.877
No. of family members			3.26	2.586	3.287	2.657
Socio-economic status			4.095**	3.995	4.174**	3.657
Husband's education			2.478	3.547	2.547	3.554
Husband's occupation			1.419	1.221	1.247	1.114
Reproductive health related characteristics						
Age at menarche					0.208	0.195
Age at marriage					3.414*	3.223
Type of marriage					0.812	0.472
Age at first pregnancy					2.668	0.373
Type of delivery					0.365	0.159
Place of delivery					0.296	0.178
R square	0.307		0.320		0.334	
Adjusted R square	0.287		0.304		0.308	
Standard error of the estimate	0.654		0.874		0.841	
F value	15.322**		12.214**		8.657*	

*Significant at 0.05 level

**Significant at 0.01 level

Table 4.5.8: Predictor variables of nutritional status of Kunbi women**N=230**

Predictors	Model 1		Model 2		Model 3	
	B	SE	B	SE	B	SE
Individual characteristics						
Age	1.841	1.917	1.572	1.501	1.745	1.543
Education	3.875**	3.612	3.654*	3.254	3.621*	3.254
Occupation	1.923	1.922	1.854	1.822	1.800	1.742
Familial characteristics						
Type of family			3.274	2.045	3.14	2.787
No. of family members			3.678*	2.685	3.783*	2.756
Socio-economic status			4.897**	3.599	4.471**	3.574
Husband's education			2.874	3.574	2.845	3.464
Husband's occupation			1.914	1.135	1.742	1.417
Reproductive health related characteristics						
Age at menarche					0.807	0.594
Age at marriage					3.441*	0.332
Type of marriage					0.218	0.174
Age at first pregnancy					4.866*	0.674
Type of delivery					-0.254	0.214
Place of delivery					0.692	0.583
R square	0.294		0.314		0.332	
Adjusted R square	0.274		0.287		0.291	
Standard error of the estimate	0.564		0.874		0.841	
F value	13.324**		11.544**		9.675*	

*Significant at 0.05 level

**Significant at 0.01 level

4.6 Qualitative findings of Halakki Vokkaliga and Kunbi women focusing on empowerment and health aspects

Women expressed their views and experiences regarding empowerment and health aspects which are reported under following themes and sub themes:

Themes	Sub-themes
1. Rich culture to cultural dilution	a) Strong ethnic clusters to migration b) Rich knowledge of ethnic medicines to extinction c) Tradition cultural practices to mainstreamed culture
2. Conventional to Contemporary lifestyle	a) Transformation from ethnic dressing to contemporary style b) Negative to positive attitude towards children's education c) Shift from agriculture to non-agriculture jobs d) Traditional food culture to localized culture e) Home remedies to Health care facilities
3. Less Empowered to Empowered	a) Home maker to employed woman b) Hardworking women and less working males c) Role of personnel from developmental departments d) No support to improved support from husbands
4. Constraints to mainstreaming	a. Language barrier b. Secluded and remote villages/hamlets c. Poor implementation of government schemes d. Ascendancy of encircling communities

1. Rich culture to cultural dilution

From the past years Halakki Vokkaliga and Kunbi communities maintained unique traditions including farm practices, food habits, health practices, ethnic medicines, dressing pattern, music, dance, painting, festivals, marriages, lifestyle etc. But now days some of their traditions got changed due to globalization. Respondents from both the communities voiced about their viewpoints regarding cultural dilution.

a) Strong ethnic clusters to migration

Kunbi people used to live in joint families and extended families in a big house. But the need of job and other factors changed their living pattern. Respondents from a joint family where they are living in a very large number expressed that,

“We are living in a very big number in the family. We are living like this from the past but many have gone to other states for work purpose...they come back during festivals...to meet the family needs they are doing other work. (S13)

‘I’m from a joint family, where we live very happily together. But here (in husband’s home) it is a nuclear family. We separated for ration card purpose. But the earlier living pattern was good.’ (S 10)

‘Many males and young boys in our village migrated to other places for job. We can’t see the families like earlier. (S4)

b) Rich knowledge of ethnic medicines to extinction

Halakki Vokkaliga and Kunbi communities are known for ethnic medicines knowledge and usage for health problems. Recent advancement in lifestyle and health seeking behaviour among them leading to disappearance of usage like earlier. Respondent opined that,

‘One of the old lady gives ethnic medicine for kidney problems and snake biting. She only knows about it. Her son is working in other place...don’t know who will continue later.(S10)

‘Our parents used home medicines a lot for many of the mild health problems. I don’t know medicinal plants usage like them, only some I know. For my child health problems I go to hospital only’.(S3)

‘I prefer to use home medicines initially for minor ailments. but for my child we take him to hospital, I feel like these home medicines don’t work for these younger generation, their resistance power is not good as us, they are not strong.(S10)

c) Tradition cultural practices to mainstreamed culture

Halakki Vokkaliga and Kunbi communities have their own farming practices, traditional varieties of agriculture and horticulture crops, cultural songs, customs of marriage

and other ceremonies, wall paintings etc. But now a day the wall paintings, cultural songs, dance hardly ever appear. Respondents said that

'I don't know how to draw chukki chittara (wall painting of the Halakki Vokkaliga community). In our home we didn't. People of my age rarely know about those paintings and songs. Mobile brought the changes and I know some film songs... (with smile) (S1)

'Earlier we used to grow ragi and vegetables in our fields. Now we are growing areca nut and spices near our home. It gives more profit than earlier. It's better to grow areca nut instead of other crops. Thinking to convert the fields to areca nut plantation. (S5)

'My grandfather used to preserve the traditional paddy varieties and we used to grow that only. But in my husband's home they brought the seeds from the market and grow. Earlier farming practice is reducing, people focusing on more yields. We have very less land too, so not getting enough income. It's better to go outside and work.'(S8)

2. Conventional to Contemporary lifestyle

a) Transformation from ethnic dressing to contemporary style

Halakki Vokkaliga women adorn themselves with beads and necklaces, heavy nose rings and distinctive attire. Kunbi women also draped the saree differently. Their dressing pattern is suitable for them to work in fields. The unique dressing pattern followed from ancient times but the younger generation departed from that. Respondents said that,

'My mother and grandmothers used to drape the saree like that. I'm not. I feel discomfort in that. I don't want to showcase me differently to outside world. People easily notice us and look somewhat differently if we wear like that... so we wear the saree like others.'(S8)

'Women above the age 50 years are wearing like that. I will not. I don't have such type of jewellery too. Now I days very few people are wearing like that, women in some of the villages older women still practicing the same. But there also younger women not.'(S3)

b) Negative to positive attitude towards children's education

In recent years, many government programmes emphasized on education. People of these communities also getting awareness about education of their children. Increasing opportunities for education, getting inspiration from the surrounding communities they are sending children to higher education to other places.

'I don't have much scope for my education during my school days. There were very less number of schools, which is also in faraway from my home. But I don't want my child to be suffered. I don't know English and much knowledge about outside. I'm thinking to keep my child in hostel for her college education, there she can get better study environment than here. (S8)

'I have completed up to SSLC. I want my child to go for engineering. Other communities in our region are studying better. Education is must for survival; we are not getting enough income from this agriculture land also. Therefore, seeking job outside is necessary (S2).

'My son is studying ITI in Karwar. My daughter is in high school. Now near to our village PU College is there, off course have to travel by bus. But it is not a big thing. I will send my daughter there. Later we can think about her further studies.(S 10)

c) Shift from agriculture to non-agriculture jobs

In the previous years Halakki Vokkaliga and Kunbi community people completely dependent on agriculture. But due to globalization, they are seeking the jobs other than agriculture work for the livelihood. In Kunbi community one person has completed PhD and running as NGO for the welfare of the community. Halakki Vokkaligas also getting into government and private sectors. Respondent expressed that,

'Earlier in our community, people are dependent on forest products and sell in the market. Now it is difficult to get forest products because of strict forest rules and regulations. In many regions forest department made people to shift to other areas because of various projects. So there is no other way, seeking jobs outside is necessary.'(S10)

'Now a days all the prices are increasing in the market. The income what we get from agriculture is not enough to meet family requirement. So people are going outside during off-season (when there is not much agriculture work) to look for other work.'(S1)

d) Traditional food culture to localised culture

The food habits of tribal population are very much diverse. They grow most of the foods what they consume or collect that from forest. But urbanization and many government rules changed the consumption pattern and food habits and they are moving towards localized culture of foods.

'We used to grow tubers, we preserve it for whole year and consume it. But now children are demanding other outside foods too much, so we buy the foods from outside market than before. It is difficult to get forest resources like earlier. '(S 10)

'Our ancestors used to hunt the animals in the forest and eat. In our culture hunting is treated as a common thing and we should eat only hunted animals. Eating domestic animals is treated as sin. But now everyone bought the non-vegetarian food from outside market and consume it.'(S12)

'Ragi ambli is our staple food since past. It gives more energy and suitable to climate of our region. Now we are consuming different foods due to availability of the products in nearby markets.'(S1)

e) Home remedies to Health care facilities

Home remedies are used extensively by the tribal communities and forest is the home for many ethnic medicinal plants. Increasing health problems and expansion of health care facilities to rural areas by government as well as non-government organization made people to go for allopathic medicines. Study participant opined that,

"In our region there were no government hospitals earlier, and only one private doctor was present. But now in our nearby village, government hospital and good doctor is there and we can get the treatment there". (S12)

'Mobile clinic visits our place once in a month and we get treatment from it, if we have any health problems. Initially we try with our home medicines but if is not work we go to doctor only. In present days, most of the people go to hospitals instead of rely on home medicines. It doesn't mean that it will not work, but it takes time.,(S10)

'We can't see home medicine providers like earlier in our places. Previously home medicine usage is very much extensive, now younger generation prefer English medicines.'(S3)

3. Less Empowered to Empowered

Empowerment of women is must for progress of that particular community. In Halakki Vokkaliga and Kunbi communities, status of women is improved in many ways compared to past years. There are many factors contributing for their betterment.

a) Home maker to employed woman

In the past years women were restricted to household work and not going to outside for employment. Respondents say that,

'The role of women is changing slightly, in our community women are searching employment outside also. (S1)

'I got the training under government scheme and now I'm a driver of municipal corporation vehicle. I'm the first lady in this taluk working as driver of government vehicle.'(S15)

b) Hardworking women and less working males

Women play a vital role in upliftment of the family as well as society. Women always work for welfare of the community. Especially Halakki Vokkaliga women are very much painstaking and work day and night during harvesting season of agriculture. Respondents opined that,

'We work throughout the day when there is more work like harvesting, vegetable growing time etc. Men also work but they spend money for bad habits.'(S6)

'I do one or the other work in home, field or in home garden. As I observed, many of our community males specially young adults spend most of the time in front of television or with friends.'(S14)

c) Role of personnel from developmental departments

Many government projects and schemes brought desirable changes in rural communities. Some of the government officers and workers are striving hard for the progress of the Kunbi community. The role of personnel from developmental departments is noticeable and respondents expressed that,

'Taluk panchayat programme officers encouraged me to go for driving training and their role is very prominent in my endeavour. I didn't know about the scheme and they give training under this national scheme and I got this opportunity. I received an award too for my success.'(S15)

'We are getting many useful advice and help from Govt. nurses, ASHA workers, Anganwadi teachers regarding health aspects. Earlier home delivery was very prevalent but now it reduced completely and I prefer hospital delivery.'(S 13)

d) No support to improved support from husbands

The husband's support is very crucial for empowerment of the women. Freedom of movement, participation in decision making and social activities, support of the husband is required. Respondents say that,

"My husband completed Ph.D and running an NGO. He treats me equally and considers my decisions too. He encouraged me to take part in tubers mela and other social activities very actively."(S14)

"I completed graduation and living in a big family. Many elders are there in family. But my husband always supports me and helps in searching jobs outside."(S 13)

4. Constraints to mainstreaming

Halakki Vokkaliga and Kunbi communities are coming to mainstreaming, but still many things which are forbidding it.

a. Language barrier

Many years ago, there are only Marathi schools in Joida taluk and majority of the people speak in Konkani and Marathi language than Kannada. It was very difficult for the government personnel to approach the people. People of aged 50 years and above don't speak in Kannada language and it is one of the constraints to reach the people by outsiders. Study participants expressed that,

"It was very difficult for our elders to communicate with outsiders and faced many problems. Now we are not facing language problem much. I know Kannada, but many can't speak fluently."(S11)

b. Secluded and remote villages/hamlets

Joida taluk is surrounded by a deciduous forest and village are in a remote places. Poor roads and transportation problem, network issues are more prevalent in this area.

"I walk minimum 3-4 kms to get the bus from my home. Roads are not in a good condition and buses are few."(S13)



Collecting information regarding traditional culture and medicinal knowledge from aged women



Plate 10: Qualitative data collection from the respondents



Traditional attire of Halakki Vokkaliga women



Traditional attire of Kunbi women

Plate 11. Traditional attire of Halakki Vokkaliga and Kunbi women

“I often face network problem in my place. As I’m an Anganwadi teacher, we have to keep regular contact with our senior officers and supervisors. I faced many difficulties due to it”.(S14)

“Network uh...what to tell...Students faced difficulty during lockdown and they didn’t attend online classes due to network issue. No one cares about this.”(S9)

c. Poor implementation of government schemes

Government try to strengthen the backward communities and initiated many schemes. But reaching the disadvantaged is also equally important. People from Halakki Vokkaliga and Kunbi communities facing lack of employment and transport problems. Respondents opined that,

‘I’m having Udyog card, according to it we have to get 180 days of work. Even though I’m having card I’m not getting work at least for 90 days. I face financial problem and there is no wage employment also near to my home’.(S6)

“We face transportation problem very much. Due to heavy rain and poor construction of roads, face difficulty in travelling. It is horrible while taking the person to hospitals in case of emergency.” (S11)

“In selected taluk more than eight schools don’t have regular teachers, and they are running by the guest teachers. They receive very less amount. Many teachers perceive Joida as punishment area due to this much heavy rain, network issue, remote areas, transport problem, fear of wild animals etc. Government has to find alternative solution for this”.(S14)

d. . Ascendancy of encircling communities

Halakki Vokkaliga and Kunbi communities surrounded by upper castes and they are dominating in most of the sectors like education, employment etc. Study respondent say that,

“In our place children of other castes perform better and they are intelligent too....our children can’t perform like them.. So they grab the opportunities.”(S9)

“People of other communities get job easily. They have wide network and they do good in examinations. Their relatives also support their education and employment. But in our community it is not happening.. because of that we face lack of employment.”(S5)

Section III

4.7 Impact of intervention on empowerment knowledge of Kunbi women

This section contended with the results of impact of intervention with the intention to improve knowledge of empowerment among Kunbi women. The results are presented under following sub-headings:

4.7.1: Empowerment knowledge among Kunbi women at pre and post-tests

4.7.2: Comparison of mean scores of empowerment knowledge between three conditions

4.7.3: Comparison of mean scores of dimensions of empowerment knowledge between at pre-test and post-tests

4.7.1: Empowerment knowledge among Kunbi women at pre and post-tests

The table 4.7.1 shows the association between empowerment knowledge and pretest, post-tests among experimental and control group. The significant association found ($\chi^2=18.34^{**}$) that, among experimental group, at pre-test majority (61.12%) had low empowerment knowledge, followed by average (30.55 %) and only three women had high empowerment knowledge. But in post-test 1, more than forty per cent fell into average empowerment knowledge followed by low (36.12 %) and high level (22.22%). Similarly, in post-test 2, fifty per cent fell into average level of empowerment knowledge followed by high level (33.34 %) and only 16.66 per cent in low level of empowerment knowledge.

With regard to control group, there was no change observed in their empowerment knowledge from pre-test to post-test and post-test-2. Hence, the association was not significant.

Therefore, hypothesis stating that there is no influence of intervention on knowledge of tribal women is rejected.

4.7.2: Comparison of mean scores of empowerment knowledge between at pre-test and post-tests

The comparative analysis showed that there was significant (F-value=11.13) gain in mean scores of empowerment knowledge from pre-test (10.14) to post-test (13.98) and post-test-2 (15.35) among experimental group. The post hoc (Tukey's HSD) also suggests that there was significant difference observed between the groups. But, no changes were noted in

Table 4.7.1: Association of empowerment knowledge among Kunbi women at pre and post-tests

Time	Levels of empowerment knowledge	Pre-test	Post-test 1	Post-test 2	χ^2
Experimental (n=36)	Low	22 (61.12)	13 (36.12)	6 (16.66)	18.34**
	Average	11 (30.55)	15 (41.66)	18 (50.00)	
	High	3 (8.33)	8 (22.22)	12 (33.34)	
	Total	36 (100.00)	36 (100.00)	36 (100.00)	
Control (n=36)	Low	22 (61.12)	21(58.33)	20 (55.56)	5.56^{NS}
	Average	10 (27.77)	11(30.55)	12 (33.33)	
	High	4 (11.11)	4 (11.11)	4 (11.11)	
	Total	36 (100.00)	36 (100.00)	36 (100.00)	

Figures in the parenthesis indicate percentage

**Significance at 0.01 level NS-Non-significant

control group. This indicates that intervention as the causal factor for increased empowerment knowledge in experimental group (Table 4.7.2a).

From the table 4.7.2b, it was evident that in experimental group, there was significant gains in all aspects such as education empowerment (F-value= 2.58), economic and social empowerment (F-value= 3.54) political and legal empowerment (F-value= 4.75) and autonomy and decision making F-value =3.13) from pre-test to post tests. In control group, the non-significant difference on all dimensions of empowerment knowledge from pre-test to post-test was evident.

Table 4.7.2a: Comparison of mean scores of empowerment knowledge between at pre-test and post-tests

Time	Score range	Experimental (n=36)	Control (n=36)
Pre-test	1-24	10.14±3.58 ^a	11.01±3.43
Post-test 1		13.98±3.11 ^b	11.56±3.12
Post-test 2		15.35±2.91 ^c	11.96±3.24
F-value		11.13**	1.52 ^{NS}

**Significance at 0.01 level NS-Non-significant

Table 4.7.3: Comparison of mean scores of dimensions of empowerment knowledge between at pre-test and post-tests

Dimensions of empowerment knowledge	Time	Experimental (n=36)	Control (n=36)
Educational empowerment (1-4)	Pre-test	1.98±1.23 ^a	2.02±0.67
	Post –test 1	3.10±0.75 ^{bc}	2.16±0.82
	Post-test 2	3.20±0.78 ^{cb}	2.28±0.94
	F-value	2.58*	2.01 ^{NS}
Economic and Social empowerment (1-6)	Pre-test	2.52±1.15 ^a	2.43±1.54
	Post –test 1	4.32±1.43 ^{bc}	2.66±1.34
	Post-test 2	4.56±1.45 ^{cb}	2.54±1.55
	F-value	3.54*	1.98 ^{NS}
Political and Legal empowerment (1-6)	Pre-test	2.12±1.51 ^a	2.36±1.11
	Post –test 1	3.32±1.43 ^b	2.43±1.38
	Post-test 2	4.77±1.16 ^c	2.58±1.46
	F-value	4.75*	1.76 ^{NS}
Autonomy and Decision making (1-8)	Pre-test	4.21±1.41 ^a	4.56±1.64
	Post –test 1	4.32±1.36 ^b	4.63±1.88
	Post-test 2	5.57±1.49 ^c	4.78±1.66
	F-value	3.13*	0.99 ^{NS}

*Significance at 0.05 level NS-Non-significant



Giving lecture during intervention programme



Plate 12: Honouring participants of Intervention programme with reading materials and gifts



Researcher telling about economic empowerment of Kunbi women in DD Chandan news during Tuber's Mela-2022



Researcher with Shri. Mahadev Velip, Rajyotsava Award winner-2021 Folk artist of Kunbi community



Researcher with Sukri Bommagouda, Padma Shri Award winner-2017 Folk singer Halakki Vokkaliga community

5. DISCUSSION

Findings of the current study entitled “Empowerment and Health Status of Halakki Vokkaliga and Kunbi tribal Women: A Study in Uttara Kannada district of Karnataka State” are discussed with the help of relevant reviews under the following headings:

- 5.1 Empowerment status of Halakki Vokkaliga and Kunbi women
- 5.2 Health status of Halakki Vokkaliga and Kunbi women
- 5.3 Influence of individual and familial factors on empowerment status of Halakki Vokkaliga and Kunbi women
- 5.4 Influence of individual and familial factors on general health of Halakki Vokkaliga and Kunbi women
- 5.5 Influence of individual and familial factors on reproductive health of Halakki Vokkaliga and Kunbi women
- 5.6 Influence of individual and familial factors on nutritional status of Halakki Vokkaliga and Kunbi women
- 5.7 Interrelationship between empowerment status and health status of Halakki Vokkaliga and Kunbi women
- 5.8 Impact of intervention on empowerment status of Kunbi women

5.1 Empowerment status of Halakki Vokkaliga and Kunbi women

In the current study, a greater proportion of Kunbi women and a greater proportion of Halakki Vokkaliga women had low and medium levels of empowerment, respectively (Fig 1). The reason could be that Halakki Vokkaliga women received more exposure and entered mainstreamed culture earlier than Kunbi women. The surrounding environment and decisiveness among Halakki Vokkaliga women made them more empowered than Kunbi women. The results of the study by Rashid and Gao (2014) and Leoni and Gunasekaran (2018) also reported that majority of the tribal women had attained only a medium level of empowerment. Leoni and Indhumathi, (2018) in their study found that the living conditions and status of the tribal women are still backward. Tribal women face problems and challenges, in getting a sustainable livelihood and a decent life, due to environmental poverty and the interference of outsiders.

Comparison of mean scores showed significant difference between Halakki Vokkaliga and Kunbi women, in that empowerment scores of Halakki Vokkaliga women was high compared to Kunbi women (Table 4.2.2). Kunbi tribal women live in remote villages and in heavily forested locations, where access to outside world is hampered by transportation and network problems. Additionally, there are extremely few economic prospects, language barrier in the area and a low level of education (table 4.2) compared to Halakki tribes whose dwelling is very much connected to mainstream society and are more recognised by the outside world.

As stated by one of the participant in the study location, “*It was very difficult for our elders to communicate with outsiders and faced many problems*’.

Another participant stated that, “*I walk minimum 3-4 kms to get the bus from my home. Roads are not in a good condition and buses are few.*”

5.2 Health status of Halakki Vokkaliga and Kunbi women

a. General health status of Halakki vokklaiga and Kunbi women

According to the study, majority of the Halakki Vokkaliga and Kunbi women were mildly affected followed by per cent were moderately affected and lesser cent were in severely affected (Fig 2). Health status of women was good, women from both the communities were having lesser health problems. This may be attributable to their dietary practises, continued exposure to a healthy environment and advantages of a lifestyle that allows people to adhere to their traditional values and customs. This helps to reduce health problems. The results was in line with the findings of Chandana and Kumar (2020) who reported, majority (75.80 %) of tribal women were not diagnosed of any chronic illness, 35.00 per cent women in the above age 40 had general health issues.

Comparing the mean scores of general health status of Halakki Vokkaliga and Kunbi women revealed a no substantial variation in the health scores (Table 4.2.3). Both Halakki Vokkaliga and Kunbi cultivate vegetables in their own gardens and consume it. Both the communities have healthy life style practice which keep them away from severe and more health complications. Both populations follow healthy lifestyles that prevent them from developing serious and further health issues.

b. Reproductive health status of Halakki Vokklaiga and Kunbi women

According to the findings, more than fifty per cent of Halakki Vokkaliga and Kunbi women had good reproductive health status, followed by average levels and poor level. (Fig 3). The women had better reproductive health, which may have been a result of many government efforts, programmes, awareness campaigns, and the work of ASHA workers improving rural women's sanitary and reproductive knowledge. Tribal women maintained their reproductive health in accordance with their own traditional practises. Maiti *et al.*, (2005) found that, tribal women had better reproductive health compared to non-tribal counterparts. Deb (2008) reported only 0.30 percent women received antenatal check-ups from traditional birth attendants. Majority (89.00 %) women had successful delivery. On the contrast, Mavelil and Srivastava (2014) reported that reproductive health risks, anaemia and abnormal blood pressure were found among women in Garo tribes.

As expressed by one of the participant, “*We are getting many useful advice and help from Govt. nurses, ASHA workers, Anganwadi teachers regarding health aspects. Earlier home delivery was very prevalent but now it reduced completely and I prefer hospital delivery.*”

The reproductive health scores of Halakki Vokkaliga were higher than those of Kunbi women when the mean scores were compared, showing a significant difference (Table 4.2.4). This might be as a result of the Halakki Vokkaliga women's slightly greater educational level and reproductive health awareness. Due to the accessibility of transportation and the absence of any communication barriers, Halakki Vokkaliga can easily approach medical professionals for any concerns regarding their reproductive health.

c. Nutritional status of Halakki Vokklaiga and Kunbi women.

In the present study, In Halakki Vokkaliga and women, more than sixty per cent (63.05 %) were having ideal weight followed by 22.60 per cent were under weight and 14.35 per cent were underweight. Kunbi women, 59.14 per cent were having ideal weight, 29.13 per cent were under weight and 11.73 per cent were overweight (Table 4.2.5). The percent of underweight were slightly high among Kunbi women. The reason may be due to, poverty to meet expenditure on food lead to inadequate nutrition and poor transportation facilities. The Kunbi community's diet is primarily high in carbohydrates, and there may be certain nutrient deficiencies among them. But, Halakki Vokkaliga people regularly consume ragi ambli in

their diet. Ragi is rich source of calcium and many nutrients. They consume variety of vegetables from their home garden. Result was on par with finding of Rokade *et al.* (2020) who stated that the BMI of tribal women in Maharashtra showed that 11.7 per cent of women were found obese and 37.40 per cent were found underweight. Sartaz *et al.* (2017) found that majority of the ethnic women of Chittagong Hill Tracts were in better nutritional status with normal BMI and daily calorie intake was according to Recommended Dietary Allowance (RDA). Ghosh (2016) quoted that among Santal-Munda tribal women, most of the women were having normal BMI (76.27 %) but quite a few of them were found to be overweight (4.23 %) as well as under nutrition was also prevalent (19.49 %) among these tribal women with 6.80 per cent severity

5.3 Influence of individual and familial factors on empowerment status of Halakki Vokkaliga and Kunbi women

a. Individual factors

b. Familial factors

a. Individual factors on empowerment status of Halakki Vokkaliga and Kunbi women

Regarding the respondents' ages, neither a significant correlation nor a comparison between age and the empowerment status of Halakki Vokkaliga and Kunbi women observed (Table 4.3.1a). However, compared to women in the younger age group, older age group women had lower empowerment scores. The correlation was found to be significant, negative correlation observed (Table 4.4.1 and 4.4.2). The age of the women was also shown in the regression analysis to be a negative predictor, but it was not significant. As the age of the participants increase, empowerment score decreased. (Table 4.5.1 and Table 4.5.2). The younger women had higher levels of education and used media and mobile more frequently than older women, which could be the cause. Younger Halakki Vokkaliga and Kunbi women were more conscious of social and economic issues than older participants. They also showed more participation in decision-making and autonomy.

With respect to education, significant association and comparison found with empowerment status. (Table 4.3.1b). Correlation also found significant where there was positive and significant correlation observed, (Table 4.4.1 and Table 4.4.2) increase in education level increased the empowerment status of the Halakki Vokkaliga and Kunbi

women. Regression results indicated education as a strong significant predictor in both Halakki Vokkaliga and Kunbi women. (Table 4.5.1 and Table 4.5.2). This may be due to women with better education involve themselves in decision making and education boosts self-confidence in an individual and in turn it helps to improve the status.

Consider to occupation, significant association and comparison found with empowerment status. (Table 4.3.1c). Correlation also found significant where there was positive and significant correlation observed, (Table 4.4.1 and Table 4.4.2) increase in occupation level increased the empowerment status of the Halakki Vokkaliga and Kunbi women. Regression analysis showed occupation as a strong significant positive predictor in both Halakki Vokkaliga and Kunbi women. (Table 4.5.1 and Table 4.5.2). Increase in occupation level enhances the socio-economic status and living conditions. Women can explore herself in different social activities sequentially it helps in empowerment of women.

b. Familial factors on empowerment status of Halakki Vokkaliga and Kunbi women

Pertaining to type of family significant difference was observed between nuclear, joint and extended families with empowerment. (Table 4.3.1d). Significant negative relationship also noted between type of family and empowerment status (Table 4.4.1 and 4.4.2). Women from joint and extended families were less like to participate in decision making and family matters. Autonomy and social participation also less. Elder members in the family mainly used to take major decisions and them less likely to encourage the women participation in that. Regression analysis showed type of family was not a significant predictor of empowerment status (Table 4.5.1 and Table 4.5.2). No. of family members also showed similar findings where significant difference between women in more number of family members were scored less in empowerment status. (Table 4.3.1e). Correlation found to be negative in that as the number of family members increases empowerment score decreased. (Table 4.4.1 and 4.4.2) In regression analysis, negative influence of number of family members observed, but it was not statistically significant. (Table 4.5.1 and Table 4.5.2).

Socio-economic status of the family showed significant association and comparison with empowerment status in both Halakki Vokkaliga and Kunbi women (Table 4.3.1f) and highly significant positive correlation was also observed (Table 4.4.1 and 4.4.2). Regression findings indicated that socio-economic status was a significant predictor of empowerment status (Table 4.5.1 and Table 4.5.2). The women who were in high socio-economic status

were better in empowerment status may be due to their level of education, occupation and support from the family.

Husband's education and occupation exhibited significant association and comparison with empowerment status in both Halakki Vokkaliga and Kunbi women (Table 4.3.1g and 4.3.1h). Positive and significant relationship also observed between husband's education and occupation with empowerment status (Table 4.4.1 and 4.4.2). Regression analysis explored that, husband's education was a significant predictor of women empowerment in both Halakki Vokkaliga and Kunbi women, but husband's occupation found to be the significant predictor in case of empowerment status of Kunbi women (Table 4.5.1 and Table 4.5.2). Husband's education and occupation are interrelated. Women whose husband's having better education and occupation likely to involve their wife in decision making and make the provision for the women for their betterment. Those who are having better employment, usually have good socio-economic status. This led the women to access to social media, subsequently their knowledge and status develop.

Regression analysis also signposted that, SHG enrolment, media usage and mobile usage were the significant positive influencers of women empowerment status in both Halakki Vokkaliga and Kunbi women (Table 4.5.1 and Table 4.5.2). Women who enrolled for SHG get economic participation and they acquire more exposure in society. They participate in various trainings through SHGs and participate in exhibitions etc. Mobile and media usage brought a desirable change in rural community where knowledge level of the people increased to a greater extent.

These above results are with the study findings of Gunasekaran (2016) found that age of women, type of marriage, education of women and her husband, occupation of women and her husband, membership in SHG and exposure to mass media were the factors significantly associated with the women empowerment. Rashid and Gao (2014) in their study revealed that was significant positive correlation with empowerment and family size, assets, personal income, media exposure and decision-making among tribal women. Women perceived poverty and lack of education as major impediments to empowerment. Kritz and Makinwa-Adebusoye (2014) who reported that, higher education, age, type of work, income of the wife had positive and significant effects on women's decision making. Choudhari (2009) stated that, empowerment of women considerably was influenced by higher education, paid work, access to media, socio-cultural norms of the community and household participation rates.

Bushra and Wajiha (2014) who stated that economic participation, economic opportunity available to women and having a bank account was influencing on women empowerment. Pujasree (2014) Educational level, employment status, health status and decision making ability helps to measure the status of women in society. Women's education has to be channelized to employment opportunities. This in turn, will increase the decision making ability of women. Women's ability to communicate with other family members and to be able to convince them indicates a decision making ability of women. When the decision making ability is higher, women can have a higher status in the household,

5.4 Influence of individual and familial factors on general health status of Halakki Vokkaliga and Kunbi women

a. Individual factors

b. Familial factors

a. Individual factors on general health status of Halakki Vokkaliga and Kunbi women

In both Halakki Vokkaliga and Kunbi women there was no significant association and difference was noted for age and health status (Table 4.3.2a). However, the women with 41-50 years age group were more in severely affected general health status. Correlation found to be significant where positive relationship observed, it indicates that, health complications increased with age (Table 4.4.1 and 4.4.2). This might be because of decline of physical health after 45 years and some women were in the menopausal condition. Some of the minor health complications appear during menopausal condition. Regression result indicates age is not a significant predictor of health status in both Halakki Vokkaliga and Kunbi women. (Table 4.5.3 and Table 4.5.4).

Education of the respondents found to significantly associate with health status in both communities. Women with higher education have better health compared to lower education. (Table 4.3.2b) Correlation also showed significant relationship with health status. Health status improved with better education. (Table 4.4.1 and Table 4.4.2). Regression results showed that, education is the significant predictor of health status in Halakki Vokkaliga women. Women with better education, practice health practices and take care and seek treatment for minor health problems (Table 4.5.3 and Table 4.5.4).

With regard to occupation, women who were working have better health status compared to who were agriculture labourer and housewife. Significant association and difference found with health status and education level of the Halakki Vokkaliga and Kunbi women. (Table 4.3.2c) Correlation matrix showed significant relationship with occupation (Table 4.5.1 and Table 4.5.2). In case of Kunbi women, regression result implies occupation as a significant predictor (Table 4.5.4).

b .Familial factors on general health status of Halakki Vokkaliga and Kunbi women

Consider to type of family, there was no significant association and difference found with type of family and general health status of Halakki Vokkaliga and Kunbi women. (Table 4.3.2d). There was no significant relationship between general health status and type of family in both the communities (Table 4.4.1 and Table 4.4.2). Regression analysis showed type of family was a not significant predictor of general health status. (Table 4.5.1 and Table 4.5.2).

Association and comparison of general health status and socio-economic status found significant (Table 4.3.2e). Women from higher socio-economic status having good health status compared to lower SES. Correlation (Table 4.4.1 and Table 4.4.2) and regression also showed significant relationship (Table 4.5.3 and Table 4.5.4). The reason may be women from higher SES take care of their health properly and they take proper treatment for health complications.

Regarding no. of family members, neither Halakki Vokkaliga nor Kunbi women's general health status nor its significance were determined to differ. (Table 4.3.2f). In neither of the communities was there a connection between no. of family members and general health status (Table 4.4.1 and Table 4.4.2). No. of family members was found through regression analysis to be a non-significant predictor of general health status (Table 4.5.3 and Table 4.5.4).

Regression analysis of reproductive health related aspects showed that, early age at marriage early age at first pregnancy and home delivery were significant predictors affects general health status of Halakki Vokkaliga and Kunbi women (Table 4.5.3 and Table 4.5.4).

General health status was shown to be non-significant for association and comparison of mean scores in husband's education and occupation both communities (Table 4.3.2g and Table 4.3.2h). Correlation and regression analysis also show no significant influence of

husband's education and occupation with general health status (Table 4.4.1 and Table 4.4.2) and (Tables 4.5.3 and Table 4.5.4).

These above results are in line with the findings of Chandana and Kumar (2020) who reported that, age of the women significantly correlated with health complications where health problems increased with age. Dar *et al.* (2017) who quoted that education and health status of women were significantly associated. Dash (2013) who reported that, educated people know about schemes and health services implemented by government and use that effectively compare to uneducated. Booth and Carroll (2012) stated that Health gap was mediated by the factors such as differences in income, education and socio-economic status between indigenous and non-indigenous Australians. Sarkar (2019) also reported as there is positive linkage between the increasing monthly income and the openness to modern medicine. This also supported by the finding of Hirdej *et al.* (1986), noted that, income loss appears to have a much stronger effect on health. Dhargupta *et al.* (2017) family income was highly significant positive relation to health status among Santhal tribes.

5.4 Influence of individual and familial factors on reproductive health status of Halakki Vokkaliga and Kunbi women

a. Individual factors

b. Familial factors

a. Individual factors on reproductive health status of Halakki Vokkaliga and Kunbi women

According to the present study findings, there were no significant association and difference observed between age, education with reproductive health status of both Halakki Vokkaliga and Kunbi tribal women. (Table 4.3.3a and Table 4.3.3b). However, correlation and regression revealed significance result of education with reproductive health status but no influence of age observed (Table 4.4.1 and Table 4.4.2) and (Table 4.5.5 and Table 4.5.6).

Occupation of Halakki Vokkaliga and Kunbi women showed significant association, difference and relationship with reproductive health status (Table 4.3.3c) and (Table 4.4.1 and Table 4.4.2). But in regression analysis occupation was not a significant predictor of reproductive health status. (Table 4.5.5 and Table 4.5.6).

The reason could be women who are well educated, working, follow good reproductive health practices and aware about family planning methods, safe motherhood, fertility regulation method and STD/AIDS. They may know about the services and benefits by the government for reproductive health issues and utilize it.

b. Familial factors on reproductive health status of Halakki Vokkaliga and Kunbi women

With regard to type of family and number of family members, non-significant association, difference found (Table 4.3.3d and Table 4.3.3e). Correlation and regression also show similar findings in both Halakki Vokkaliga and Kunbi women. (Table 4.4.1 and Table 4.4.2) and (Table 4.5.5 and Table 4.5.6).

Socio-economic status showed significant association, difference (Table 4.3.3f) Correlation and regression analysis of socio-economic status also showed significant finding in Halakki Vokkaliga and Kunbi women. (Table 4.4.1 and Table 4.4.2) and (Table 4.5.5 and Table 4.5.6). The reason could be women from high SES have more access to better health services and use of contraception properly.

With respect to husband's education there was significant association, difference observed (Table 4.3.3g), correlation and regression also showed significant influence in both Halakki Vokkaliga and Kunbi women. (Table 4.4.1 and Table 4.4.2) and (Table 4.5.5 and Table 4.5.6). But with husband's occupation no such findings observed (Table 4.3.3h). This may be due to educated husbands know about fertility regulation methods and reproductive health related problems. They assist the women in taking care and management of their reproductive health during pregnancy and later.

Regression analysis of reproductive health related characteristics showed early age marriage, early age at first pregnancy and home delivery were significant contributors (Table 4.5.5 and Table 4.5.6). In the earlier days home delivery was most prevalent and this was done by traditional birth attendants. The early marriage, early age of pregnancy and unsafe home deliveries have unfavourable effect on women reproductive health status. Women married at an early age were exposed to frequent childbearing, unplanned motherhood and abortions which negatively affected their health status.

The above results are consistent with the study findings of Jose *et al.* (2014) found that, women with higher education had significantly higher level reproductive health. Salechin (2012) revealed that higher income and economic factors had influence on reproductive health. Income and economic development account for reproductive health of the women. Marriage after 18 years directly influenced better reproductive health of the tribal women. Maiti *et al.* (2005) also reported that, low socio-economic factors contributing to the low reproductive health status. Mavelli and Srivatsava (2019) stated that, educational status was considered as one of the greatest contributor to reproductive health status and effects reproductive health in several ways. It may enhance the ability to time-tested reproductive health methods, age at marriage, pregnancy preferences and family planning. Prakash *et al.* (2011) also suggested that early age at marriage had detrimental effects on the reproductive health status of women.

5.4 Influence of individual and familial factors on nutritional status of Halakki Vokkaliga and Kunbi women

a. Individual factors

b. Familial factors

a .Individual factors on nutritional status of Halakki Vokkaliga and Kunbi women

Age, education, and occupation were not found to significantly differ between Halakki Vokkaliga and Kunbi tribal women, with respect to nutritional health status according to the results of the current study. (Tables 4.3.4a, Table 4.3.4b and Table 4.3.4c) However, correlation and regression showed a significant relationship between education and nutritional status (Table 4.4.1 and 4.4.2) and (Table 4.5.7 and Table 4.5.8). But as increase in age obesity increased.

a .Familial factors on nutritional status of Halakki Vokkaliga and Kunbi women

The number of family members and the type of family have statistically significant relationship, yet there is a difference (Tables 4.3.4e and Table 4.3.4f). Both Halakki Vokkaliga and Kunbi women exhibit similar results in both correlation analysis (Table 4.4.1 and Table 4.4.2). In big families women may not get adequate food and always she is the last one to have food.

Socioeconomic level showed a significant association and difference. (Table 4.3.3g) Significant results from correlation and regression analyses of socioeconomic status were also found in Halakki Vokkaliga and Kunbi women. (Table 4.4.1 and Table 4.4.2) and (Table 4.5.5 and Table 4.5.6). The cause can be because women from high SES backgrounds have more access to food choices and adequate nutrition.

Both Halakki Vokkaliga and Kunbi women demonstrated no substantial influence on the husband's education and occupation in terms of association, difference, correlation, and regression (Table 4.3.3g and Table 4.3.3h) (Table 4.4.1 and Table 4.4.2), and (Table 4.5.5 and Table 4.5.6).

Early marriage, early age at first pregnancy, have significant contributions, according to a regression analysis of parameters associated to reproductive health (Table 4.5.5 and Table 4.5.6). Early marriage and early pregnancies may cause bad impact on their nutritional status.

These results are on par with the study findings of Mohandas *et al.*, (2019) who found that, participants who were less than 30 years of age (0.001), had significantly higher odds of under nutrition. Rokhade *et al.* (2020) also in their study in Maharashtra stated that obesity increased significantly with the increase in age. Poojashree (2014) Lack of awareness about nutritional requirements mostly leaves the tribal women weak, anaemic and they suffer from various diseases. During pregnancy, special attention is required to be given to women otherwise that will affect the health of both the mother and child.

5.7 Interrelationship between empowerment status and health status of Halakki Vokkaliga and Kunbi women

From the study it was observed that, there was significant interrelationship found between general health status, reproductive health status and empowerment status in both the communities. But significant interrelationship observed with nutritional status and empowerment status in case of Halakki Vokkaliga women (Table 4.4.3 and 4.4.4). If women are empowered, they can take proper health care and utilize health services especially reproductive health effectively. Their decision making and autonomy influence on her health related aspects. As good health is the prerequisite of every person, it has to be achieved through proper self-care. When women are empowered then she can take care of her health as well as family efficiently. The result is consistent with the study finding of Khan *et al.* (2013) who reported that, there was a significant relationship between the maternal health care and

the women's autonomy and Sado *et al.* (2014) stated that, women those who took two or more decisions in the family and women having high self-esteem were more likely to have received post natal care services.

5.8 Impact of intervention on empowerment status of Kunbi women

It was observed that, educational intervention proved to be effective, there was substantial improvement in empowerment knowledge of Kunbi women in all the dimensions of empowerment.(Table 4.6.1 and Table 4.6.2) Women expressed positive outcome of intervention programme in decision making, educational, political, social and economic dimensions. Result is in line with the study result of Rani and Devi (2021) who quoted that, intervention found to be effective among women respondents to develop and enhance their empowerment status through decision-making skills. Ismayilova *et al.* (2017) who reported that, economic intervention showed benefits that go beyond changes in financial wellbeing and increased women's status as well as improved family relationships.

It is a harsh reality that, these tribal women especially Kunbi women continue to lag behind in many areas, despite the existence of various constitutional provisions and policies for women. They also face a number of challenges. In Halakki Vokkaliga and Kunbi community, education level of women is low because earlier people of these communities had the thought that, education does not yield any immediate economic return, so tribal parents prefer to engage their children in remunerative employment which supplements the family income. In Halakki Vokkaliga and Kunbi community absence of any stable source of income is a major deterrent for the women to reach their potential. They live at below the poverty level. Halakki Vokkaliga and Kunbi tribal people who live in rural areas engage in a variety of low-level activities in order to meet their basic requirements and supplement their income. The majority of them are involved in agricultural operations of some kind. Tribal women are not typically engaged in any form of continuous labour and, like their male counterparts, are most often seen to be employed in agricultural activities. They work really hard and make a considerable contribution to the family's economic well-being, yet they remain impoverished mostly as a result of the lack of appropriate efforts directed towards their needs. Only a small proportion of tribal men and women are employed in government-related positions.

6. SUMMARY AND CONCLUSION

The present investigation on “Empowerment and health status of Halakki Vokkaliga and Kunbi tribal women: A study in Uttara Kannada district of Karnataka” was conducted during the period of 2019-2022 in Halakki Vokkaliga and Kunbi communities residing areas of Uttara Kannada district with the following objectives.

1. To assess the empowerment status of Halakki Vokkaliga and Kunbi women.
2. To assess the health status of Halakki Vokkaliga and Kunbi women.
3. To conduct situational analysis on empowerment and health status of Halakki Vokkaliga and Kunbi women through ethnographic case-study.
4. To study the relationship between the individual and familial characteristics with the empowerment and health status of Halakki Vokkaliga and Kunbi women.
5. To develop the intervention package to improve the empowerment knowledge of Kunbi women and test the efficacy of intervention package.

A QUAN-qual mixed research method (sequential design) was employed wherein QUAN–quantitative research method remains a dominant research method followed by a less dominant qual–qualitative research method.

Under Quantitative research method, differential design was employed to study the difference between Halakki Vokkaliga and Kunbi women on dependent variables such as empowerment status and health status (general health, reproductive health and nutritional status).

Correlational design was used to study the relationship between independent variable and dependent variables.

Experimental research design was used to study the efficacy of the intervention program in improving the empowerment knowledge in Kunbi women who underwent intervention for being low on empowerment status. A time series design including one pre-test and two post-tests with an interval of seven sessions between the two post-tests were used to measure the change in empowerment knowledge. It was carried out between experimental and control group to study the efficacy of intervention programme. In qualitative research method ethnographic case study was used.

The target population of the study was Halakki Vokkaliga and Kunbi community women in reproductive age group (20-50 years). The target sample of the study was Halakki Vokkaliga and Kunbi community women in the age group between 20-50 years, who were married, non-pregnant and non-lactating. The respondents were drawn randomly (in four different directions so as to represent entire district) from the villages where Halakki Vokkaliga and Kunbi communities resided in Uttara Kannada district. The Halakki Vokkaliga sample comprised of 230 women from fourteen villages. The Kunbi sample comprised of 230 women from twenty two villages. The total sample included 460 women from both the communities.

In the first phase, Halakki Vokkaliga and Kunbi community women residing villages were selected the Uttara Kannada district. After selecting the villages, Anganwadi teachers of that village had been contacted to get the preliminary information about the population and number of households. Pilot study was done on a sample of 30 women from each community to test the reliability of the tools and to get acquaintance with the questionnaires. The reliability of the tools was tested using Split half method and reliability was found to be above 0.70 for each measure. After the pilot study, home visits were made to collect the research data of the Halakki Vokkaliga and Kunbi women. Women of reproductive age group were selected and interviewed individually at the household level. Initially rapport build was made and later, questionnaires were administered. General information schedule eliciting information on individual, familial, social and reproductive information were asked. Empowerment status questionnaire by Rashid and Gao (2014), PGI-2 health questionnaire by Wig *et al.* (1978), Reproductive health practice scale by Hassan MK (2002) and Socio-economic status (SES) scale (Aggrawal *et al.*, 2005) were the tools used for the study. Anthropometric measurements such as height, weight, waist circumference and hip circumference were measured. Qualitative case studies on health practices and empowerment status were done. Intervention package to improve knowledge on empowerment status was developed. Based on the analysis of the data, an educational intervention was provided to that community where status of women is low compare to its counterpart.

Descriptive and inferential statistical such as chi-square, correlation, bivariate analysis, one way ANOVA and step wise regression were employed to know the association,

difference and relationship between dependent variable and independent variables and to know predictor variables.

Salient findings of the study

1) Empowerment and health status of Halakki Vokkaliga and Kunbi women

- ❖ Among Halakki Vokkaliga women, 42.60 per cent were in medium level of empowerment status followed by 27.40 per cent were in high level and 30 per cent were in low level of empowerment. In Kunbi women, more than forty per cent (42.17 %) were in low level of empowerment followed by 38.27 per cent in medium level and less than twenty per cent (19.56 %) were in low level of empowerment.
- ❖ A significant difference was observed between mean scores of empowerment status of Halakki Vokkaliga and Kunbi women, implying better empowerment status of Halakki Vokkaliga (29.53) women compared to Kunbi women (22.54).
- ❖ Among Halakki Vokkaliga women, majority (75.22 %) were mildly affected followed by moderately affected (16.09 %) and only 8.69 per cent were severely affected. Similar trend was observed in Kunbi women where, 73.40 per cent were mildly affected followed by moderately affected (17.39 %) and severely affected (9.13 %).
- ❖ There was no significant difference observed between mean scores of health status of Halakki Vokkaliga and Kunbi women.
- ❖ In Halakki Vokkaliga women, nearly sixty per cent (58.69 %) were having good reproductive health status followed by average level (25.66 %) and poor level (15.65 %). Similar result trend was observed among Kunbi women where 52.61 per cent were having good reproductive health status followed by average level (28.70 %) and poor level (18.69 %).
- ❖ Significant difference was observed between mean scores of reproductive health status of Halakki Vokkaliga and Kunbi women where reproductive health of Halakki Vokkaliga women (55.01) was better compared to Kunbi women (52.32).
- ❖ In Halakki Vokkaliga women, more than sixty per cent (63.05 %) were having ideal weight followed by underweight (22.60 %) and 14.35 per cent were found to be overweight. Among Kunbi women, 59.14 per cent were having ideal weight, 29.13 per

cent were under weight and only 11.73 per cent were overweight. However, none of them were obese in both the communities.

- ❖ With regard to lean body mass index, among Halakki Vokkaliga women, more number (62.18 %) were in normal group followed by 25.22 per cent were underweight and 12.60 per cent were obese. In Kunbi women, 57.40 per cent had normal followed by underweight (32.60 %) and obese (10.00 %).
- ❖ Pertaining to waist to hip ratio, in Halakki Vokkaliga women more number (83.92 %) were normal and 16.08 per cent were having abdominal obesity. In Kunbi women also similar results was observed where, highest number (88.70 %) of women were normal and only 11.30 per cent were having abdominal obesity.
- ❖ Comparison of mean scores showed no difference between nutritional status of Halakki Vokkaliga and Kunbi women.

2) Influence of individual and familial characteristics on empowerment Halakki Vokkaliga and Kunbi women

- ❖ Association and comparison of age with empowerment status was found non-significant in Halakki Vokkaliga and Kunbi women.
- ❖ Association and comparison of education with empowerment status was found significant in Halakki Vokkaliga and Kunbi women, in that women who were having less education and no schooling scored less indicating significant difference between the levels of education.
- ❖ Association and comparison of occupation with empowerment status was found significant in Halakki Vokkaliga and Kunbi women where, working women scores was significantly higher compared to agriculture labourer/housewife women inferring high empowerment among working women.
- ❖ Comparison of mean scores of types of family and empowerment status found to be significant for Halakki Vokkaliga and Kunbi women. Empowerment mean scores of nuclear family women was high compared to joint and extended families.
- ❖ Association and comparison of socio-economic status with empowerment status was found significant in Halakki Vokkaliga and Kunbi women where women from upper

middle social economic status where better were scored higher compared to women from poor and very poor socio-economic status.

- ❖ Comparison of means scores of number of family members with empowerment status was found significant in Halakki Vokkaliga women, in that women with less number of family members scored better compared to more number of family members. But no significant association and difference found in case of Kunbi women with regard to number of family members with empowerment status.
- ❖ There was significant association and comparison between husband's education and empowerment status in Halakki Vokkaliga and Kunbi women indicated that with better scores for the women whose husbands have more education scored better in empowerment status.
- ❖ The husband's work and empowerment status were found to be significantly associated and difference in the mean scores was also significant for both Halakki Vokkaliga and Kunbi women in that the mean empowerment scores of women whose husbands worked were higher than those of other groups.

3) Influence of individual and familial characteristics on general health status of Halakki Vokkaliga and Kunbi women

- ❖ The association and comparison of mean scores of the age with general health status were found non-significant indicating no influence of age on health status of both Halakki Vokkaliga and Kunbi women.
- ❖ Comparison of mean scores of general health status and education found to be significant both Halakki Vokkaliga and Kunbi women. Mean health scores of women with more education was better compared to their counterparts.
- ❖ Comparison of mean scores of women's occupation and general health status found significant where working women scores was significantly higher compared to agriculture labourer/housewife in Halakki Vokkaliga and Kunbi women.
- ❖ Non- significant association and difference found between type of family and general health status was observed for Halakki Vokkaliga and Kunbi women.
- ❖ Significant result found between social economic status and general health status where the women from upper middle socioeconomic status scored were having better health

score compared to the women from poor and very poor socio- economic status of Halakki Vokkaliga and Kunbi women.

- ❖ Significant result found between number of family members and general health status of Halakki Vokkaliga and Kunbi women where women having 1 to 5 family members had better health status compared to the women who were having more than 10 family members.
- ❖ There was significant result found between husband's education and general health status status in Halakki Vokkaliga and Kunbi women indicated that with better scores for the women whose husbands have more education scored better in health status.
- ❖ Non- significant result found between husband's occupation and general health status was observed for Halakki Vokkaliga and Kunbi women.

4) Influence of individual and familial characteristics on reproductive health status of Halakki Vokkaliga and Kunbi women

- ❖ There was no significant influence of age on reproductive health status of Halakki Vokkaliga and Kunbi women.
- ❖ Non-significant association and comparison observed between education and reproductive health status of Halakki Vokkaliga and Kunbi women.
- ❖ Association and comparison revealed highly significant result found between occupation and reproductive health status of Halakki Vokkaliga and Kunbi women. Mean reproductive health scores of working women was higher compared to non-working women.
- ❖ Association and comparison of type of family and reproductive health status of Halakki Vokkaliga and Kunbi women showed non-significant result.
- ❖ Significant result found between social economic status and reproductive health status of Kunbi women where the women from upper middle socioeconomic status scored were having better reproductive health compared to the women from poor and very poor socio- economic status. But, in Halakki Vokkaliga women no such influence found.
- ❖ Number of family members and reproductive health status of Halakki Vokkaliga and Kunbi women revealed non-significant.

- ❖ There was significant result found between husband's education and reproductive health status status in Halakki Vokkaliga and Kunbi women indicated that with better scores for the women whose husbands have more education scored better in health status.
- ❖ Non- significant result found between husband's occupation and reproductive health status was observed for Halakki Vokkaliga and Kunbi women.

5) Influence of individual and familial characteristics on nutritional status of Halakki Vokkaliga and Kunbi women

- ❖ The association and comparison of mean scores of the age with general health status were found non-significant indicating no influence of age on nutritional status of both Halakki Vokkaliga and Kunbi women.
- ❖ Comparison of mean scores of nutritional status and education found to be significant both Halakki Vokkaliga and Kunbi women. Mean health scores of women with more education was better compared to their counterparts.
- ❖ Comparison of mean scores of women's occupation and nutritional status found significant where working women scores was significantly higher compared to agriculture labourer/housewife in Halakki Vokkaliga and Kunbi women.
- ❖ Significant association and difference found between type of family and nutritional status was observed for Halakki Vokkaliga and Kunbi women. Women in nuclear families have better nutritional status compared to joint and extended families.
- ❖ Significant result found between social economic status and nutritional status of Halakki Vokkaliga and Kunbi women where the women from upper middle socioeconomic status scored were having better nutritional status compared to the women from poor and very poor socio- economic status.
- ❖ Significant result found between number of family members and nutritional status of Halakki Vokkaliga and Kunbi women where women having 1 to 5 family members had better nutritional status compared to the women who were having more than 10 family members.
- ❖ There was no significant result found between husband's education and nutritional status in Halakki Vokkaliga and Kunbi women.

- ❖ Non- significant result found between husband's occupation and nutritional status was observed for Halakki Vokkaliga and Kunbi women.

6) Correlation between independent variables and empowerment and health status of Halakki Vokkaliga and Kunbi women

- ❖ Higher education, working other than agriculture labourer/housewife, higher socio-economic status, husband's higher education and husband's occupation were positively and significantly correlated with empowerment status of Halakki Vokkaliga and Kunbi women.
- ❖ Education, working status, socio-economic status, husband's education, husband's occupation were negatively and significantly correlated with general health status in Halakki Vokkaliga and Kunbi women. Health problems increases with lower education, low level of employment, low SES, lower education of the husband and low level of employment of the husband.
- ❖ Halakki Vokkaliga and Kunbi women with higher education, employment, husband's higher education and better employment possess good reproductive health.
- ❖ There was positive and highly significant correlation between health status and empowerment status, nutritional status and reproductive health status were positively and significantly linked with health status in Halakki Vokkaliga and Kunbi women.
- ❖ Education, working status and SES were positively and significantly correlated with nutritional status where, higher education, better employment and better SES increased the nutritional status of Halakki Vokkaliga and Kunbi women.

6) Combined effects of selected factors on empowerment and health status of Halakki Vokkaliga and Kunbi women

- ❖ Education, occupation, socio-economic status, husband's education, SHG enrolment, media usage and mobile usage frequency were the significant predictors of empowerment status and contributing 43 per cent and 44 per cent variance to the Halakki Vokkaliga and Kunbi women respectively.
- ❖ Education, socio-economic status, husband's education, age at marriage, age at first pregnancy and type of delivery were the significant predictors of general

health status and contributing 35 per cent and 34 per cent variance to the Halakki Vokkaliga and Kunbi women respectively.

- ❖ Education, socio-economic status, husband's education, age at marriage, age at first pregnancy and type of delivery were the significant predictors of reproductive health status and causing 38 per cent and 36 per cent variance to the Halakki Vokkaliga and Kunbi women respectively.
- ❖ Education, socio-economic status and age at marriage were the significant predictors of nutritional status and subsidising 30 per cent and 29 per cent variance to the Halakki Vokkaliga and Kunbi women respectively.

7) Halakki Vokkaliga and Kunbi women's view towards empowerment and health aspects Ethnographic case study was conducted on a sample of 15 women (7 Halakki Vokkaliga and 8 Kunbi) aged 20-50 years from the study area. Qualitative analysis depicted participant's views towards empowerment and health aspects which were presented in following themes and sub themes:

Themes	Sub-themes
1. Rich culture to cultural dilution	a) Strong ethnic clusters to migration b) Rich knowledge of ethnic medicines to extinction c) Tradition cultural practices to mainstreamed culture
2. Conventional to Contemporary lifestyle	a) Transformation from ethnic dressing to contemporary style b) Negative to positive attitude towards children's education c) Shift from agriculture to non-agriculture jobs d) Traditional food culture to localized culture e) Home remedies to Health care facilities
3. Less Empowered to Empowered	a) Home maker to employed woman b) Hardworking women and less working males c) Role of personnel from developmental departments d) No support to improved support from husbands
4. Constraints to mainstreaming	a. Language barrier b. Secluded and remote villages/hamlets c. Poor implementation of government schemes d. Ascendancy of encircling communities

9) Impact of intervention on empowerment knowledge of Kunbi women

Intervention which was provided to improve the empowerment knowledge of Kunbi women proved to be effective in enhancing their knowledge in all the dimensions of empowerment *viz* educational, economic - social, political- legal, autonomy -decision making. Significant difference was observed between pre-test to post tests in experimental group.

Implications and recommendations:

- ❖ Majority of the Halakki Vokkaliga and Kunbi women were in medium and low empowerment status, suggesting that there is a need to improve the empowerment status of tribal women by implementing various schemes through government and non-government institutions. Govt. programmes such as Udyam Sakhi portal for Women Entrepreneurs, Pradhan Mantri Dakshta aur Kushalata Sampann Hitgrahi Yojana, New Swarnima for women are running for empowerment of women these should be utilized to maximum extent and awareness can be created through intervention to empower these women.
- ❖ It has been pointed out that, low levels of economic activity and living conditions below the poverty level is a major problem faced by the tribal women. A practical way of dealing with this problem can be to provide skills and training to women which will help them in carry out income generating activities through self-help groups. Micro credit programmes should be extended to provide small loans to these people for self-employment to generate income for self and for their families.
- ❖ As per the Sustainable Developmental Goal (SDG), achieving women empowerment by 2030 should be successfully accomplished with the empowerment of tribal women and more number of programmes should be implemented by government bodies, NGO's and institutional collaboration to upliftment of status of women.
- ❖ It has been witnessed that, migration of people in search of employment opportunities is practicing in both Halakki Vokkaliga and Kunbi community, this can be avoided through creating income generating activities at local level. As the culture of Halakki Vokklaiga and Kunbi community is disappearing, to preserve that global recognition for their traditional attire, folk art and songs can be attempted. Preparing beads necklace, folk art, value addition to tubers etc. can be taken as entrepreneurial activities to sustain their culture and livelihood. The government should provide a market for their agricultural, forest produce, handicraft and traditional goods.

- ❖ The health status of the tribal women was explored to assess their awareness regarding their health. Health status of the women is better, still there is a need to concentrate on health and welfare schemes for the women and effective implementation of those to reach the disadvantaged sections in the community. Sometimes they lack essential nutrients. Many times they suffer from various diseases as there is a lack of health and hygiene awareness. Thus, increasing the literacy rate and providing opportunities for gainful employment for tribal women will be instrumental in bringing about anticipated change in the health status of tribal women.
- ❖ Role of ASHA worker and anganwadi teachers is very prominent in upholding reproductive and nutritional status of women, so additional trainings should be provided to them regarding health care practices, personal hygiene and nutrition.
- ❖ Tribal students are underrepresented in higher education. To encourage them, tribal students pursuing higher education, particularly in medical, engineering, and other vocational fields, should be provided with special scholarships to help them succeed.
- ❖ Many schools in remote areas of the district have teacher's problem. Proper security and residential facilities have to be done for teachers to reduce the problem of transportation and effective time management in the schools. Appropriate monitoring should be done by Department and School Education.
- ❖ Security of students, especially of adolescent girls is of great concern in remote areas. In this regard, residential schools or hostel facilities can be established to reduce the risk of wild animals, transportation problem in turn it minimises the dropout rates.

Future Research

1. A study on comparison of health, nutritional status and empowerment of tribal and non-tribal women can be conducted.
2. Similar study on other tribal communities of Uttara Kannada district Gouli, Gond and Siddhi can be conducted.
3. Qualitative design dominating study on empowerment and health aspects in all tribal communities of Uttara Kannada district can be conducted.
4. Similar studies can be expanded to other tribal communities in the Karnataka state.

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APPENDIX I

GENERAL INFORMATION OF THE RESPONDENTS

Part-I

1. Name of the respondent:

2. Age:

3. Address:

4. Occupation:

Income:

5. Length of occupation: Full time / Part time

6. Type of family: Nuclear / Joint / Extended

7. No. of family members: Adults: Children:

8. Family composition:

Sl. No.	Name	Age	Gender	Relation with the respondent	Education	Occupation	Income

Part-II

1. Age at menarche:

2. Age at marriage:

3. Type of marriage: Consanguineous / Non consanguineous

4. Age at first pregnancy:

5. Total pregnancies:

6. No. of children:

7. Type of delivery:

8. Dietary Habits: a) Vegetarian b) Non Vegetarian

9. Hb level:

10. Last Hb level checked:

a) 3 months b) 6 months c) 1 Year d) More than 1 year

11. Anthropometric measurements:

Weight (Kg):

Height (in cm):

Waist circumference:

Mid-upper arm circumference:

13. Which type of medical care you prefer for general health problems (such as fever, headache, body pain etc.)

a) Traditional medicine b) Government hospital c) Private hospital

Part-III**1. Are you a member of Self Help Group? Yes / No****2. If yes, name of the SHG:****3. Activities carried out at the SHG?****4. Do you have any bank account? Yes / No****5. Do you use media (television, newspaper etc)****6. Media usage: Regular / Irregular****7. Do you use mobile?****8. If yes, Mobile usage: Independently / With the assistance of others****Qualitative questions****1) Tell about your food habits.****2) What are the traditional medicines you use in your daily life?****3) What is your perception regarding health of your community women?****4) How is the health status of your community women? Do you think any issues to be transformed concerning to health practices?****5) What are the activities you perform for your livelihood?****6) Your perception regarding attitude towards women within your community?****7) What is your outlook about literacy level of the women over the years?****8) What is your opinion in relation to gender role over a decade?****9) What is your view about need of empowerment of women in the present context? Has it archived in your community?****10) Tell about the constraints you come across in your daily life.**

APPENDIX II

Empowerment questionnaire

Autonomy (AUT)	Alone (2)	Jointly (1)	Husband (0)
Exercise control on family income and expenditure			
Lend/Spend money as per personal need and interest			
Work outside home			
Provide economic or any support to other relatives			
Joining different societies or activities			
Inviting and hosting guests			
Seeking treatment for self/other family members			
Taking food /purchase food whenever necessary			
Deciding about number and when to have children			
Using mobile phone			
Handle bank account			
Vote in Local/Parliament election independently			
Participation in social and development activities (PSDA)	Yes (1)	No (0)	
Campaign for political candidates/leadership in social activities			
Protesting against unfavourable issues			
Confidence of meeting official people			
Asking for public facilities			
Participation in any NGO/Cooperative/Cultural Society/ SHG			
Awareness about political and legal issues (APLT)	Yes (1)	No (0)	
Name of the chairman of the Panchayat of your area			
Name of the member of parliament/ minister in your area			
Significance of registering marriage			
Law of inheritance			
Right age for marriage of boys and girls			
Aware about govt welfare schemes/programmes			
Laws about child labour			
Laws about restricting dowry/violence against women			
Participation in decision making (PIDM)	Wife (2)	Jointly (1)	Husband (0)
Enrolment of children in school			
Going to hospital/health care facility			
Going to public places/programmes/shopping			
Spend money for household affairs			
Adoption of family planning			
Marriage of children			
Borrowing or lending money			
Purchase of land or other assets			
Visiting friend's/ relative's house			

APPENDIX III

PGI -2 Health Questionnaire

Below are given some statements regarding your physical and mental wellbeing. Read them carefully and tick right mark for suitable answers for you.

Sl. No	Sentences	Often	Sometimes	Rarely	Never
1	I often get watering of eyes.				
2	I feel heaviness of the eyes.				
3	I feel burning sensation in the eyes.				
4	My apatite is not good.				
5	My digestion is poor.				
6	I get bleaching.				
7	My taste remains bad.				
8	I often get wind formation in stomach.				
9	I feel heaviness of stomach and often it bets distended.				
10	I have to go to toilet straight after meals.				
11	I feel sick in stomach.				
12	I get vomiting.				
13	I always feel thirsty.				
14	I have got fears like – fear of dark, crowds, closed spaces, <i>etc.</i>				
15	I find trouble in getting off to sleep or staying asleep.				
16	I feel fun down.				
17	I get shakes of hands or body.				
18	I suffer from backache.				
19	I feel tired all the time.				
20	I wish to do everything but can't.				
21	I don't feel like doing anything.				
22	I feel heaviness in the head.				
23	I feel as if head is going to explode.				
24	I often get headache.				
25	I feel heat coming out of the body.				
26	I get pessimistic of heart.				
27	I get sinking sensation.				
28	I get palpitation of heart.				
29	I feel empty headedness.				

Sl. No	Sentences	Often	Sometimes	Rarely	Never
30	I find difficulty in passing water.				
31	I get panic or fainting attacks.				
32	I feel edgy.				
33	I feel my “brain is getting weak”.				
34	I am becoming forgetful.				
35	I feel scared if someone speaks loud.				
36	I remain frightened all the time; not sure what will happen next.				
37	I feel mixed up when I talk to others.				
38	I can’t tolerate noises.				
39	I get easily irritated.				
40	I have become superstitious.				
41	Many silly ideas come into my head.				
42	I can’t forget the past happenings.				
43	I don’t feel like talking and mixing with others.				
44	I feel like crying.				
45	I don’t feel happy.				
46	I don’t feel interested enough in the family.				
47	I feel like going away somewhere.				
48	Many times I wish I was dead.				
49	I am afraid that I may or have become the victim of some incurable.				
50	I find no relief even after or have become the victim of some incurable.				

APPENDIX IV

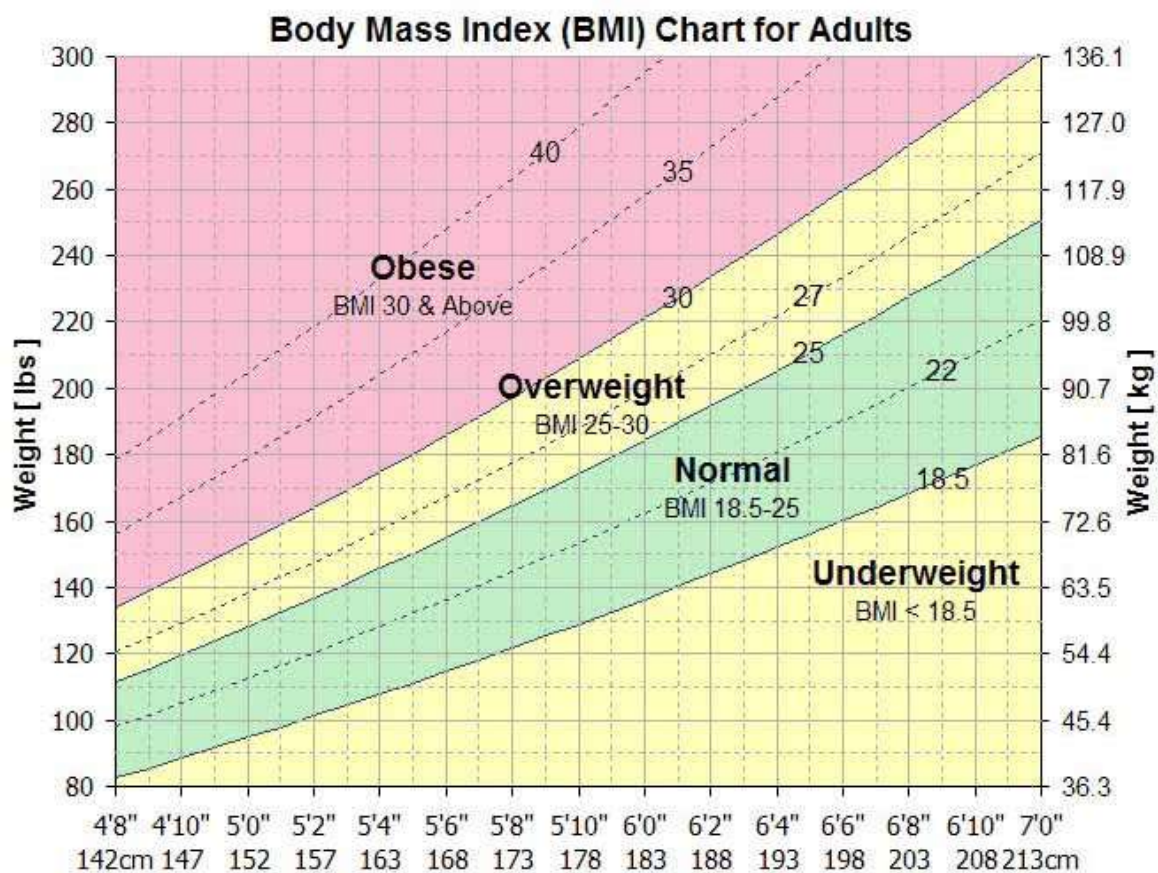
REPRODUCTIVE HEALTH PRACTICE SCALE

Hassan MK (2002)

SI No.	Question	Always	Sometimes	Never
1.	Do you advise girls not to marry below 18 years of age?			
2.	Have you advised married girls below 18 years of age not to conceive?			
3.	Is your menstruation regular?			
4.	Do you experience any difficulties related to your menstrual cycle?			
5.	Do/did you suffer from any kind of infection during menstruation?			
6.	Do you use sanitary napkins during menstruation?			
7.	Do you maintain menstrual hygiene?			
8.	Do you go to the doctor or health center for checkups during pregnancy?			
9.	Have you undergone blood check-up during pregnancy?			
10.	Do you take iron tablets during pregnancy?			
11.	Do you follow dietary advice during pregnancy and lactation?			
12.	Do you take medication without doctor prescription during pregnancy?			
13.	Do you experience any complications during pregnancy?			
14.	Do you experience any problems during lactation period?			
15.	Do you prefer/advice to go for normal delivery or caesarean section?			
16.	Do you take vaccines and check-ups after child birth?			
17.	Have you undergone pregnancy wastage?			
18.	Do you use any protective measure during sexual intercourse?			
19.	Do you use birth control methods to have spacing between children?			
20.	Do you take birth control pills for not having child?			
21.	Do you experience pain or difficulty during sexual intercourse?			
22.	Do you suffer from any sexually transmitted disease?			
23.	Do you want to have contact with the person suffer from AIDS/STD?			
24.	Do you take advice from doctor/ANM/ health centre for your reproductive health issues?			

APPENDIX V

Nutritional status assessment



APPENDIX VI

SOCIO-ECONOMIC STATUS SCALE

Aggarwal *et al.* (2005)

Q 1. Monthly per capita income from all sources (total monthly income /no. of family members)

- 1) >50000 2) 20000-49999 3) 10000-19999 4) 5000-9999 5) 2500-4999 6) 1000-2499 7) <1000

Q 2. Education of either husband or wife who is more educated among them

1. Professional qualification with technical degrees or diplomas e.g. Doctor, Eng. CA, MBA, etc.
2. Postgraduation (non-technical incl. Ph.D)
3. Graduation ಪದವಿ
4. 10th class pass but <Graduation
5. Primary pass but <10th
6. <Primary but attended school for at least one year
7. Just literate but no schooling
8. Illiterate

Q 3. Occupation of husband, otherwise wife.

1. Service in Central/State/Public undertakings or Owner of a company employing >20 persons or self employed professional viz Doctors, CAs, Eng. Etc.
2. Service in Private sector or independent business employing 2-20 persons
3. Service at shops, home, transport, own cultivation of land
4. Self employed e.g. shops, Rehdies or petty business with income >5000
5. Self employed with income <5000 (labourer, house wife)
6. None of the family member is employed

Q 4. Family possessions (presence of each item given below will carry score of .1.)

- 1) Refrigerator 2) TV 3) Radio/Transistor/Music system 4) AC 5) Washing Machine 6) Telephone 7) Mobile Tel 8) Credit card 9) Sanitary lat. 10) Any newspaper subscribed throughout the month

Q 5. Living in a type of house

1. Own house with 5 or more rooms
2. Own house with 3-4 rooms
3. Rented/Govt. house with 5 or more rooms
4. Own house with 1-2 rooms
5. Rented/Govt. house with 3-4 rooms
6. Rented/Govt. house with 1-2 rooms
7. Own jhuggi
8. Rented jhuggi
9. No place to live, pavement, mobile cart

Q 6. Possession of a vehicle or equivalent

1. 2 or more cars/Tractors/Trucks
2. 1 Car /Tractor/Truck 1
3. 1 or more scooter(s)/Bullock cart (s) 1
4. 1 or more cycles (not baby cycle)
5. None of the above

Q. 7 No. of earning members in the family (Nuclear/Joint)

1. 3 or more members earning and income pooled
2. 2 or both husband and wife earning
3. Only 1 family member earning
4. No earning member

Q 8. No. of children head of the family has/had

- 1) 0-1 2) 2 3) 3 4) 4 5) 5 6) >6

Q 9. Facility of some essentials in the family

1. Both tap water supply and electricity
2. Only one of above two is present
3. None is present

Q10. Education of children (in relation to head of the family)

Note : Exclude under 5 children for this item. A child applicable here is one who is 5 yrs or above.

1. All children going/ever gone to school/college
2. >50% children ever gone/going to school/college
3. < 50% children ever gone/going to school/college
4. No child ever gone/going to school/college

Q 11. Employment of a domestic servant at home

1. Employed >2 full time servants on salary for domestic work
2. Employed only 1 full time servant on salary for domestic work
3. Employed > 3 part time servants on salary for domestic work
4. Employed 1-2 part time servants on salary for domestic work
5. Employed no servants for domestic work

Q 12. Type of locality the family is residing

1. Living in urban locality
2. Living in rural locality
3. Living in resettlement colony
4. Living in slums/jhuggis
5. No fixed living and mobile

Q 13. Caste of the family

1. Upper caste 2. OBC
3. Dalits 4. Tribals

Q. 14. Members of family gone abroad in last three years (official or personal)

1. Whole family
2. Only husband and wife
3. Only 1 family member
4. None

Q 15. Possession of agricultural land for cultivation

1. Own agricultural land >100 acres
2. Own agricultural land 51-100 acres
3. Own agricultural land 21-50 acres
4. Own agricultural land 6-20 acres
5. Own agricultural land 1-5 acres
6. No agricultural land

Q 16. Possession of non-agricultural land/land for housing or other type of land

1. Own non-agricultural land/land for housing >1000 Sq Yards
 2. Own non-agricultural land/land for housing 501-1000 Sq. Yards
 3. Own non-agricultural land/land for housing 25-500 Sq. Yards
 4. Own non-agricultural land/land for housing <25 Sq. Yards
- OR Does not own non-agricultural land/land for housing at all

Q 17. Presence of milch cattles in the family for business or non-business purposes

1. Own 4 or more milch cattles
2. Own 1-3 milchcattles
3. Own 1 milch cattle
4. Does not own any milch cattle

Q 18. Presence of non milchcattles or pet animals in the family.

1. Own 2 or more
2. Own 1

Q 19. Besides the house in which the family is living, the family owns other house or shop or shed etc. of any size whether given on rent or not

1. Owns 3 or more
2. Owns 2 or more
3. Owns 1
4. Does not own any

Q 20. Positions held (besides the positions as employee) by any one member in the family

1. Holding position of 3 or more official or non-official organizations viz. president/ chairman/Secretary/ Treasurer etc.
2. Holding position of 1-2 official or not-official organizations viz. president/chairman/Secretary/ Treasurer etc.
3. Holding position as member only of executive or other committees of official or non-offical organizations.
4. Does not hold any such position

Q 21. Parental support in the form of non-movable property

1. >50 acres of agricultural land -OR -a house/plot >1000 sq yards -OR -Both
2. 21-50 acres of agricultural land -OR-a house/plot 501- 1000 sq yards -OR - Both
3. 1-20 acres of agricultural land -OR -a house /plot 100-500 sq yards -OR-Both
4. No agricultural land -BUT - a house/plot 25-100 sq yards
5. No parental property

Q22. Total amount of income tax paid by the family (include all the earning members IT)

- | | |
|----------------------|--------------------|
| 1. >10 lacs | 2. 1-10 lacs |
| 3. >50000 but <1 lac | 4. >20000 - <50000 |
| 5. >10000-<20000 | 6. >5000-<10000 |
| 7. <5000 | |

APPENDIX VII

Self-structured questionnaire to assess women's empowerment knowledge

a) Educational empowerment

- 1) Education is considered as one of the basic need in the modern world. Yes/No
- 2) Do you know govt. schemes for girl's education in India? Mention one.
- 3) What is the minimum age of education in India?
- 4) What are the benefits of education? Mention any two benefits.

b) Economic and Social empowerment

- 1) Economic freedom is necessary for women. Yes/No
- 2) Do you know govt scheme for economic empowerment of women? Mention one.
- 3) What are the income generating activities can be done using available resources in your area? Write one.
- 4) Advantage of economic empowerment of women.
- 5) Do you know about health related schemes in India?
- 6) Advantage of social empowerment of women.

c) Political and legal empowerment

- 1) What is the minimum age of voting in India?
- 2) One third of seats in panchayats and municipalities are reserved for women. Yes/ No
- 3) Legal age of marriage in India is 21 years for females. Yes/No
- 4) Dowry is prohibited in India. Yes/No
- 5) There is a right to equal pay between women and men for equal work. Yes/No
- 6) Do you know govt. scheme/services for women under difficult circumstances? Mention one.

d) Autonomy and Decision making

- 1) Women should know how to handle her bank account. Yes/No
- 2) Women should have reproductive autonomy. Yes/No
- 3) Women should seek permission of husband for everyday household expenditures and matters. Yes/No
- 4) There is no role of women deciding number and when to have children. Yes/No
- 5) Women should also take part in deciding enrolment of her children in the school. Yes/No
- 6) It is necessary to involve women in decision making process of major household expenditures such as buying home, assets etc. Yes/No
- 7) Women should have the freedom of seeking medical treatment for self. Yes/No
- 8) Women should know about the financial matters of the family. Yes/No

APPENDIX VIII

Opinionaire of intervention programme

ಕಾರ್ಯಕ್ರಮದ ಕುರಿತು ಅಭಿಪ್ರಾಯಗಳು ಕಾರ್ಯಕ್ರಮದ ಕುರಿತು ಅಭಿಪ್ರಾಯಗಳು

1. Mention the usefulness of this intervention programme.

ಈ ಕಾರ್ಯಕ್ರಮದಿಂದ ತಮಗಾಗುವ ಉಪಯುಕ್ತತೆ

.....

2. Did this intervention programme create interest in you? Yes/No

ಈ ಕಾರ್ಯಕ್ರಮವು ತಮಗೆ ಆಸಕ್ತಿ ಹುಟ್ಟಿಸಿತೋ ಹೇಗೆ? ಹೌದು/ಇಲ್ಲ

3. Can the knowledge learnt from intervention programme be initiated into day to day living?
 Yes/No

ಈ ಕಾರ್ಯಕ್ರಮದ ವಿಷಯವನ್ನು ನಿಮ್ಮಲ್ಲಿ ಅಳವಡಿಸಿಕೊಳ್ಳಬಹುದೆ? ಹೌದು/ಇಲ್ಲ

4. Did you find the intervention programme to be useful?? Yes/ No. If Yes how??

ಈ ಕಾರ್ಯಕ್ರಮ ನಿಮಗೆ ಪ್ರಯೋಜನಕಾರಿ ಎನಿಸಿತೆ? ಹೇಗೆ ಹೌದು/ಇಲ್ಲ

.....

5. What is your opinion about the duration and number of sessions of intervention programme.

ಈ ಕಾರ್ಯಕ್ರಮವನ್ನು ಇನ್ನು ಉತ್ತಮಗೊಳಿಸಲು ತಮ್ಮ ಸಲಹೆಗಳು:

.....

A GUIDE FOR IMPROVING EMPOWERMENT KNOWLEDGE OF KUNBI TRIBAL WOMEN

(AN EDUCATIONAL PACKAGE)



By

Priya Ramesh Hegde
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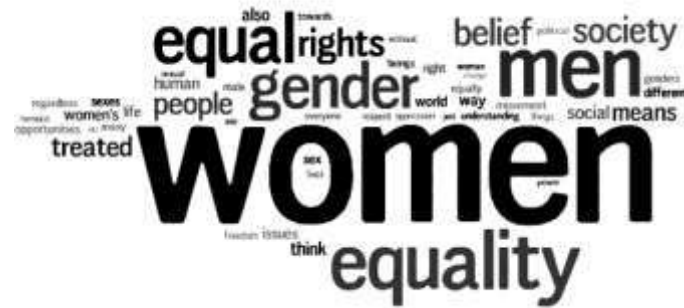
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UNIVERSITY OF AGRICULTURAL SCIENCES
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C O N T E N T S

Sl.No.	Topics
A.	Introduction to women empowerment, Gender Equality and Gender Equity
1.	Women Empowerment: Meaning, Dimensions and Its Need
2.	Gender Equality and Gender Equity
B.	Educational empowerment of women
3.	Importance of Girl's Education
4.	Schemes for Girls Education
C.	Political and legal empowerment of women
5.	Constitutional Provision for Women
6.	Women Welfare Schemes
D.	Economic empowerment of women
7.	Information on Income generating activities
8.	Schemes to improve Women Economic Empowerment
9.	Agriculture related Schemes in India
E	Social empowerment of women
10.	Promotion of Social Empowerment of women: Role of SHG
11.	Balanced diet and Diet during different stages of Life
12.	Under nutrition and Over nutrition among Women
13.	Health related Schemes for Women
F	Decision making and interpersonal skills among women
14.	Facilitating Decision Making among Women
15.	Promoting Confidence, Self-esteem and Leadership among women



A. Introduction to women empowerment, Gender Equality and Gender Equity

There is no chance for the welfare of the world unless the condition of women is improved. It is not possible for a bird to fly on only one wing.

-Swami Vivekananda

1. Women Empowerment: Meaning, Dimensions and its need

Objectives of the session:

In this session, the participants will learn about

- + to understand the meaning of “Women Empowerment” and its dimensions
- + what is the need and benefits of women empowerment

Overview of the session

Sl. No.	Particulars	Duration
I	Welcome the participants and get to know each other	15 min
II	Understanding purposes of the intervention programme and the topics to be covered in the whole intervention programme	20 min
III	Slide show on “Meaning of Women Empowerment” and its dimensions; need and benefits of women empowerment”	60 min
IV	Video show on “Women Empowerment”	15 min
V	Discussion and Winding Up	10 min
	Total duration	120 min (2 hours)

Meaning of Women Empowerment

Empowerment meaning is 'to empower', and 'to give power to'. The word was first used in the 17th century and has meanings like 'authorize', 'delegate', or 'enable'. It is a multifaceted, multi-



dimensional and multi layered concept.



It is the process of enabling people to increase control over their lives, to gain control over the factors and decisions that shape their lives, to increase their resources and qualities and to build capacities to gain access, partners, networks, a voice, in order to gain control. (United Nations Department of Economic and Social Affairs, 2012).

Women empowerment refers to promoting women's sense of self-worth, their ability to determine their own choices, and their right to influence social change for themselves and others (United Nations Population Fund UNFPA, 2005).

It is the process of increasing the personal, political, social or economic strength of individuals and communities. Empowerment of women and girls concerns women and girls gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources and actions to transform the structures and institutions which reinforce and perpetuate gender discrimination and inequality.

According to the United Nations, women's empowerment mainly has five components:

- ✓ Generating women's sense of self-worth;
- ✓ Women's right to have and to determine their choices;
- ✓ Women's right to have access to equal opportunities and all kinds of resources;
- ✓ Women's right to have the power to regulate and control their own lives, within and outside the home;
- ✓ Women's ability to contribute in creating a more social and economic order

Need of Women Empowerment

Women are the inevitable part of any society. Their every working role influences the society by all means.



Women are often in disadvantageous positions with regard to their health and well-being, safety and security, nutritional aspects, employment, wages etc. Therefore, women empowerment has received an increasing amount of attention during the last two decades.

Empirical research studies in low- and middle-income countries have found that women's empowerment can play an important role on development outcomes.



In the area of maternal health, several dimensions of women's empowerment have been found to be important determinants of maternal health care utilization such as participation in household decision-making, financial autonomy, and freedom of movement.

The achievement of gender equality and women empowerment is the fifth Sustainable Development Goal (SDG-5) that is to be accomplished up till 2030. .

The tribal population is an integral part of India's social fabric. Women in a tribal society play a vital role in their social, cultural, economic and religious ways of life and are considered as an economic asset in their society.

They are still lagging far behind in the different walks of life like education, employment, good health etc. The tribal women often face the problems of loss of control over natural resources, lack of education, displacement and rehabilitation, problems of health and nutrition, gender issues, erosion of identity, lack of access to health care services and education and the victim of domestic violence and rape etc (Heggade and Heggade, 2017).



Tribal communities and tribal women lag far behind in social networking. The empowerment of the tribal population has been a major concern. Past two decades have witnessed a steady increase in the awareness regarding need to empowerment of women (Muniyandi, Singh, 2012).

There are many factors associated with tribal women empowerment such as age, education, work participation, cultural norms etc. It is crucial to increase and improve the social, economic, political, and legal strength of the women, to ensure equal-right to women, and to make them confident enough to claim their rights, such as:

- Freely live their life with a sense of self-worth, respect, and dignity.
- To make their own choices and decisions.
- Have equal rights to participate in social, religious, and public active cities
- Have equal social status in the society
- Have equal rights for social and economic justice
- Determine financial and economic choices
- Get an equal opportunity for education.
- Get equal employment opportunities without any gender bias

The concept of Self Help Group is proving to be a helpful instrument for the women empowerment. Entrepreneurship development and income generating activities are a feasible solution for empowering tribal women.

Tribal women's empowerment and their participation had significant positive effects on health and quality of life in the community and family.

Empowerment improves maternal and child nutritional status, reproductive health and health seeking behaviour outcomes. Many government and non government organizations, national programmes, entrepreneurship and skill development programmes, intervention activities help to improve tribal women status and wellbeing.

Empowerment of Women Leads to Empower the Nation

Empowered women foster the progress of family/society. Women must be empowered as ambassadors of natural resources and as contributors to socio-economic advancement of the community. Empowered women mean women who can make their own decisions for their individual benefits as well as for the society.



Educationally Empowered Women Leads to an Educated Nation

Educate a man; you educate a man. You educate a woman; you educate a generation.” Educationally empowered women in every corner of the earth are crucial for a brilliant educated nation and a stable future. Girls are the future mothers of any nation. The education every girl receives is more likely to make education a prominent priority for her offspring.



That has a ripple effect of constructive change in the society as well as the country. If a family or society manage proper supports to empower a female by investing on her education, health, financial means, security, or in overall social growth that empowered strong lady awards the nation with good fertility, well controlled population growth, lowered infant and child death and improved family health as well as an educated nation. This then ultimately coupled with enhances in women's participation sustainable social development.

Empowered Women Foster the progress of Family/Society

The financial freedom of women is being considered as an advancement for a country. Economic empowerment of women led to development of family and community means enabling equal access to knowledge, resources and monetary affluence for women and leveraging their creativity, aptitude and



determination for the family/community.

Women's financial empowerment is the process of achieving equal right to and control over economic resources and assuring they can use them to exert magnified control over other areas of their lives. Access to and control over physical and financial assets and properties are pivotal for women's economical security and sustain individual and household economic development.

Empowered Women Ensures Global Sustainable Development

Research shows global sustainable development has a strong inter link between environmental sustainability and women's empowerment. As women are the fundamental managers of all major natural resources along with coercive agents of change. Women have been and are continued to be the key actors in pathways to green transformation and sustainability. In numerous cases found that women are often more directly reliant on natural resources and managing them efficiently by unpaid work of securing fuel, shelter, food and water to support their family. The disproportionate duty that women bear for doing unpaid work and continuing the invisible contribution is an essential restraint on their capacity to agonize their rights to integrating women's empowerment into sustainable development.

Empowered Women Ensures Global Gender Equality

Property and land rights are the key to women's empowerment, to empower entire communities give women property rights. Rights relating to land give a significant amount of control over self and others, and change the way people think and interact with the world. The essence of women empowerment is substituting patriarchy with parity.



Land is one of the most important modes of property as a scarce natural resource, a tool of human functioning, a strong demarcation of power relationships and a source of income, security, status and recognition. Since 'empowerment' entails equal rights in land and economic participation, this paper further argues that 'empowerment of women' essentially requires changing gender relations that discriminate against women and place them at a disadvantaged position and that state commitment in changing policy, law, institutional mechanisms and social structures necessary for the empowerment of women.

2. Gender Equality and Gender Equity

Objectives of the section:

In this session, the participants will learn about

- ✚ meaning and importance of Gender equity and Gender equality;
- ✚ Concept of female sex ratio, literacy rate, child marriage and gender based violence
- ✚ Ways to achieve gender equality

Overview of the session:

Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	10 min
II	Video show on “Gender inequality”	15 min
III	Slide show on Gender equity and Gender equality; Concept of female sex ratio, literacy rate, child marriage and gender based violence	30 min
IV	Share experiences and feelings in a confidential group environment; Think about our own life experiences as women, and about ways in which society sometimes oppresses us.	15 min
V	Slide show on “Ways to achieve Gender Equality”	20 min
VI	Activity on “Equality of Work”	20 min
V	Discussion and Winding Up	10 min
	Total duration	120 min (2 hours)

Gender Equality

Gender equality is the state of equal ease of access to resources and opportunities regardless of gender, including economic participation and decision-making; and the state of valuing different behaviours, aspirations and needs equally, regardless of gender.



Gender equality is when people of all genders have equal rights, responsibilities and opportunities. Everyone is affected by gender inequality - women, men, trans and gender diverse people, children and families. It impacts people of all ages and backgrounds.

Gender equality prevents violence against women and girls. It's essential for economic prosperity. Societies that value women and men as equal are safer and healthier. Gender equality is a human right. Everyone benefits from gender equality.

The gender pay gap is influenced by a number of factors

- Lack of women in senior leadership positions
- Discrimination in hiring and pay decisions
- Lack of flexible work and affordable child care
- Over-representation of migrant and refugee women in low paid and insecure work
- Barriers to employment for single mothers, women with a disability and women from culturally diverse backgrounds
- Sexism, sexual harassment, bullying and workplace violence against women.
- Condoning of violence against women



- Men's control of decision-making and limits to women's independence
- Rigid gender roles and stereotypes
- Male relationships that emphasise aggression and disrespect towards women
- Two to three times more women than men experience mental health problems like depression and anxiety. Harmful stereotypes about sexuality and body image play a part in this.
- The gender pay gap and Inequality at work puts women at higher risk of physical and mental illness.
- Gender-based violence and harassment affect how and when women access and use public services and spaces.

Gender Equity

The process of being fair to men and women, boys and girls, and importantly the equality of outcomes and results. Gender equity may involve the use of temporary special measures to compensate for historical or systemic bias or discrimination. It refers to differential treatment that is fair and positively addresses a bias or disadvantage that is due to gender roles or norms

or differences between the sexes. Equity ensures that women and men and girls and boys have an equal chance, not only at the starting point, but also when reaching the finishing line. It is about the fair and just treatment of both sexes that takes into account the different needs of the men and women, cultural barriers and (past) discrimination of the specific group.





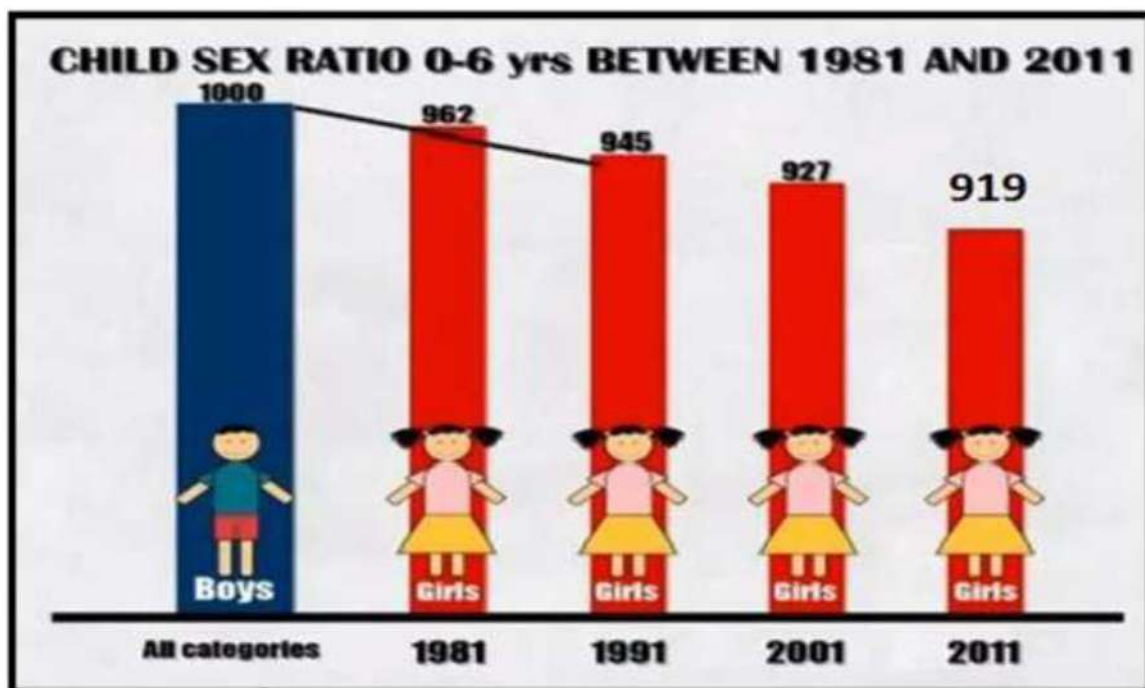
Equality = Sameness
GIVING EVERYONE THE SAME THING → It only works if everyone starts from the same place

Equity = Fairness
ACCESS TO THE SAME OPPORTUNITIES → We must first ensure equity before we can enjoy equality

Equity image credit: Please note, this image was adapted from an image © 2014, Saskatchewan Health Region

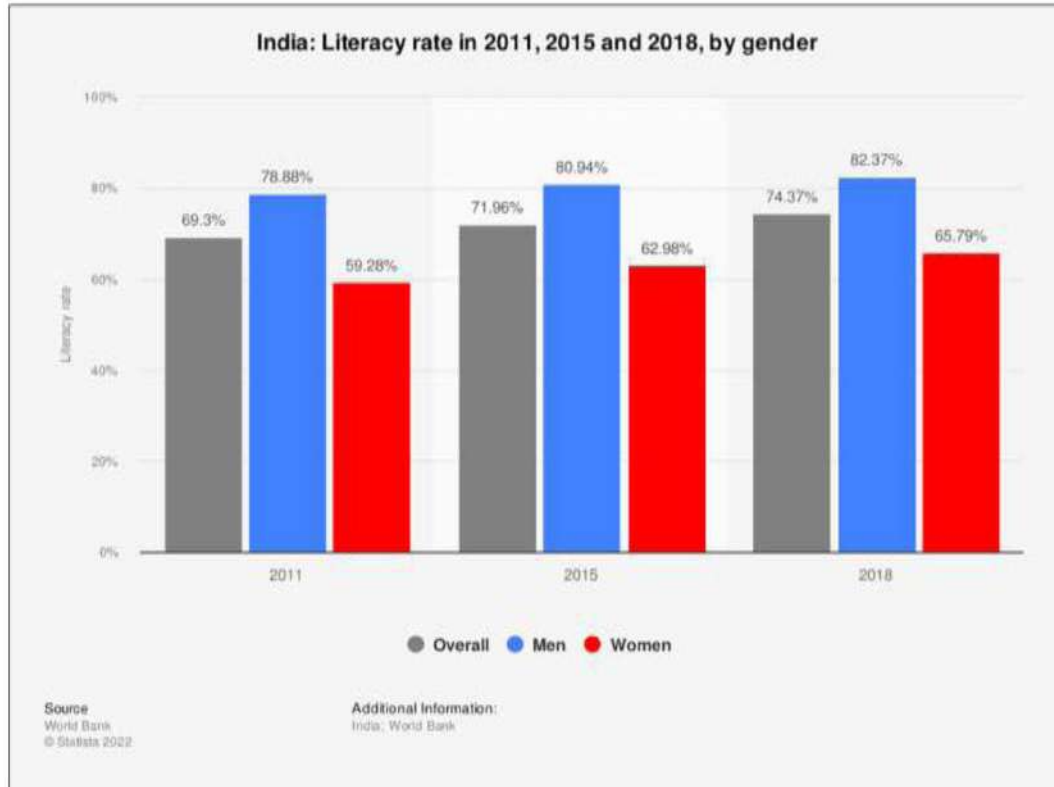
Female Sex ratio

The sex ratio is the ratio of males to females in a population. For every 1,000 males, the country now has 1,020 females, according to the National Family Health Survey-5 (NFHS-5), a nationwide survey by the ministry of health for the period between 2019 and 2021. This is the first time the sex ratio has tipped in favour of females.



Literacy rate

The literacy rate is defined by the percentage of the population of a given age group that can read and write. Literacy rate of India 2021 is 74.04%. The Male literacy rate is 82.14% and Female literacy rate is 65.46% according to Census 2021.



Child marriage

Child marriage usually refers to a social phenomenon practised in some societies in India, where a young child (usually a girl below the age of fifteen) is married to an adult man. The second form of practice of child marriage is that in which the parents of the two children (the girl and boy) arrange a future marriage. In this practice, the individuals (the boy and girl) do not meet one another until they reach the marriageable age, when the wedding ceremony is performed. As per law, the marriageable age is 21 for males and 18 for females.

Gender inequality, social norms, perceived low status of girls, poverty, lack of education, safety concerns about girl children and control over sexuality are considered to be reasons for prevalence of child marriages. Girl children in rural areas are more affected than their urban counterparts.

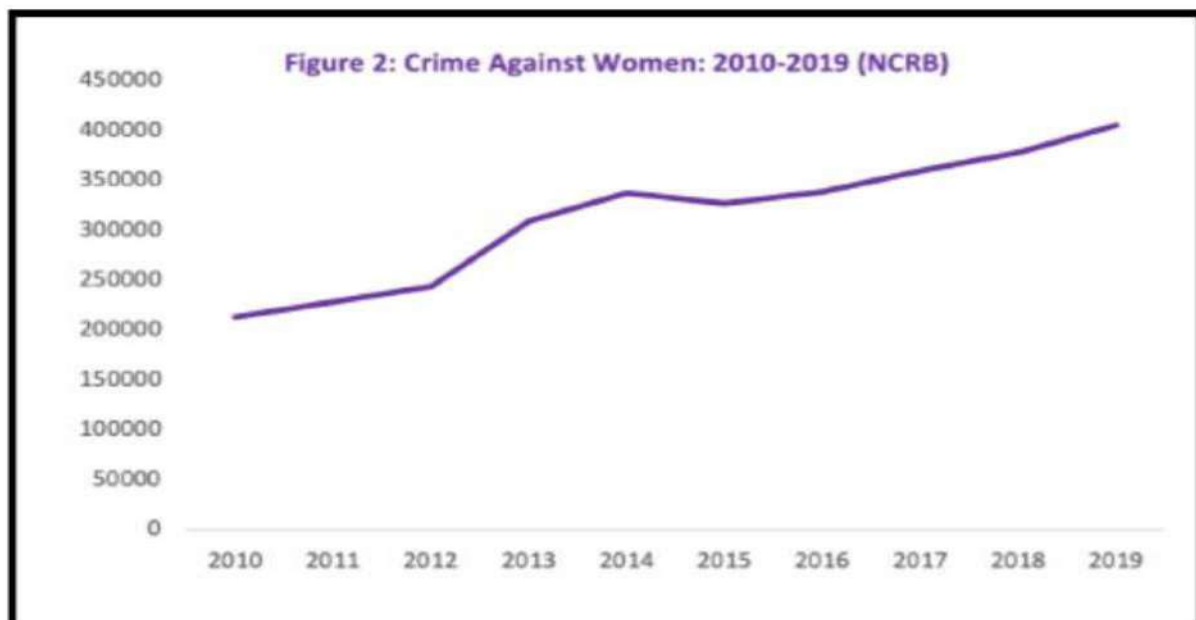
Facts about child marriages in India

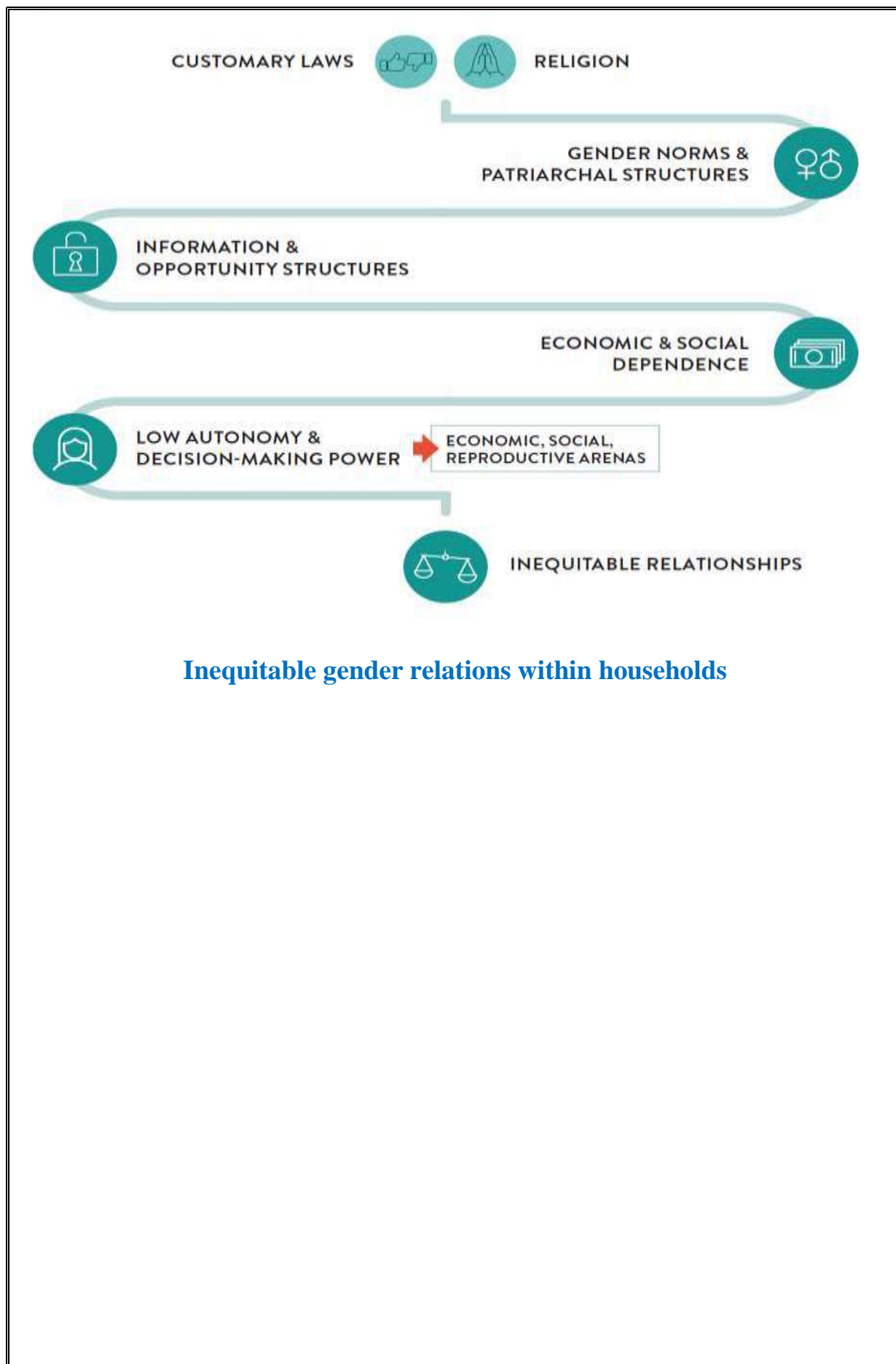
Child marriage prevalence is generally defined as the percentage of women 20-24 years old who were married or in union before age 18. India is estimated to have over 24 million child brides. 40% of the world's 60 million child marriages take place in India according to the National Family Health Survey. India has the 14th highest rate of child marriage in the world, according to the International Center for Research on Women.

According to NFHS 5, the problem is much bigger in rural India at 27 per cent while in urban India, underage marriage accounted for 14.7 per cent of marriages. The data shows that 6.8 per cent of females aged between 15 to 19 years were already mothers or pregnant at the time of the survey, this is a marginal decline from 7.9 per cent recorded between 2015 and 2016. The rural-urban difference was prominent, with 3.8 per cent of women falling in the early pregnancy category in urban areas and 7.9 per cent in rural areas.

Gender based violence

Gender-based violence (GBV) [a] or violence against women and girls is regarded as a global pandemic that affects one in every three women across their lifetime. An estimated 736 million women become victims of intimate partner violence (IPV), or non-partner sexual violence, or both, at least once in their life.





Activity

EQUALITY AT WORK

Objectives

- To understand the concept of equality at work
- To discuss inequality issues at the workplace
- To discuss measures to promote equality at the workplace

Materials required:

- Flipchart or large sheet of paper
- Marker

Exercise

- Place the flipchart or hang a large sheet of paper at a place where all participants can see it.

- Explain to participants that you would like to discuss the different treatment of men and women at the workplace.

- Introduce two people X and Y:

X and Y are working for a small enterprise. They do exactly the same type of work and both work 8 hours a day. They are both working two years for this enterprise. X earns 4000 rupees and Y earns 2000 per month.

- Draw a scale that is unbalanced because at one side is the salary of X and at the other side the salary of Y.

- Ask the participants the following questions:

- What do they see?
- Why is this happening?
- Does it happen at their work?
- Do they think it is fair?
- What can be done about it in their view?

WAYS TO ACHIEVE GENDER

EQUALITY

Share the household chores

All adults living in the same home should take responsibility for the household chores and children's care.



Offer the bus seat to pregnant women. Advocate for baby-changing facilities in all public bathrooms. Put pressure on governments and companies to offer maternity and paternity leave.

Notice signs of violence

Seek help and support if you or someone you know is suffering in an abusive relationship.



Less than 40 percent of women who experience violence seek help.*

*United Nations: "The World's Women 2015: Trends and Statistics"

Scold chauvinist and racist attitudes

Do not keep silent when listening to comments that belittle women, black people, indigenous people, LGBTQI people and other groups. And don't ignore public harassment or assault.



Vote for women

Find out who the female candidates are, especially those from underrepresented communities.



Be fair

Value, encourage and hire different types of teams. In the initial phase of an employee recruitment process, eliminate the name, photo and address from CVs to guarantee impartiality.



Increasing the number of women in a team of managers by 2.5 percent increases innovation revenue by 1% *

*Boston Consulting Group study, 2018

Provide (or fight for) equal wages

Support initiatives within your company promote equal pay for employees with equivalent positions.



For every dollar a man receives, a woman earns 70-90 cents **

**United Nations, "The World's Women 2015: Trends and Statistics"

Support Women

Encourage a safe environment for reporting discrimination, sexual harassment and racism. Assist in the creation of committees empowered to investigate such complaints.



Provide comprehensive training

Promote diversity and anti-bias courses for all employees.





B. Educational Empowerment of women



3. Importance of Girl's Education

In this session participants will know about,

-Importance of educating the girls

-Benefits of girl's education

Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	15 min
II	Slide show on "Importance of educating the girls"	45 min
III	Share their own experiences regarding schooling	20 min
IV	Video show on "Promoting Girl's Education"	20 min
V	Discussion on education opportunities in their area and Winding Up	20 min
	Total duration	120 min (2 hours)

Introduction

Education is a vital part of a living being, whether it is a boy or a girl. Education assists an individual to be smarter, to learn new things, and to know about the facts across the globe. Educating the girl child leads to every perspective of education that strives at improving the skill and experience of girls. This comprises the general education at schools, colleges, professional education, vocational education, and technical education, etc.





It is sad that some communities still discriminate against the education of the girl child. Girl's education is the need of the hour. Without educating the girls of the country we can't hope for a developed nation. Girl's education is like sowing the seed which gives rise to green, cheerful, and full grown family plant. It is said that if we educate a man, we educate a man only, but if we educate a woman, we educate the whole family. This highlights the importance of female education.

Education is regarded to be the grounds of our community because it is one of the quickest and most efficient methods of encouraging economic growth in any nation. It is perceived to be the important key to terminating poverty and crime towards females. Educating the girls promotes children's and women's endurance rates and health issues, child marriage, empowers women both at their workplace and also their home, and assist in dealing with climate change.



Understanding the significance of women's education, the administration and various non-government organizations took several projects to increase women's education. So now here we will know the significance of girl education

IMPORTANCE OF GIRL'S EDUCATION IN OUR SOCIETY

EDUCATED FUTURE GENERATIONS: By sending a girl to school, she is far more likely to ensure that her children also receive an education.

ASSIST IN BUILDINGS MORE STABLE COMMUNITIES: Education offers strength



and versatility which allows the nation to improve at a quicker rate from any dispute. The overall quality education can even assist prevent disputes in the first place by giving knowledge on social skills, problem-solving, and critical thinking at the schools. When the main education is essential to

girls and secondary education that can be a transformative perspective in their life.

PROMOTE GENDER EQUALITY: In today's society, gender equality continues to be a prevalent problem because of the persistent gap in terms of access to chances for women and men. Gender equality is a basic human right that every human being is entitled to regardless of race, sexuality, ethnicity, or religion. The role men and women play in society is completely determined and as a result, there is a gender gap. When girls in our community are more educated, more influence is placed on gender equality.

As women get equality, human rights become a powerful value of societies as women in governance tend to fight for underprivileged groups. Women's leadership in government also becomes more prevalent, and when women lead, women push for more impartial rules of governance.

ALLOW GIRLS TO MAKE THEIR OWN

DECISION: Educated girls gave higher courage and independence to make decisions that change their lives. They are better promoted to examine the social imperative that women reside in the home, growing children and doing the regular housework. Education from the best schools in India enables young women to think beyond cultural standards and continue their desires for a better life.



STRENGTHENS ECONOMIES AND ADVANCES THE FIGHT TO END POVERTY:

One of the clearest and obvious benefits of educating girl child is the prospect for the economic development of a country. The similar even affects the country's Gross Domestic Product (GDP) rate with an increase in women education participation. When women of a country are learned and educated, the whole economy develops and flourishes.



POSITIVE CHANGE FOR FUTURE

GENERATIONS: The educated girl becomes an

educated woman. Offering girls with education is a primary step in developing future generations of healthy, educated, and empowering girls. Educated women of the community can become future leaders, direct towards transformation, and build more powerful and significant societies. And therefore a nation is regarded only as wealthy because of its citizens.

CHOICE TO OPT A PROFESSION OF HER CHOICE: It is one of the vital importance of girl child education. The educated girls can demonstrate to be strong in their several professions. When the girl child has the chance to be educated it offers her the better opportunity to become a successful engineer, doctor, or the choice of the profession she wishes.

IMPROVED LIFE AND HEALTH: Educating girl child assist in the improvement of a good life. The girl can read and learn about her rights. They won't be trodden down about her rights. There will be a general improvement in their life. Educated girls bring an awareness of the importance and health and hygiene. Through educating girls they can lead a healthy lifestyle.

Girl child education is one of the most vital concepts. Every girl in our society must have to be educated because education is the most influential and vital weapon that can be used to solve the difficulties of human lives.

DECREASE INFANT MORALITY: Children of educated women are less likely to die before their first birthday. Primary education alone helps reduce infant mortality significantly, and secondary education helps even more.

INCREASE INVOLMENT IN POLITICAL PROCESS: Educated women are more likely to participate in political discussions, meetings, and decision-making, which in turn promotes a more representative, effective government.

DECREASE DOMESTIC ANDSEXUAL VIOLENCE: Educated girls and women are less likely to be victims of domestic and sexual violence or to tolerate it in their families.

DECREASE SUPPORT FOR MILITANCY: As women become more educated, they are less likely to support militancy and terrorism than similarly educated men.

IMPROVE SOCIO-ECONOMIC GROWTH : Educated women have a greater chance of escaping poverty, leading healthier and more productive lives, and raising the standard of living for their children, families, and communities.

4. Schemes for Girls Education

In this session participants will know about

-Different schemes to encourage Girl's education

-Information on eligibility criteria, procedure and benefits of different central and state government schemes for promoting girl child education

Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	15 min
II	Slide show on detailed information on different schemes for Girl's education by the central and state government	60 min
VI	Discussion on queries to enrol for the scheme And analyze the percentage enrolment in the group	30 min
V	Winding Up and distribution of folder on this topic to every participants	15 min
	Total duration	120 min (2 hours)

1. Beti Bachao Beti Padhao Scheme

Launched on 22nd January 2015 by the Prime Minister of India in Haryana, the Beti Bachao Beti Padhao Scheme ensures survival, protection and education of girl children. The scheme aims to address issues of the declining sex ratio over the past few years, create social awareness and enhance the efficiency of welfare services developed for girls.



Who are the beneficiaries of this scheme?

The Beti Bachao Beti Padhao Scheme is applicable to the whole country. However, to ensure maximum reach, this scheme is divided into 3 groups. These are -

- Primary Group (young and married couples, pregnant mothers and parents)
- Secondary Groups (the youth of India, adolescents, in-laws, doctors, private hospitals, nursing homes, diagnostic centres)
- Tertiary Groups (general people of the country, religious leaders, voluntary organisations, frontline workers, officials, media and women SHGs Sector)



What are the eligibility criteria to avail the benefits of this scheme?

- ✚ A family with a girl child (Indian) below 10 years of age is eligible.
- ✚ A family with a girl child must have a Sukanya Samridhi Account (SSA) opened in any nationalised bank.

What is the application process to avail this scheme?

- ❖ Step-1- Visit the registered bank or post office.
- ❖ Step-2- Collect and fill in the application form of the Beti Bachao Beti Padhao Scheme.
- ❖ Step-3- Attach the required documents and submit the application form.

What are the documents required to apply for this scheme?

- ✓ Birth Certificate of the girl child
- ✓ Passport size photograph
- ✓ Proof of Identity of the Parents (Aadhaar Card, Ration Card, etc.)
- ✓ Proof of Address (Passport, utility bills like water, driving licence, telephone, electricity etc.)

2. Sukanya Samridhi Yojana

Sukanya Samridhi Yojana (SSY), was launched in 2015, in order to promote the welfare of girl child. It encourages



parents to invest and build funds for the future studies and marriage expenses of the girl's children.

How does the scheme work?

For the first investment, Rs 250 rupees is to be invested and after that, the investments are to be done in the multiples of 150 rupees, which brings the annual investment to 1.5 lakhs. The process continues for the next 15 years, after which the amount matures and it is ready to be withdrawn.

Benefits to be drawn from Sukanya Samriddhi Yojana

This scheme is protected by a triple exemption, as it is exempted from tax under section 80C of the income tax Act. Under the triple exemption, the amount invested is tax-free, the interest earned is tax-free and the matured amount is also tax-free.



The future of a girl child is still limited to marriage in many parts of the country. This scheme not only helps parents to gather money for marriage expenses but also take care of a girl's child's education costs, which often gets overlooked.

The form for this scheme is easily available in any branch of the India Post Office or any commercial bank which is approved by the central government

3. Balika Samriddhi Yojana

Balika Samriddhi Yojana is another central government scheme to support girls in financially vulnerable sections of society. This scheme ensures the enrolment and retention of girl child in primary and secondary schools.

It aims at the prosperity of a girl's child and provides them with a better quality



education.

To avail of the benefits of Balika Samridhi Yojana, the girl's child should belong to a family below the poverty line (BPL).

The Balika Samridhi Yojana offer Rs. 500 to the mother on delivery of the girl child, along with an annual scholarship for the child's education. In the rural areas, families below the poverty line according to the criteria specified under Swarna Jayanti Gram Swarozgar Yojana will get the benefits. Girl students of class 1 to 3 will get Rs. 300, for each class, students of class 4 and 5 will get Rs.500, and Rs. 600 respectively. Students of class 6 to 7 will get Rs. 700, students of class 8 will get Rs. Rs. 800, and in class 9 and 10, the girl students will get Rs.1000.



Balika Samridhi Yojana

This scheme intends to benefit the girl students throughout their school education-period, and promote education for all. Any financial issue should not restrict them from having adequate school education, at least till secondary level

Benefits of Balika Samridhi Yojana

One of the motives of the scheme is to prevent a girl's infanticide and break the stigma relating to a girl's child's birth. The child sex ratio (CSR), as per the 2011 census, is 940 females to 1000 males. But in some states of India, the situation is more gruesome.

Hence, to create awareness and remove the entire stigma surrounding the birth of a girl, schemes like these are needed. When girls being born aren't treated with happiness, such schemes are a way to motivate those who have daughters and also help the girls to be educated and stand on their own feet.

This scheme also aims at ensuring that no girl's child becomes a victim of child marriage and attains the legal age of marriage before she is married off.

This scheme looks after every girl child registered under BSY, and helps them be trained in income-generating activities that would make them financially independent and hence, can lead their own life by breaking all the stereotypes around them.

4. Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)

Another national scheme named Rajiv Gandhi Scheme for Empowerment of Adolescent

Girls (RGSEAG)-'Sabla' was introduced to empower girls of 11-18 years of age through nutrition, health care, and life skills education. The union government had identified that girls and women suffer from a lack of nutrition than men. To mitigate this gap, the government



introduced these schemes, along with the education-related schemes for girl students. The girls are provided with Supplementary Nutrition adequate calories, protein and micronutrients, per day for 300 days in a year, along with health check-ups and referral services. Under the non-nutrition segment, the government provides training to adolescent girls. According to reports, around 100 lakh adolescent girls per year, are expected to be benefited under the scheme.



C. Political and legal Empowerment of Women

5. Constitutional Provision for Women

In this session, the participants will learn about

- Why it is important to know about the constitutional provision for women
- Different constitutional provisions for women
- Women rights and its significance

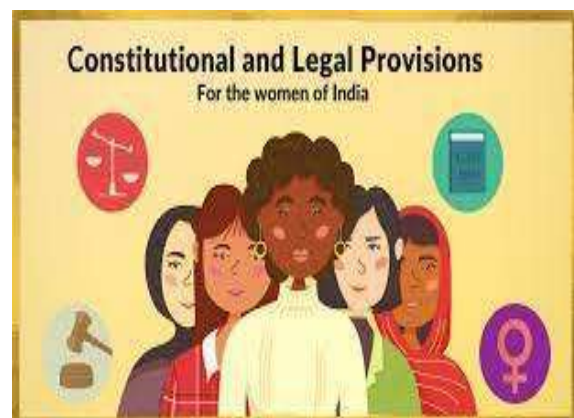
Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	10 min
II	Video show on “Harassment on Women”	15 min
III	Slide show on “Constitutional and Legal Provisions for women”	30 min
V	Role play on “Domestic violence on women”	20 min
VI	Slide show on “Women rights and its significance”	30 min
V	Discussion and Winding Up	15 min
	Total duration	120 min (2 hours)

Preamble of the Constitution

Under the Constitutional law, women have equal rights as men so as to enable them to take part effectively in the administrative of the country.

Equality before law

Article 14 embodies the general principles of equality before law and equal protection of laws.



Prohibition from discrimination on grounds of religion, race, caste, sex or place of birth.

- Article 15(1) and (2) prohibits the state from discriminating against any citizen only on the basis of any one or more of the aspects such as religion, race, caste, sex, place of birth or any of them.
- Article 15(3) makes it possible for the state to create special provisions for protecting the interests of women and children.
- Article 15(4) empowers the State to create special arrangements for promoting interests and welfare of socially and educationally backward classes of society.



Equality of Opportunity

Article 16 provides for equality of opportunity for all citizens in matters relating to employment or appointment to any office under the state.

- Article 39 requires the State to direct its policy towards securing for men and women equally the right to an adequate means of livelihood [Article 39(a)]; and equal pay for equal work for both men and women [Article 39(d)].
- Article 39A directs the State to promote justice, on the basis of equal opportunity and to promote free legal aid by suitable legislation or scheme or in any other way to ensure that opportunities for securing justice are not denied to any citizen by reason of economic or other disabilities.



Humane Conditions at Work

Article 42 directs the State to make provision for securing justice and humane conditions of work and for maternity relief.

Fundamental Duty

- ✓ Article 51A (e) enjoins upon every citizen to renounce practices derogatory to the dignity of women.
- ✓ Reservation of seats for Women in Panchayats and Municipalities.
- ✓ Article 243 D (3) and Article 243 T(3) provide for reservation of not less than one third of total number of seats in Panchayats and Municipalities for women to be allotted by rotation to different Constituencies.
- ✓ Article 243 D (4) T(4) provides that not less than one third of the total number of officers of chairperson in the Panchayat and Municipalities at each level to be reserved for women.

Voting rights/Electoral law

- ✓ Not less than one-third seats shall be reserved for women. Such seats may be allotted by rotation to different constituencies in a Panchayat.
- ✓ The office of the chairperson in the Panchayat at the village or any other level shall be reserved for SCs, STs and women in such manner as the legislature of state may, by law provide.
- ✓ Reservation of seats for women in Municipalities is provided.

To uphold the Constitutional mandate, the state has enacted various legislative measures intended to ensure equal rights, to counter social discrimination and various forms of violence and atrocities and to provide support services especially to working women. Although women may be victims of any of the crimes such as 'Murder', 'Robbery', 'Cheating' etc, the crimes, which are directed specifically against women, are characterized as 'Crime against Women'. These are broadly classified under two categories.

Woman Rights - The principle of gender equality is enshrined in the Indian Constitution

The principle of gender equality is enshrined in the Indian Constitution in its Preamble, Fundamental Rights, Fundamental Duties and Directive Principles. The Constitution not only grants equality to women, but also empowers the State to adopt measures of positive discrimination in favour of women.

Within the framework of a democratic polity, our laws, development policies, Plans and programmes have aimed at women's advancement in different spheres. India has also ratified various international conventions and human rights instruments committing to secure equal rights of women. Key among them is the ratification of the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) in 1993.

Constitutional Provisions

The Constitution of India not only grants equality to women but also empowers the state to adopt measures of positive discrimination in favour of women for neutralizing the cumulative socio economic, education and political disadvantages faced by them.

Fundamental Rights, among others, ensure equality before the law and equal protection of law; prohibits discrimination against any citizen on grounds of religion, race, caste, sex or place of birth, and guarantee equality of opportunity to all citizens in matters relating to employment. Articles 14, 15, 15(3), 16, 39(a), 39(b), 39(c) and 42 of the Constitution are of specific importance in this regard.

Constitutional Privileges

1. Equality before law for women (Article 14)
2. The State not to discriminate against any citizen on grounds only of religion, race, caste, sex, place of birth or any of them (Article 15 (i))
3. The State to make any special provision in favour of women and children (Article 15 (3))
4. Equality of opportunity for all citizens in matters relating to employment or appointment to any office under the state (Article 16)

5. The State to direct its policy towards securing for men and women equally the right to an adequate means of livelihood (Article 39(a)); and equal pay for equal work for both men and women (Article 39(d))
6. To promote justice, on a basis of equal opportunity and to provide free legal aid by suitable legislation or scheme or in any other way to ensure that opportunities for securing justice are not denied to any citizen by reason of economic or other disabilities (Article 39 A)
7. The State to make provision for securing just and humane conditions of work and for maternity relief (Article 42)
8. The State to promote with special care the educational and economic interests of the weaker sections of the people and to protect them from social injustice and all forms of exploitation (Article 46)
9. The State to raise the level of nutrition and the standard of living of its people (Article 47)
10. To promote harmony and the spirit of common brotherhood amongst all the people of India and to renounce practices derogatory to the dignity of women (Article 51(A) (e))
11. Not less than one-third (including the number of seats reserved for women belonging to the Scheduled Castes and the Scheduled Tribes) of the total number of seats to be filled by direct election in every Panchayat to be reserved for women and such seats to be allotted by rotation to different constituencies in a Panchayat (Article 243 D(3))
12. Not less than one- third of the total number of offices of Chairpersons in the Panchayats at each level to be reserved for women (Article 243 D (4))
13. Not less than one-third (including the number of seats reserved for women belonging to the Scheduled Castes and the Scheduled Tribes) of the total number of seats to be filled by direct election in every Municipality to be reserved for women and such seats to be allotted by rotation to different constituencies in a Municipality (Article 243 T (3))

14. Reservation of offices of Chairpersons in Municipalities for the Scheduled Castes, the Scheduled Tribes and women in such manner as the legislature of a State may by law provide (Article 243 T (4))

Legal Provisions

To uphold the Constitutional mandate, the State has enacted various legislative measures intended to ensure equal rights, to counter social discrimination and various forms of violence and atrocities and to provide support services especially to working women.

Although women may be victims of any of the crimes such as Murder, Robbery, Cheating etc, the crimes, which are directed specifically against women, are characterized as Crime against Women. These are broadly classified under two categories.

The Crimes Identified Under the Indian Penal Code (IPC)

1. Rape (Sec. 376 IPC)
2. Kidnapping & Abduction for different purposes (Sec. 363-373)
3. Homicide for Dowry, Dowry Deaths or their attempts (Sec. 302/304-B IPC)
4. Torture, both mental and physical (Sec. 498-A IPC)
5. Molestation (Sec. 354 IPC)
6. Sexual Harassment (Sec. 509 IPC)
7. Importation of girls (up to 21 years of age)

6. Women Welfare Schemes

In this session participants will learn about,
 -Different schemes by Govt. of India for the welfare of the women and enrolment procedure

Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	15 min
II	Slide show on “Information on different schemes by Govt. of India for the Welfare of the Women	75 min
V	Discussion and Winding Up	10 min
	Total duration	120 min (2 hours)

Women welfare schemes in India has benefited women in multiple ways,

- Women have been able to gain social security.
- They can gain advanced training related to skill development and others and increase earning opportunities.
- Women can address their issues more freely and quickly with the government or local concerning authorities.
- Working mothers can now ensure proper care of their children by keeping their children at day care facilities. Thus, they need not compromise their jobs/careers for family.
- They can ensure dignified living (at government hostels) away from home.

1. Working Women Hostel

To promote safe accommodation and environment for working women and provide day care facilities for their children, the Government of India has introduced the ‘Working Women Hostel Scheme’. Through



this women empowerment scheme, the Government provides grant-in-aid for construction and new hostel buildings and extension of an existing building in rented premises.

Who are the beneficiaries of this scheme?

- Working Women (single, widowed, married, divorced, separated).
- This scheme provides a particular preference for working women belonging to the disadvantaged sections of society.
- The Scheme guidelines also provide for the reservation of seats for physically challenged beneficiaries.

What is the eligibility criteria to avail the benefits of this scheme?

- Working women whose husband or immediate family does not reside in the same city/area.
- Women undertaking training (not exceeding one year) for a job
- The consolidated gross income per month should not cross the limit of
 - ☐ 50,000 in the metropolitan city and
 - ☐ 35,000 in other cities.



What is the application process to avail this scheme?

- ❖ Step-1: Approach the WCD department of your concerned state.
- ❖ Step-2: Collect the application form and fill it in with the correct details.
- ❖ Step-3: Submit the application form and other essential documents.

What are the documents required to apply for this scheme?

- ✓ Duly fill-in application form
- ✓ A certificate from the employer with all the details of the gross salary, including allowances.
- ✓ Medical Certificate from a registered practitioner
- ✓ Identity Proof (PAN/Driving Licence/Pass Port/ Any other valid document issued by Government)
- ✓ Passport-size photographs

Note: The requirement of documents may vary from one state to another.

2. One Stop Centre Scheme

Next in the list of women empowerment schemes in India comes One Stop Centre Scheme. It is a centrally sponsored scheme and is funded through the Nirbhaya fund. State governments receive 100% central assistance to protect women affected by violence (gender-based such as acid attacks, rape, and sexual



harassment) in public and private spaces. This scheme facilitates emergency (medical), legal aid and counselling, non-emergency services under one roof to combat all forms of violence against women.

Who are the beneficiaries of this scheme?

All women affected by violence, irrespective of class, caste, region, religion, marital status or sexual orientation, can get benefits under the One Stop Centre Scheme.

What are the eligibility criteria to avail the benefits of this scheme?

All women, including girls aged below 18.

What is the application process to avail this scheme?

- ✚ Since this is a different kind of scheme (which provides shelter, medical assistance, etc.), there is no such specific application process.
- ✚ However, women affected by violence can reach for help by any of the following methods,
- ✚ By communicating by own self
- ✚ Through women helpline and other emergency response helpline
- ✚ Through any person, i.e., public servant (as defined under section 21 of Indian Penal Code, 1860), friend, NGO, relative, volunteer



Once the complaint is registered (be it SMS or internet), a text message will reach DPO/PO/ CDPO DYSP /CMO /SHO/ DM/ SP/PO of the district/area as per requirement. Also, if the victim comes in person to register an application or any other person comes on her behalf, the case details will be updated in a system, and a Unique ID will be generated.

3. Women Helpline Scheme

Women Helpline Scheme is one of the government schemes for women empowerment that intends to give 24x7 emergency responses to women affected by violence in private or public spaces. The universalisation of women helpline numbers has been done in every State and Union Territory through a single toll-free number (181) that provides immediate support to women nationwide. Further, this scheme creates awareness about women empowerment schemes and programs.



Who are the beneficiaries of this scheme?

Any women or girls facing violence or willing to know about various women related schemes or programs.

What is the application process to avail this scheme?

Women suffering from violence in public and private spaces can contact for instant help or rescue through the following ways,

- ✓ Step-1: Telephone (mobile phones through calls, mobile apps and fax messages, SMS/text messaging, landlines)
- ✓ Step-2: Internet (emails, social networking sites such as web page, Face book, Twitter, MyGov.in, etc. web-posts, web-interface)



In this service, a victim's number is tracked or located. If a call gets disconnected or interrupted while a victim is stating her issue due to being sick or disabled, emergency services will reach there (by tracking address) immediately.

4. Mahila E-Haat

It is an initiative launched by the Ministry of Women and Child Development. It is one of the women empowerment schemes in India which provides an opportunity for women entrepreneurs for using technology and presents their products (made/manufactured/sold) on an online platform.



With only mobile and internet connections, women entrepreneurs can showcase their products along with descriptions and photographs. Here, buyers can also reach sellers telephonically, physically, through email or any other medium. The list of products may include clothing, fashion accessories, pottery, boxes, home décor, toys and many other things. This initiative supports the 'Make in India' program through an online platform.

Which sector does this scheme target?

Women and Child Development

What is the eligibility criteria to avail the benefits of this scheme?

Women entrepreneurs must be Indian citizens.

Products sold must be legal.



What is the application process to avail this scheme?

Step-1: Visit the official website of Mahila E-Haat.

Step-2: Click on 'Join Us'.

Step-3: A new webpage, i.e., Mahila E-Haat initiative registration will open. Fill in the registration form with correct details and submit it to complete the application process

What are the documents required to apply for this scheme?

- Aadhaar card
- PAN card
- Address proof
- Bank account details

5. STEP (Support to Training and Employment Program for

Women)

One of the most effective women empowerment schemes in India is STEP (Support to Training and Employment Program for Women). It was introduced to provide training in skill development and to assure employment to women. This government-backed scheme offers grants to institutions and organisations to conduct the training programme.



Who are the beneficiaries of this scheme?

Marginalised (with special focus on SC/ST households, women-headed households and families below the poverty line), asset-less rural women and urban poor.

What are the eligibility criteria to avail the benefits of this scheme?

- Women of 16 years of age or above
- Institutions or organisations registered under the Societies Registration Act, 1860/ Indian Trusts Act, 1882 (Not for Profit)/ other statutes.
- Non-government organisations/voluntary organisations registered under the Societies Registration Act or Indian Trust Act.
- Co-operative societies are registered under the Co-operative Societies Act



What is the application process to avail this scheme (for organisations and institutions)?

- Step-1: Eligible NGOs must register themselves on NITI Aayog Portal or NGO-PS Portal and generate a unique ID.
- Step-2: Submit the project proposals online to the Ministry of Women and Child Development.

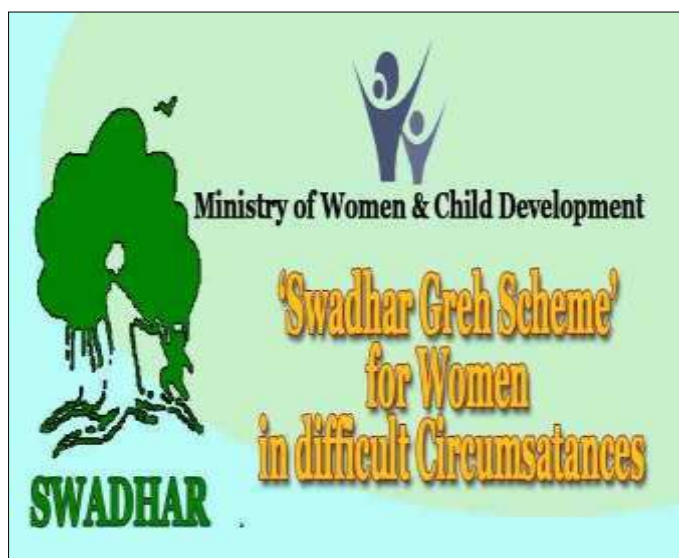
- **Step-3:** The State Government will address these proposals and forward them to the Ministry of Women and Child Development with a recommendation.
- **Step-4:** A pre-screening Committee will verify these proposals and pass them on to the Project Appraisal Committee for final approval.
- **Step-5:** Once the selection is made, the fund will be given to the registered NGO.

What are the documents required to apply for this scheme?

- Balance sheet, income and expenditure account and receipt and payment account (audited and of the previous 3 years).
- Proof of experience in the sector concerned.
- Document stating that the course follows the stipulations of the National Skills Qualification Framework (NSQF).
- Annual Report (previous 3 years).
- Copy of Registration Certificate (if any).6.

6. SWADHAR Greh

SWADHAR Greh, one of the Government schemes for women's empowerment in India, aims to provide shelter, food, clothing, social, economic and health security. This scheme provides legal assistance to women and helps them take initiative for readjusting in societies.



Who are the beneficiaries of this scheme?

- Women who are deserted and do not have any economic and social support.
- Homeless women (who survived natural calamity but do not have economic support)
- Women prisoners (released but do not have a family)
- Trafficked women or girls rescued or escaped from a brothel
- Women suffering from AIDs, HIV

What Is the Eligibility Criteria to Avail the Benefits of This Scheme?

Women aged 18 years or above

What Is the Application Process to Avail This Scheme?

- **Step-1:** Visit the nearest Gram Panchayat, municipal corporation office.
- **Step-2:** Collect the application form and fill it in with important information.
- **Step-3:** Submit the duly filled application form along with other documents.



What Are the Documents Required to Apply for This Scheme?

Aadhaar Card and other documents as instructed by the concerned authority

7. Mahila Shakti Kendras (MSK)

Another popular women empowerment scheme in India is Mahila Shakti Kendra. It aims to provide one-stop convergent support services to women to develop skills, generate employment opportunities, and increase digital literacy. This scheme is operational at multiple levels, such as national level, state



level, and district level. The Government intends to cover the 115 most backward districts by establishing 920 Mahila Shakti Kendras.

Who Are the Beneficiaries of This Scheme?

Rural women

What Is the Eligibility Criteria to Avail the Benefits of This Scheme?

Women must be a resident of India.

8. 24/7 Helpline for Women Affected by Violence

With the objective of further improving safety and security of women across the nation and in line with Union Government's efforts towards overall betterment of women, the National Commission for Women has launched the 24/7 helpline number - 7827170170. For any emergency assistance please call 112.



The helpline aims to provide 24/7 online support to women affected by violence through referral by linking them with appropriate authorities such as police, hospitals, District Legal Service Authority, psychological services etc.

The Helpline is being operated from the premises of the National Commission for Women, New Delhi.

Objectives

- To provide Digital Complaint Registration System for women in distress through trained counsellors
- To facilitate psychological counselling or referral to the appropriate agencies such as
 - Police
 - Hospitals
 - District Legal Service Authority (DLSA)
 - Protection Officer (PO)
 - One Stop Crisis Centre (OSC).
- To provide information about the appropriate support services, government agencies, etc.
- For any emergency assistance please call 112.

Who can seek support?

Any girl or woman aged 18 years and above can seek help by calling on this Helpline.

Efforts of NCW for women safety

NCW under its statutory mandate has been looking into complaints under various categories of violence/deprivation of women rights from across the country. These complaints are received in writing or online through its website i.e., www.ncw.nic.in. The Commission processes complaints to facilitate in providing adequate and expeditious relief to women ensuring suitable redressal of grievances. In order to strengthen and expand the complaint platform, the Commission took the initiative to start this Digital Helpline.



D. Economic Empowerment of Women

7. Information on Income generating activities

1. Phenyl making



2. Mushroom Cultivation



3. Value addition to tubers



8. Schemes to improve Women Economic Empowerment

In this session participants will learn about,

- Schemes implemented by Govt. of India to improve the participation of women in entrepreneurial activities
- Detailed description about the schemes

Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	20 min
V	Slide show on “Women Empowerment Schemes”	80 min
V	Discussion and Winding Up	20 min
	Total duration	120 min (2 hours)

1. Udyam Sakhi portal for Women Entrepreneurs

Over the past few years, India has record growth in women entrepreneurship and more women are pursuing their career in this direction. In India, there are about 8 million women who have started or are running their businesses. Apart from that, women have 24% share in corporate senior management positions in India.

UDYAM SAKHI, a Ministry of Micro, Small & Medium

Enterprises initiative, is a network for nurturing social entrepreneurship creating business models revolving around low-cost products and services to resolve social inequities.



Mission

Udyam Sakhi seeks to encourage women entrepreneurs and to aid, counsel, assists and protect their interests. It also preserve free competitive enterprise and to maintain and strengthen the overall economy of our nation.

The Udyam Sakhi helps Indian women to start, build and grow businesses. It recognises that women entrepreneur in the industry is critical to economic recovery and strength, in building nation's future, and to helping India compete in today's global marketplace.

Services offered

UDYAM SAKHI provides assistances primarily through its Programmatic Functions:

- Entrepreneurship Learning Tools e.g. Preparing Business Plan.
- Incubation facility
- Training programmes for fund raising
- Providing MENTOR
- One to one Investor Meet
- Provide Market Survey Facility
- Learning and Development (Education, Information, Technical Assistance & Training)

The services can be accessed at <http://www.udyamsakhi.org/index.php>

2. Mahila Samriddhi (Micro Finance Scheme for women)

Objectives

To provide Micro Finance to women entrepreneurs belonging to the target group.

Eligibility

a) Women belonging to Backward Classes, as notified by Central Government/State Governments from time to time.



b) Applicant's annual family income should be less than Rs. 3.00 Lakh.

c) In a SHG 60% of members can be from Backward Classes and remaining 40% members may be from other weaker section like SC/Handicapped/Minorities etc.

Salient Features

- 1. Maximum loan limit per SHG: Rs.15.00 Lakh**
- 2. Maximum loan limit per beneficiary: Rs.1, 25,000/-**
- 3. Maximum number of women in one SHG: 20**

Implementation

The scheme is to be implemented by Channel Partners in rural and urban areas by way of financing the women beneficiaries either directly or through Self-Help Groups (SHGs).

Pattern of Finance

NBCFDC loan	: 95%
Channel Partner/Beneficiary contribution	: 05%
Rate of Interest	
From NBCFDC to Channel Partner	: 1% p.a.
From Channel Partner to SHG/Beneficiary	: 4% p.a.

Repayment

Loan is to be repaid in quarterly instalments within 4 Years (including the moratorium period of six months on the recovery of principal).

For more information contact Toll Free No.18001023399

3. New Swarnima for Women

Objectives

Inculcating the spirit of self-dependence among the women of Backward Classes under Term Loan.



Eligibility

The women belonging to Backward Classes as notified by the Central/ State Governments from time to time shall be eligible for loan under this scheme.

Applicant's annual family income should be less than Rs. 3.00 Lakh.

Salient Features

The target group of the "New Swarnima" scheme of NBCFDC is the women belonging to Backward Classes having annual family income less than Rs.3.00 Lakh.

The beneficiary women is not required to invest any amount of her own on the projects upto cost of Rs.2,00,000/-.

The rate of interest on the amount of loan is less as compared to the general loan scheme of the Corporation.

Maximum Loan Amount : Rs. 2.00 Lakh (per beneficiary)

Pattern of Financing

NBCFDC Loan : 95%

Channel Partner Contribution : 05%

Rate of Interest

From NBCFDC to Channel Partner : 2% p.a.

From Channel Partner to beneficiary : 5% p.a.

Repayment

Loan is to be repaid in quarterly instalments with maximum 8 years (including the moratorium period of six months on the recovery of principal)

For more information contact Toll Free No.18001023399

4. Pradhan Mantri Dakshta Aur Kushalta Sampann Hitgrahi Yojana

PM-DAKSH (Pradhan Mantri Dakshta Aur Kushalta Sampann Hitgrahi) Yojana was launched by the Ministry of Social Justice & Empowerment (MoSJ&E), Government of India in 2020-21 as part of a National Action Plan for skilling of marginalized persons covering SCs, OBCs, EBCs, DNTs, Sanitation workers including waste pickers.



Objective

The main objective of the PM-DAKSH Yojana is to increase the skill levels of the target youth by providing them short term and long term skills, followed by assistance in wage/self-employment. Besides above, the skill levels of artisans would be enhanced through Upskilling/Reskilling programmes and enable them to increase their incomes within their practicing vocations.

Key Features of the Scheme:

There are four types of skill development training programmes under PM-DAKSH Yojana viz; (i) Up-skilling/Re-skilling, (ii) Short Term Training Programmes, (iii) Long Term Training Programmes, and (iv) Entrepreneurship Development Programme.

Training free of cost for the trainees, 100% grants by Government.

Stipend of Rs.1, 000/- to Rs.1, 500/- per month per trainee for trainees having 80% and above attendance in short term and long term training.

Wage compensation @ Rs.3000/- per trainee (Rs. 2500/- as per PM-DAKSH and Rs.500/- as per Common Cost Norms for trainees having 80% and above attendance in Reskilling/Up-skilling.

Trained candidates will be provided certification after successful completion of training and assessment.

Trained candidates will be provided placement after assessment and certification.

Eligibility

Candidates of age group 18-45 years belonging to any of the following categories can apply for the training programme under PM-DAKSH:

- **Persons belonging to Scheduled Castes - No annual income limit**
- **Other Backward Classes (OBCs) having Annual Family Income below Rs. 3.00 lakh**
- **Economically Backward Classes (EBCs) having Annual Family Income below Rs.1.00 lakh**
- **De-Notified, Nomadic and Semi-Nomadic Tribe (DNT) - No annual income limit**
- **Safai Karamcharis - No annual income limit**

How to apply

Publicity of Skill Development Training Programmes is made through advertisement in local newspapers or any other print or electronic media from time to time. The interested candidates need to register on the Portal for enrolment in the skill development training programmes.

The link for registration is <https://pmdaksh.dosje.gov.in/student>

Documents Required

- **Persons belonging to Scheduled Castes**
- **Caste Certificate issued by the Competent Authority of State Government/UT Administration.**
- **Other Backward Classes (OBCs) having Annual Family Income below Rs. 3.00 lakh**
- **OBC Certificate issued by an appropriate Authority of State Government/UT Administration and**
- **Annual Family Income Certificate below Rs.3.00 lakh issued by the appropriate authority of the State Government/UT Administration or self-certified and duly endorsed by a Gazetted officer as defined by the appropriate Government. It is explicitly clarified that endorsement by public representatives, Gram Pradhan, Sarpanch, Councilor, notaries etc. will not be acceptable. Further, valid Below**

Poverty Line (BPL) card and Antodaya Anna Yojna (AAY) cards will also be acceptable as commensurate proof of annual family income of the beneficiary being within Rs.1.00 lakh per annum.

- **Economically Backward Classes (EBCs) having Annual Family Income below Rs.1.00 lakh**
- **Annual Family Income Certificate below Rs.1.00 lakh issued by the appropriate authority of the State Government/UT Administration or self-certified and duly endorsed by a Gazetted officer as defined by the appropriate Government. It is explicitly clarified that endorsement by public representatives, Gram Pradhan, Sarpanch, Councilor, notaries etc. will not be acceptable. Further, valid Below Poverty Line (BPL) card and Antodaya Anna Yojna (AAY) cards will also be acceptable as commensurate proof of annual family income of the beneficiary being within Rs.1.00 lakh per annum.**
- **No Caste Certificate is required in case of EBCs.**
- **De-Notified, Nomadic and Semi-Nomadic Tribe (DNT)**
- **Undertaking in the form of self-declaration of the candidate of his/her specific caste, date of birth and address alongwith the endorsement by the local Pradhan of the Community/Cluster to this effect.**
- **Safai Karamchari including his/her dependents.**
- **Occupation Certificate duly issued by an appropriate authority.**

9. Agriculture related Schemes in India

Objectives of the session:

In this session, the participants will learn about

-Detailed information on different agriculture schemes by central and state governments for welfare of farmers

-Eligibility criteria, benefits and enrolment procedure

Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	10 min
II	Slide show on “Agriculture related schemes in India”	90 min
V	Discussion and Winding Up	20 min
	Total duration	120 min (2 hours)

1. Agriculture Infrastructure Fund

The Union Cabinet in July 2020 has approved a new pan India Central Sector Scheme called Agriculture Infrastructure Fund (National Agriculture Infra Financing Facility). The scheme shall provide a medium - long term debt financing facility for investment in viable projects for post-harvest management Infrastructure and community farming assets through interest subvention and financial support.

Scheme duration: The duration of the Scheme shall be from FY2020 to FY2032 (10 years).

Government of India
Ministry of Agriculture and Farmers Welfare

Atmanirbhar Bharat Abhiyan Through Agri Infrastructure Fund

Golden Opportunity to Invest Through the Schemes of National Horticulture Board in convergence with Agri Infrastructure Fund

Priority Sectors

- Integrated Post Harvest Management Facility (IPHM) for Horticulture (A, B, Pack House, Packing Shed/Unit, Cold Chain, Post Harvest Processing units, Packing Processing etc.)
- Integrated Cold Chains with facilities for collection, bulk, sorting, packing, grading, drying and packaging.
- Processing
- Packing/Dispatch
- Primary Processing of F&V, Aquaculture, Dairy and Poultry
- Cold Storage and Controlled Atmosphere Storage

Pattern of Assistance

A. For Post Harvest Infrastructure

Credit linked back-ended subsidy @ 25% of total investment (50% for IPHM) and @ 35% for other sectors (IPHM, Cold Storage and Controlled Atmosphere Storage).

B. For Cold Storage and Controlled Atmosphere Storage

Credit linked back-ended subsidy @ 35% for projects in general sector and @ 50% for projects in Horticulture, Dairy and Poultry sectors.

For more details about Agri Infrastructure Fund Scheme please visit agrifund.gov.in and for the Schemes of NHBF visit nhbf.gov.in

National Horticulture Board
Ministry of Agriculture and Farmers Welfare, Govt. of India
B-1, Institutional Area, Sector 16, Okhla, New Delhi - 110025 (India)
Ph: 011-24-2342380, 2347441, 2342000-00, Fax: 011-2423817
E-mail: nhbf@nhbf.gov.in, nhbf@nhbf.gov.in

WATER: 000-000-APPLICAT-0000 FOR 80-FORMS-F&V-APPENDIX-1-F&V

Benefits

- All loans under this financing facility will have interest subvention of 3% per annum up to a limit of Rs. 2 crores. This subvention will be available for a maximum period of seven years.
- Further, credit guarantee coverage will be available for eligible borrowers from this financing facility under Credit Guarantee Fund Trust for Micro and Small Enterprises (CGTMSE) scheme for a loan up to Rs. 2 crores. The fee for this coverage will be paid by the Government.
- In case of FPOs the credit guarantee may be availed from the facility created under FPO promotion scheme of Department of Agriculture, Cooperation & Farmers Welfare (DACFW).
- Moratorium for repayment under this financing facility may vary subject to minimum of 6 months and maximum of 2 years.

Checklist of Documents

- Bank's loan application form / Customer Request Letter for AIF Loan duly filled and signed
- Passport size photographs of the promoter/partners/director
- Identity proof – Voter ID card/PAN card/Aadhaar card/Driving license
- Address Proof :
- Residence: Voter ID card/Passport/Aadhaar card/Driving license/Electricity Bill/Latest property Tax Bill
- Business Office/Registered Office: Electricity Bill/Latest Property Tax Receipt/Certificate of Incorporation in case of Companies/Certificate of Registration in ca of partnership Firms
- Proof of Registration
- In case of Company : Article of Association
- In case of Partnership : Certificate of Registration of Firm with Registrar of Firm
- In case of MSMEs : Certificate of Registration with District Industries Centre (DIC)/Udyog Aadhar Copy
- Income Tax Return for last three years, If available.

- **Audited Balance Sheet of last 3 Years, If available.**
- **GST Certificate, if applicable.**
- **Land ownership records – title deed/lease deed. If applicable, then Permission to mortgage the Immovable Property from the Lessor in case the Property is Leasehold (for primary security)**
- **ROC Search Report of the Company**
- **KYC documents of the promoter/firm/company**
- **Copy of Bank Statement for last one year (If available)**
- **Repayment track record of existing loans (Loan Statement)**
- **Net Worth Statements of promoter**
- **Detailed Project Report**
- **As applicable - Local authority permissions, Layout plans/estimates, Building sanction**

2. Credit facility for farmers

Loan facility is available through a large network of Commercial Banks, Regional Rural Banks and Cooperative Credit Institutions in the country to fulfil the crop loan and term loan needs of the farmers.

S.NO	Credit Facility	Quantum of Assistance
1	Interest Assistance Collateral / security-free loan	Crop loan upto Rs.3 lakhs at 7% rate of interest. This interest rate becomes 4% due to 3% interest subvention incentives provided to those farmers who repay crop loan on time. No need of collateral security for farm loan up to Rs 1.6 lakh
2	Kisan Credit Card	Farmers can avail crop loan through Kisan Credit Card. Loan /credit limit is fixed on the basis of crop sown and area under cultivation. Kisan Credit Cards are valid for 3-5 years. Farmers are also provided risk coverage in the event of accidental death/ disability. Crop coverage loans are covered under the Crop Insurance Scheme.
3	Investment Loan	Loan facility to the farmers is available for investment purposes in the areas viz. Irrigation, Agricultural Mechanization, Land Development, Plantation, Horticulture and Post-Harvest Management

3. Pradhan Mantri Fasal Bima Yojana

Objectives

- To provide insurance coverage and financial support to the farmers in the event of failure of any of the notified crop as a result of natural calamities, pests & diseases.
- To stabilise the income of farmers to ensure their continuance in farming.
- To encourage farmers to adopt innovative and modern agricultural practices.
- To ensure flow of credit to the agriculture sector.

Highlights of the scheme

- ✓ There will be a uniform premium of only 2% to be paid by farmers for all Kharif crops and 1.5% for all Rabi crops. In case of annual commercial and horticultural crops, the premium to be paid by farmers will be only 5%. The premium rates to be paid by farmers are very low and balance premium will be paid by the Government to provide full insured amount to the farmers against crop loss on account of natural calamities.
- ✓ There is no upper limit on Government subsidy. Even if balance premium is 90%, it will be borne by the Government.
- ✓ Earlier, there was a provision of capping the premium rate which resulted in low claims being paid to farmers. This capping was done to limit Government outgo on the premium subsidy. This capping has now been removed and farmers will get claim against full sum insured without any reduction.
- ✓ The use of technology will be encouraged to a great extent. Smart phones will be used to capture and upload data of crop cutting to reduce the delays in claim payment to farmers. Remote sensing will be used to reduce the number of crop cutting experiments.

Farmers to be covered

- All farmers growing notified crops in a notified area during the season who have insurable interest in the crop are eligible.
- To address the demand of farmers, the scheme has been made voluntary for all farmers from Kharif 2020.
- Earlier to Kharif 2020, the enrolment under the scheme was compulsory for following categories of farmers:

- **Farmers in the notified area who possess a Crop Loan account/KCC account (called as Loanee Farmers) to whom credit limit is sanctioned/renewed for the notified crop during the crop season. and**
- **Such other farmers whom the Government may decide to include from time to time.**
- **Voluntary coverage: Voluntary coverage may be obtained by all farmers not covered above, including Crop KCC/Crop Loan Account holders whose credit limit is not renewed.**

Calendar of activity

Activity	Kharif	Rabi
Loaning period (loan sanctioned) for Loanee farmers covered on Compulsory basis.	April to July	October to December
Cut-off date for receipt of Proposals of farmers (loanee & non-loanee).	31 July	31st December
Cut-off date for receipt of yield data	Within a month from final harvest	Within a month from final harvest

How to apply

Farmers can apply online for Crop Insurance at the link <https://pmfbv.gov.in>

How to report crop loss and claim insurance

The farmer can report crop loss within 72 hours of occurrence of any event through the Crop Insurance App , CSC Centre or the nearest agriculture officer.

Claim benefit is then provided electronically into the bank accounts of eligible farmer.

4. Group Accident Insurance scheme for Fishermen

Group Accident Insurance scheme (GAIS) is being offered as part of the Pradhan Mantri Matsya Sampada Yojana (PMMSY) to offer insurance coverage to all the Fishers of the country.

The scheme is being implemented by National Fisheries Development Board (NFDB) through M/s Oriental Insurance Company Limited (OICL).

Beneficiaries covered

Fishers include fish workers, fish farmers and any other category of persons directly involved in fishing and fisheries related allied activities.

Men or women fishers in the age group of 18 to 70 years shall be eligible for insurance coverage.

Benefits

Eligible beneficiaries covered under insurance scheme will receive

- ✦ Rs.5.00 lakh against death or permanent total disability
- ✦ Rs. 2.50 lakh against permanent partial disability
- ✦ Rs. 25,000 against accidental hospitalization

The entire premium amount will be shared between the Center and State as per the funding pattern of the PMMSY. Thus, no beneficiary contribution is envisaged.

How to apply for the scheme

Please contact your state Fisheries department for enrolment in the scheme.

5. KCC for animal husbandry and fisheries**Objective**

To provide adequate and timely credit support under a single window to the farmers for activities related to Animal Husbandry and Fisheries.

Eligibility

Farmers, Dairy/Poultry farmers, Fishers, Fish Farmers either individual or joint borrower, Joint Liability Groups or Self Help Groups including tenant farmers, who are rearing dairy animals/ sheep/ goats/ pigs/ poultry/ birds/ rabbit and having owned/ rented/ leased sheds/ who own or lease registered fishing vessel/boat, possess necessary fishing license/ permission for fishing in estuary and sea, fish farming/ mariculture activities in estuaries and open sea and any other State specific fisheries and allied activities.

Loan amount

Farmers who already have KCC based on their land ownership, can get their KCC credit limit enhanced, though interest subvention shall be available only to the extent of Rs 3 lakhs.

Although the general limit for KCC credit without collateral remains Rs. 1.6 lakh, but the case of farmers whose milk is directly procured by Milk Unions falls under tie up arrangements between the producers and processing units without any intermediaries, and hence the credit limits without Collateral can be upto Rs.3 lakh.

Interest subvention for the KCC loan

KCC holders will get the benefits of interest subvention and prompt repayment incentive up to the credit limit of Rs 3 lakh for Animal Husbandry activities. Interest subvention will be available for Animal Husbandry farmers @ 2% per annum at the time of disbursed of loan and another @ 3% per annum in case of prompt repayment as prompt repayment incentive.

Whom to contact

Contact the nearest bank branch.

6. National Scheme of Welfare of Fishermen

Background

The Centrally Sponsored 'National Scheme of Welfare of Fishermen' provided financial assistance to fishers for construction of house among other things. The said scheme has ended on 31 March, 2020. The Department is currently implementing the Pradhan Mantri Matsya Sampada Yojana (PMMSY) for the welfare of the fishermen.

Benefits to the Fishermen

Fishermen who are in the marine and inland sector are entitled for the following benefits under the scheme.

Livelihood and nutritional support for socio-economically backward active traditional fishers families during fishing ban/lean period. Under this component, assistance is provided @ Rs. 4500/- per fishers which includes Rs. 3000/- per fishers to be provided by the Governemntal and Rs. 1500/- to be contributed by the beneficiary for three months consisting of fishing ban/lean periods and Insurance to Fishers.

The insurance coverage for fishers includes (i) Rs.5, 00,000/- against accidental death or permanent total disability, Rs.2,50,000/- for permanent partial disability and Insurance coverage for hospitalization expenses in the event of accident for a sum of Rs. 25,000/-.

Eligibility

The States should keep the following criteria in view while selecting beneficiaries under the scheme:-

- Beneficiary should be a member of a functional local fishers cooperative society/Federation/any other registered body.
- Beneficiary should be Below Poverty Line (BPL) and of between 18 and 60 years of age
- The beneficiary fishers will save Rs. 1500 over a period of 9 months during fishing season annually towards their contribution with a bank designated by the State/UT Department of Fisheries. States/UTs will devise suitable modalities to ensure transparency and smooth implementation of this activity. Depositing of beneficiary contribution on a lump sum basis in a period of one or two months may be avoided.

How to apply

The scheme is to be implemented by the respective States and Union Territories (UT's).

Whom to contact

Contact the Department of Animal Husbandaries, Dairying and Fisheries of the respective state.

7. PM Kisan Maan Dhan Yojana

Government has launched the Pradhan Mantri Kisan Maan Dhan Yojana (PM-KMY) on 12.9.2019 with a view to provide social security to Small and Marginal Farmers in their old age when they have no means of livelihood and minimal or no savings to take care of their expenses.

Benefits

Under this scheme, a minimum fixed pension of Rs.3,000/- is provided to the small and marginal farmers, subject to certain exclusion criteria, on attaining the age of 60 years. It is a voluntary and contributory pension scheme. The eligible farmer is required to contribute to a Pension Fund between Rs.55 to Rs.200 per month depending on the entry age. The Central Government also contributes in equal amount to the Pension Fund.

Eligibility

Small and Marginal Farmer (SMF) - a farmer who owns cultivable land upto 2 hectare as per land records of the concerned State/UT.

How to apply

The enrolment to the Scheme can be done through self registration online or through the Common Service Centres in various states. The enrolment is free of cost.

8. Pradhan Mantri Kisan Samman Nidhi

Pradhan Mantri Kisan Samman Nidhi (PM-KISAN) is a new Central Sector Scheme to provide income support to all landholding farmers' families in the country to supplement their financial needs for procuring various inputs related to agriculture and allied activities as well as domestic needs.



Eligibility

All land holding eligible farmer families (subject to the prevalent exclusion criteria) are to avail of the benefits under this scheme.

The following categories of beneficiaries of higher economic status shall not be eligible for benefit under the scheme.:

- **All Institutional Land holders.**
- **Farmer families in which one or more of its members belong to following categories**
- **Former and present holders of constitutional posts**
- **Former and present Ministers/ State Ministers and former/present Members of Lok Sabha/ Rajya Sabha/ State Legislative Assemblies/ State Legislative Councils, former and present Mayors of Municipal Corporations, former and present Chairpersons of District Panchayats.**
- **All serving or retired officers and employees of Central/ State Government Ministries /Offices/Departments and its field units Central or State PSEs and Attached offices /Autonomous Institutions under Government as well as regular employees of the Local Bodies (Excluding Multi Tasking Staff /Class IV/Group D employees)**
- **All superannuated/retired pensioners whose monthly pension is Rs.10,000/-or more**
- **(Excluding Multi Tasking Staff / Class IV/Group D employees) of above category**
- **All Persons who paid Income Tax in last assessment year**
- **Professionals like Doctors, Engineers, Lawyers, Chartered Accountants, and Architects registered with Professional bodies and carrying out profession by undertaking practices.**

Benefits

Under the PM-KISAN scheme, all landholding farmers' families shall be provided the financial benefit of Rs. 6000 per annum per family payable in three equal installments of Rs. 2000 each, every four months.

How to apply

- ❖ The eligible farmers may apply with the village Patwaris, revenue officials or other designated officers / agencies and submit their required details to them.
- ❖ Farmers can also visit their nearest Common Service Centres (CSCs) for registration in the Scheme upon payment of fees.
- ❖ Farmers can also do their self-registration through the Farmers Corner in the PM KISAN portal.

9. Pradhan Mantri Krishi Sinchai Yojana

Pradhan Mantri Krishi Sinchayee Yojana (PMKSY) was launched on 1st July 2015 with the motto of 'Har Khet ko Pani' for providing end to end solutions in irrigation supply chain, viz., water resources, distribution network, farm level applications and improving water use efficiency. Micro irrigation (MI) is being popularized to ensure 'Per Drop – More Crop' (PDMC).



Pradhan Mantri Krishi Sinchai Yojana

Assistance for soil management

1. Water Carrying Pipes: @ 50% of the cost limited to Rs. 50/- per meter from HDPE pipes, Rs. 35 per meter for PVC pipes and Rs. 20/- per meter for HDPE laminated oven lay flat tubes with maximum ceiling of Rs. 15,000 per farmer/beneficiary for water carrying pipes.
2. Drip Irrigation System for Oil Palm: As per the specification of PMKSY guidelines.
3. Plastic/RCC based water harvesting structure/ farm pond /construction of community tank (100 meter x 100 meter x 3 meter) For smaller size ponds/tanks, cost will be admissible on pro rata basis, depending upon command area depending upon

command area: Rs. 20 lakhs per unit in plain areas; and Rs. 25.00 lakhs per unit in hilly areas with 500 micron plastic lining/RCC lining, for 10-hectare command area.

4. Water Storage in Farm Pond/ Dug well (Measuring 20 meter x 20 meter x 3 meter) by individual. For smaller size ponds/dug wells, cost will be admissible on pro rata basis: Rs. 1.50 lakhs per beneficiary for plain areas & Rs. 1.80 lakhs/beneficiary for hilly areas with 300 micron plastic lining/RCC lining, for 2-hectare command area.

5. Sprinkler Set for pulses,wheat & Nutri-Cereals: Rs. 10,000/ha. or 50% of the cost whichever is less.

6. a) Creation of borewell at Oil Palm farm: Assistance as per NMSA guideline i.e. 50% of the cost limited to Rs. 25,000/- per borewell/tube well subject to condition that these are not installed in critical, semi-critical and over exploited ground water zones.

(b) Water Harvesting Structures/ponds: 50% of the cost (Construction cost Rs. 125/- per cubic meter for plain and Rs. 150/- per cubic meter for hilly areas) limited to Rs. 75,000/- for plane areas and Rs. 90,000/- for hilly areas including lining.

E. Social Empowerment of Women, Health and Nutrition of women



10. Promoting Social Empowerment of women

Objectives of the session:

In this session, the participants will learn about

- ✚ ways to promote “Women Empowerment”
- ✚ to get an inspiration from the real stories on “Women Empowerment”
- ✚ income generating activities suitable to locality

Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	10 min
II	Slide show on “Ways to Promote Women Empowerment”	20 min
III	Inspirational stories on “Women Empowerment”	20 min
IV	Lecture on income generating activities suitable to locality	60 min
V	Discussion and Winding Up	10 min
	Total duration	120 min (2 hours)

Women’s economic empowerment is the capacity of women and men to participate in, contribute to and benefit from growth processes in ways that recognize the value of their contributions, respect their dignity and make it possible to negotiate a fairer distribution of the benefits of growth. Women’s economic empowerment increases women’s access to economic resources and opportunities including jobs, financial services, property and other productive assets, skills development and market information. Women’s economic participation and empowerment are



fundamental to strengthening their rights and enables them to have control over their lives and exert influence in society (OECD -2011).

Social empowerment refers to the ability of women and girls to act individually and collectively to change social relationships and the institutions and discourses that exclude them and keep them in poverty. At home, this for instance involves the ability of women to decide and discuss with their partner whether or not to use contraceptives. Outside their home, it means that women and girls can build positive relationships, participate in social activities and decision making, without being restricted by gender norms

When women have empowered they, in turn, contribute to their family's income and become active change leaders in their communities. It is no gainsaying that if you build a woman, you build a community; and a small investment in a woman is a smart investment. When she is empowered, her generation and her family is empowered.

Adult Education and Training: Investing and building the capacities of rural women will improve their business, social, economic and financial skills. Capacity building and adult training range from providing adult education, life, and social skills training. Adult education and training (education entrepreneurship) is a huge industry and it can be channelled to help rural women to be empowered.

One of the greatest barriers to the sustainable development of women is their lack of access to quality adult education and training. When women have access to quality holistic personal, emotional and entrepreneurial development training opportunities, they will be empowered to speak for themselves. They become confident and can speak up against every abuse and violence. And will not wait for anyone to speak on their behalf but will rise and become voices of positive change and advocacy for equality, justice, and progress.

Vocational Skills and Businesses: expand their businesses. Over the years, rural women have committed themselves to farming, fishing, and trades. Today they eagerly looking for news to enhance their daily living activities and to become more efficient in



all sectors within their community. Agencies can design women development programs that are focused in providing core skills programs that can help them access markets to sell their farm products; understand the value chain of their industry and basic of micro business management and operations.

Access to Financial Facilities: Rural women are consistently looking for different avenues to access microloans, Farming tools, business management and operational tools. A woman who has committed herself to work will do more and multiply her efforts if she has access to basic tools for effectiveness and productivity. Project or program designs focus on women empowerment should be that which helps women access interest-free loans, basic business tools and farm equipment. One of the keys to creating multipliers effect an increase in the building of sustainable small businesses in communities is to help women have access to basic facilitating tools for their daily engagement.

Inspirational stories

1. Home maker to Nutrition Entrepreneur

Manjula was happily settled as a homemaker to look after her family. Her life took a huge turn when her daughter Suhana fell sick very badly. The child had to be admitted to hospital because of vomiting blood. Even with medication Suhana's health deteriorated day by day. The doctor advised Manjula to try traditional home remedies Ragi Ganji (Finger Millet Powder gruel) to improve her condition. With her SHG network and local knowledge in millets and medicinal herbs, she prepared a Millet mix powder with ragi millet and other local ingredients. Manjula gave it to her child for a week and slowly she saw Suhana's improvement. Not only did the millet mix stop the child's vomiting, but it also made her stronger. Doctor was amazed with Suhana's recovery as it was faster than they anticipated. Her millet mix gave good results. This incident was an eye opener for Manjula. She realized that her millet mix had a market opportunity and decided to become a producer cum seller of it.

Being an SHG member proved to be of immense help to her as the SHG provided her support in many ways. She got training on entrepreneurship and marketing skills through Sanjeevini Officials. Along with her saving of Rs. 5000, she took a loan of Rs.

15000 from her SHG as the initial investment. She became the entrepreneur of “Arki” Home Made product – a traditionally produced health mix. She followed traditional cooking style wherein the millets are dried in sunlight and cooked in wooden stove. According to Manjula, the wooden stove enhanced the taste of the powder.

Her fellow SHG members and friends were her first customers. After their first purchase, they were quiet happy with the millet mix and started buying regularly from her. Slowly the villagers came to know about the health benefits and soon her product was is high demand. She followed a demand oriented marketing method as she took orders first and then freshly made the Millet mix. This helped her in cutting the marketing cost. The per unit cost of preparing the Millet mix is around Rs. 130 to Rs. 150 and she sold the product at Rs. 250 per unit. Gradually, along with Millet mix she also made other items such as sambar powder, chilli powder and so on. Now Manjula is earning around Rs. 30,000 per month and her investment has risen to Rs. 3 to 4 lakhs rupees.

Even though she had no prior experience in selling, she was able to go ahead improving her product because of her training and valuable feedback from her customers. It was through this feedback that she understood that her millet mix is helping sugar patients in keeping their sugar levels under control. Mr. Sundreshan, a fellow villager and Manjula’s customer says the Millet mix keeps him energized even though he is diabetic. The Home Made products with brand name “Arki” was listed as one of the top quality products in Government E- Marketing place (GEM). Through Sanjeevini – KSRLPS, she participated in SARASMELA held in Calcutta during November 2019, where she got good sales for her product and also, the top officials of Bangladesh who visited the event were very impressed by her product and praised her.

2. Climbing the Social Ladder through the SHGs

From being a farmer in 2014 to being a Bank Sakhi and Master Bookkeeper today, Smt. Lovitoli of Hukuthu SHG, Khukiye village under Satakha block, Zunheboto district, Nagaland has steadily emerged from a shy woman into a leader inspiring others to be like her. Lovitoli’s is a tale of accomplishments and gratitude in face of abject poverty.

Aged 40 yrs old, wife of a farmer and a mother of 7 children, Lovitoli was introduced to the SHG in 2014 with much objection from her husband, who now is proud of her

accomplishment and supports her unconditionally. During one of the capacity building sessions, a story about a successful woman who was an amputee motivated her to gravitate towards new learnings every day. A mere house wife, who had no idea about alternative source of income, apart from farming, and didn't know how to start a livelihood, she pushed herself to build her capacity and support her family as well as her community. From a poor member she went on to become the Master Book keeper and gradually became a Bank Sakhi. It was not easy for a farmer to learn bookkeeping let alone teach her counterparts. Supported by her conviction that when a woman puts her mind on something, she can achieve it despite any hurdles, she grilled herself into learning and applying her knowledge in the field. Today, she has opened 430 SHG bank accounts, and is regularly supporting 79 SHGs from the Block in bookkeeping and access to financial services.

Apart from building her skills, she also enhanced her livelihoods with the support received from the SHGs. With the loans accessed from the SHG, she purchased a cow and gradually increased it to 6 cows. And with the income from multiple livelihoods sources, the family was able to build their home and afford good education for their 7 children who were earlier deprived of proper education due to their poverty. Her net income from various livelihoods source is Rs. 8,000/- per month.

Lovitoli says,

Before I joined the SHG, I thought my life revolved around my home and agricultural field; that my hands are for spade and mud, but over the years, I have learned to operate a computer and now able to support the SHGs in our Block with various financial services. I used to see myself within the four corners of my house

playing the role of a typical, dutiful wife. It never occurred to me that one day I would be teaching and serving the community, especially my counterparts. I am forever grateful to NSRLM and the SHG platform.

Source: Inspirational Stories of Aatmanirbhar Rural Women

11. Balanced diet and Diet during different stages of Life

In this session participants know about,

- Balanced diet
- Importance of diet during different stages of life-
- Body mass index
- Things to do stay fit

Overview of the session

Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	10 min
II	Video show on “Importance of Balanced diet”	20 min
III	Slide show on “Balanced diet and Diet during different stages of Life”	45 min
IV	Nutrition cards Game	30 min
V	Discussion and Winding Up	15 min
	Total duration	120 min (2 hours)

Nutrients that we obtain through food have vital effects on physical growth and development, maintenance of normal body function, physical activity and health. Nutritious food is, thus needed to sustain life and activity. Our diet must provide all essential nutrients in the required amounts. Requirements of essential nutrients vary



with age, gender, physiological status and physical activity. Dietary intakes lower or higher than the body requirements can lead to under nutrition (deficiency diseases) or over nutrition (diseases of affluence) respectively. Eating too little food during certain significant

periods of life such as infancy, childhood, adolescence, pregnancy and lactation and eating too much at any age can lead to harmful consequences. An adequate diet, providing all nutrients, is needed throughout our lives. The nutrients must be obtained through a judicious choice and combination of a variety of foodstuffs from different food groups.

Carbohydrates, fats and proteins are macronutrients, which are needed in large amounts. Vitamins and minerals constitute the micronutrients and are required in small amounts. These nutrients are necessary for physiological and biochemical processes by which the human body acquires, assimilates and utilizes food to maintain health and activity

Balanced diet

A balanced diet is one which provides all the nutrients in required amounts and proper proportions. It can easily be achieved through a blend of the four basic food groups. The quantities of foods needed to meet the nutrient requirements vary with age, gender, physiological status and physical activity. A balanced diet should provide around 50-60% of total calories from carbohydrates, preferably from complex carbohydrates, about 10-15% from proteins and 20-30% from both visible and invisible fat.



What should we eat?

- Eat variety of foods to ensure a balanced diet.
- Ensure provision of extra food and healthcare to pregnant and lactating women.
- Promote exclusive breastfeeding for six months and encourage breastfeeding till two years or as long as one can.
- Feed home based semi solid foods to the infant after six months.
- Ensure adequate and appropriate diets for children and adolescents, both in health and sickness.

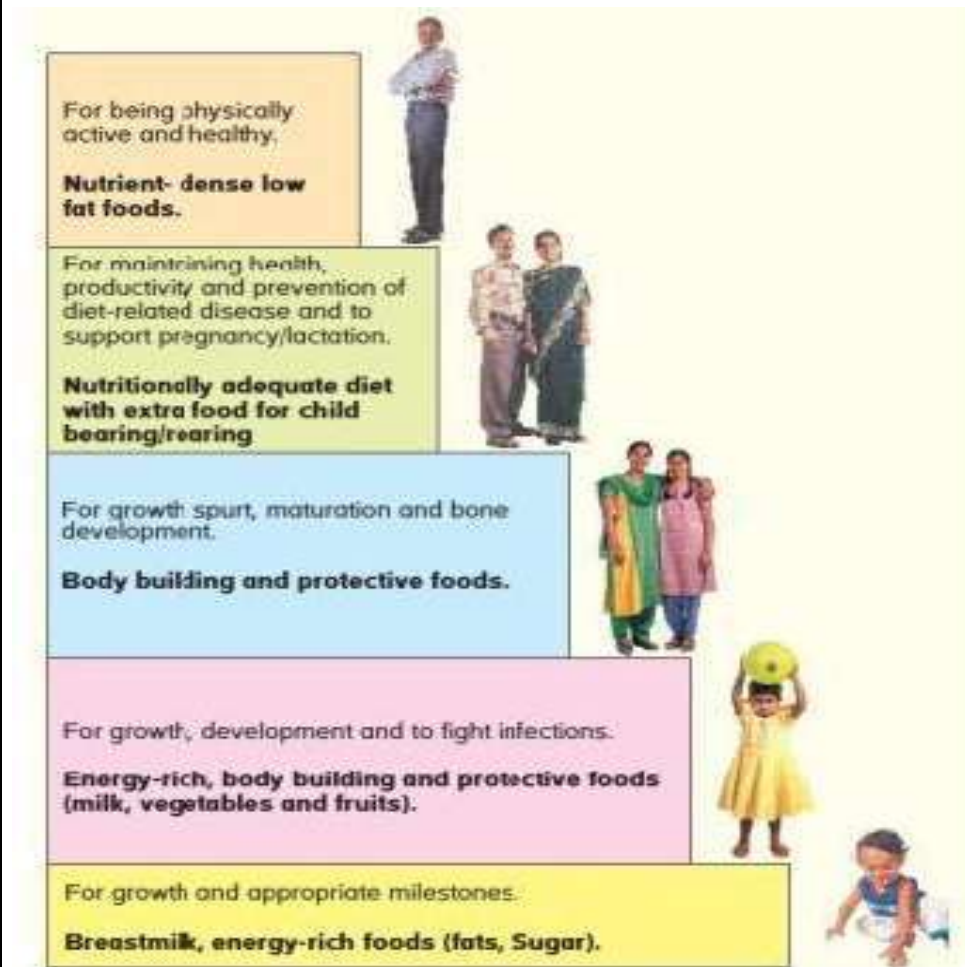
- **Eat plenty of vegetables and fruits.**
- **Ensure moderate use of edible oils and animal foods and very less use of ghee/ butter/ vanaspati.**
- **Avoid overeating to prevent overweight and obesity.**
- **Exercise regularly and be physically active to maintain ideal body weight.**
- **Restrict salt intake to minimum.**
- **Ensure the use of safe and clean foods.**
- **Adopt right pre-cooking processes and appropriate cooking methods.**
- **Drink plenty of water and take beverages in moderation.**
- **Minimize the use of processed foods rich in salt, sugar and fats.**
- **Include micronutrient-rich foods in the diets of elderly people to enable them to be fit and active.**

Which vegetables and fruits should be consumed?

We should consume fresh, locally available and preferably seasonal vegetables and fruits. They have more micronutrients and are tasty. However, no single fruit or vegetable provides all the nutrients you need. The key lies in eating a variety of them and with different colors. Include commonly consumed leafy greens, tomatoes and other vegetables, apart from those which are yellow, orange, red, deep red, purple coloured citrus fruits, being vitamin C-rich enrich the diets significantly. Along with these, try selecting some new vegetables and fruits to your meals.



IMPORTANCE OF DIET DURING DIFFERENT STAGES OF LIFE



Senior Citizens: For being physically active and healthy require nutrient dense low fat foods.

Pregnancy: For maintaining health, productivity and prevention of diet-related diseases and to support pregnancy/lactation require nutritionally adequate diet with extra food for child bearing/rearing.

Adolescent: For growth spurt, maturation and bone development require body building and protective foods.

Child Age: For growth, development and to fight infections require Energy, body building and protective food.

Infant: For growth and appropriate milestones require Breast milk, energy rich foods.



How much should we consume?

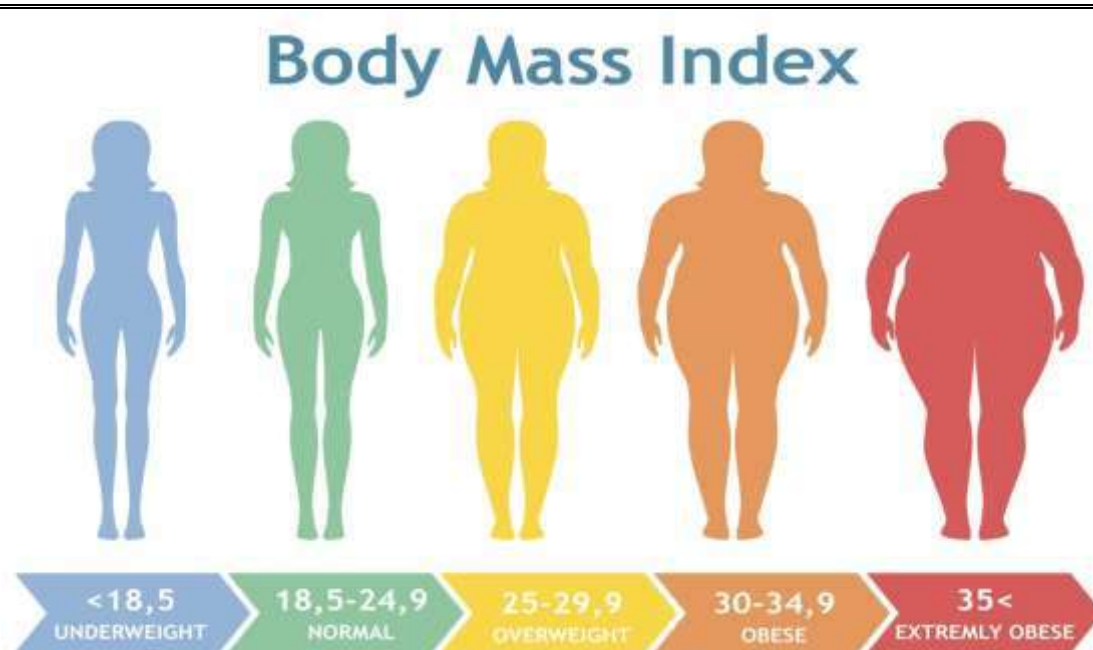
The Expert Committee of the Indian Council of Medical Research, taking into consideration the nutrient requirements, has recommended that every individual should consume at least 300 g of vegetables (GLV : 50 g; Other vegetables : 200 g; Roots & Tubers : 50 g) in a day. In addition, fresh fruits (100 gm), should be consumed regularly. Since requirements of iron and folic acid are higher for pregnant women they should consume 100g of leafy vegetables daily. High calorie vegetables and fruits to be restricted for overweight/ obese subjects.

Reference man and Reference woman

RDA suggested for Indian population is based on the reference man and reference woman.

Reference man and Reference woman are defined on the basis of body weights of well nourished healthy adults who have satisfactory growth during their childhood and are currently leading a healthy and moderately active life living under normal comfortable conditions.

Reference man is between 20-39 years of age, height 163 cm and weight of 60kg. Reference woman is between 20-39 years of age, height 151 cm and weight 50 kg. For a taller and heavier person the RDA values have to be more than what is given here.



Six things to do to stay fit

Staying fit is as crucial as the heart pumping blood throughout the body and the Brain functioning to maintain balance in our body. Being fit is the least we can do owing to healthcare situation and needs prevailing currently!! Different types of pollution at ever rising levels and diseases at its mighty best, weakening immune system. The diseases that earlier used to strike humans after their 40s, now it will



not seem much astonishing to know that a child born being diagnosed with such diseases or during their much innocent childhood time. Be it Obesity or any other lifestyle disease, humans of every age group is prone to them. Staying fit is the best Preventive care one can undertake to stay away at a safe distance from them.

Balanced Diet: Intake of food and eating habits play a major and prime role in the way we live our life and with what kind of lifestyle-healthy or unhealthy. A balanced diet consists of various constituents of food in accurate and appropriate quantity and quality according to the requirement of individual. It is easily digestible and contains appropriate ratio between proteins, fats and carbohydrates that is 1:1:4 for overall development of body in the fit proportion. The diet may vary from person to person according to the body requirements as per consultation from a dietician or family doctor.

Active lifestyle: This plays a pertinent role in maintaining fitness. School children should prefer walking instead of being driven by any kind of vehicle if it is at a walking distance. Stairs can be used instead of elevators. Rather than sticking to T.V or mobile screens one should opt for outdoor games. In this manner one could lead a more active lifestyle by adding to it more efforts physically.



Yoga and exercises: Research studies have proved that stress and tension leads to weight gain and ruin fitness levels. These activities are greatly beneficial in relieving those and therefore should be used for keeping a good control on weight and body fitness. Also this controls your weight by burning excess calories stored in body and therefore plays a significant role in maintaining healthy weight when partnered with balanced meals.

Avoid fatty foods: Fats are maximum contributors to number of calories. These extra number more than the required number, tends to accumulate in the body, so better to avoid it, the more you can, the more are the Chances of you remaining fit.

Avoid overeating: This means that consuming right amount of food strictly as per needs of the body. The more food consumed, the more calories consumed beyond requirements hence accumulation, thus increasing the chances of obesity and lifestyle diseases. Better consume within right amount!!

Do not skip meals: Skipping meals is a strict No as against myths by individuals on dieting for the fit body, such as breakfast, lunch and dinner. Once you skip any meal,

you will definitely go for overeating during the next meal time leading to weight gain, as this increases hunger and results in greater food consumption next time.

Avoid alcohol, smoking and drugs: Always keep this in your mind that these addiction agents tend to weight gain. Alcohol is directly absorbed from the stomach in the blood stream and easily stored as fats. So avoid it altogether to facilitate body fitness.

Follow these simple ways to follow fitness and raise toast to the healthier you by adding life to your days through leading a fit lifestyle!!

Contaminated and adulterated foods are major causes for several food-borne illnesses

- **Safe and good-quality foods are essential for maintaining good health**
- **Naturally-occurring toxins, environmental contaminants and adulterants in foods constitute a health hazard.**
- **Consumption of unsafe foods can lead to food-borne diseases.**
- **Buy food items from reliable sources after careful examination.**
- **Wash vegetables and fruits thoroughly before use.**
- **Store the raw and cooked foods properly and prevent microbial, rodent and insect invasion.**
- **Refrigerate perishable food items.**
- **Maintain good personal hygiene and keep the cooking and food storage areas clean and safe.**
- **Always use thoroughly cleaned utensils for cooking/ eating.**

12. Under nutrition and Over nutrition among Women

In this session participants know about,

- Undernourishment among women
- Obesity in women
- Nutrition during pregnancy

Overview of the session:

Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	10 min
II	Slide show on “Under nutrition and Over nutrition ”	40 min
V	Video show on “Effects of improper nutrition among women”	20 min
VI	Slide show on “Nutrition during Pregnancy”	30 min
V	Discussion and Winding Up	10 min
	Total duration	120 min (2 hours)

Undernourishment among women

A quarter of women of reproductive age in India are undernourished, with a body mass index (BMI) of less than 18.5 kg/m (Source: NFHS 4 2015-16). It is well known that an undernourished mother inevitably gives birth to an undernourished baby, perpetuating an intergenerational cycle of under nutrition.



Undernourished girls have a greater likelihood of becoming undernourished mothers who in turn have a greater chance of giving birth to low birth weight babies, perpetuating an intergenerational cycle. This cycle can be compounded further in young mothers, especially adolescent girls who begin childbearing before they have grown and developed enough. When mothers take only short intervals between pregnancies and have many children, this can exacerbate nutrition deficits, which are then passed on to their children. Foetal stunting is largely caused by the mother’s inadequate nutrition before conception and in the first trimester.

The major reason for stagnant levels of under nutrition among Indian children is because of a failure so far to adequately prevent under nutrition when it happens most - in the womb, which is caused by poor nutrition of women before and during pregnancy.

Obesity and Nutrition

Obesity is a state in which there is a generalized accumulation of excess fat in adipose tissue in the body leading to more than 20% of desirable weight. Obesity has several adverse health effects and can even lead to premature death. Obesity leads to high blood cholesterol, high blood pressure, heart disease, diabetes, gall bladder stone and certain types of cancer.

Causes

- Over-eating and reduced physical activity together lead to obesity.
- Obesity and over-weight are caused by a chronic imbalance between energy intake and energy expenditure.
- High intake of dietary fat also causes obesity.
- Complex behaviour and psychological factors also cause over-eating and thus lead to obesity.
- Metabolic errors in energy utilization may favour fat accumulation. Obesity in childhood and adolescence can lead to adult obesity. Among women, obesity develops just around pregnancy and after menopause.

How to reduce weight?

- Eat less fried foods.
- Eat more fruits and vegetables.
- Eat more fiber-rich food items like whole grains, grams and sprouts.
- Do regular exercise to keep the body weight within normal limits.
- Slow and steady reduction in body weight is advised.
- Severe fasting may lead to health hazards. Enjoy a variety of foods needed to balance your physical activity.
- Eat small meals regularly at frequent intervals.
- Cut down sugar, fatty foods and alcohol.
- Use low-fat milk.
- Weight reducing diet must be rich in protein and low in carbohydrates and fat.

Nutrition during Pregnancy

Demand for nutritious diet is high during pregnancy. Extra food is required to meet the needs of the foetus and the pregnant women. In India, it is observed that diets of women belonging to the poorer groups are similar to non-pregnant and non-lactating women even during pregnancy and lactation.

- Maternal malnutrition leads to high prevalence of low birth weight infants and high maternal and infant mortality.
- Additional foods are required to improve the birth weight and to increase mother's body fat deposits.
- Lactating women need more nutritious food for optimum milk output.
- Dietary requirements of pregnant women
- Diet of a pregnant woman has a direct influence on the weight of the baby at birth.
- Diet during pregnancy should contain larger amounts of protective foods.
- Pregnant women need an additional 300 kcal of energy, extra 15 gm of protein and 10 gm fat from mid pregnancy onwards.
- During pregnancy and lactation additional amount of calcium is required for proper formation of bone and teeth and also for secretion of breast milk.
- Iron deficiency anemia during pregnancy increases maternal mortality and the incidence of low birth weight. Hence, consuming iron-rich food is essential.



Do's and don'ts during pregnancy

Eat more food during pregnancy and lactation.

An additional meal is preferable.

Eat more whole grain, sprouted grams and fermented food.

Take milk/meat/egg.

Eat plenty of vegetables and fruits.

Do not use alcohol and tobacco.

Take medicine only when prescribed.

Take iron, folate and calcium supplements regularly after 14-16 weeks of pregnancy and continue the same during lactation.

Beverages like tea and coffee bind dietary iron and make it unavailable; hence they should be restricted before and soon after a meal.

Pregnant women need walking and other physical activity and should avoid heavy physical work, particularly during the last month of pregnancy.

13. Health related Schemes for Women

Objectives of the session:

In this session, the participants will learn about

- ✚ Detailed information on women health related schemes
- ✚ Strategic model of “Women Empowerment”
- ✚ Winding up by revising the content

Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	10 min
II	Slide show on “Health related Schemes for Women”	20 min
III	Explaining Strategic model of “Women Empowerment”	15 min
IV	Revision and honouring the participants	45 min
	Total duration	90 min (1 1/2 hours)

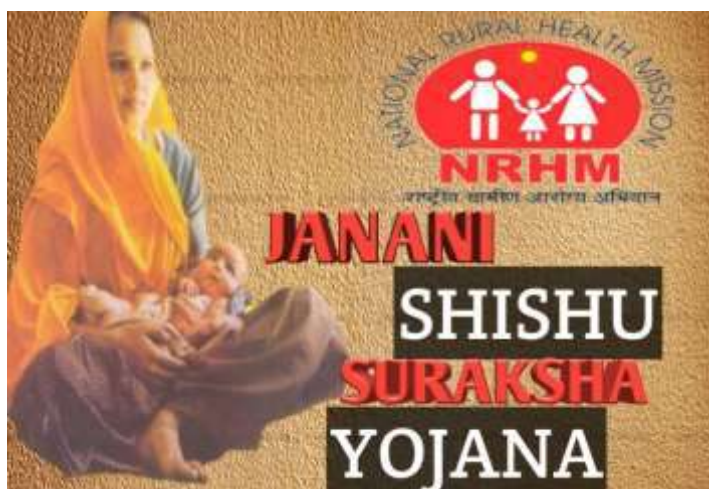
1. Janani Shishu Suraksha Karyakaram (JSSK)

Brief Objective

The scheme is estimated to benefit pregnant women who access Government health facilities for their delivery. Moreover it will motivate those who still choose to deliver at their homes to opt for institutional deliveries.

The scheme was launched in June

2011 to eliminate out-of-pocket expenses for both pregnant women and sick infants.



Benefits

Free and Cashless Delivery, Free C-Section, Free diet during stay in the health institution - 3 days in case of normal delivery and 7 days in case of caesarean section.

In 2014, the programme was extended to all antenatal & post-natal complications of pregnancy and similar entitlements have been put in place for all sick newborns and infants (up to one year of age) accessing public health institutions for treatment.

Eligibility

It is an initiative to provide completely free and cashless services to pregnant women including normal deliveries and caesarean operations and sick newborn (up to 30 days after birth) in Government health institutions in both rural & urban areas.

Under JSSK pregnant women will get following Benefits:

- Free and cashless delivery
- Free C-Section
- Free drugs and consumables
- Free diagnostics
- Free diet during stay in the health institutions
- Free provision of blood
- Exemption from user charges
- Free transport from home to health institutions
- Free transport between facilities in case of referral
- Free drop back from Institutions to home after 48hrs stay



Under JSSK a newborn and sick child upto 1 year (infants) will get following Benefits:

- Free drugs and consumables.
- Free essential Diagnostic.
- Free provision of Blood.



- Free diet facilities.
- Free transport facilities from home to health institutions, between health institutions in case of referral.
- Free drop back facility from institution to home.
- Exception from all kind of user charges.

How to apply

Any nearby Govt. health centre

Whom to contact

Ministry of Health and Family Welfare

2. Rashtriya Kishor Swasthya Karyakram (RKSK)

Brief Objective

The Rashtriya Kishor Swasthya Karyakram was launched on the 7th January, 2014. The programme envisions enabling all adolescents in India to realize their full potential by making informed and responsible decisions related to their health and well-being and by accessing the services and support they need to do so.



Benefits

Improve nutrition, Improve sexual and reproductive health, Enhance mental health, Prevent injuries and violence, Prevent substance misuse.

Eligibility

This includes both males and females, urban and rural; in school and out of school; married and unmarried adolescents.

How to apply

Application form at Rashtriya Kishor Swasthya Karyakram (RKSK)

Whom to contact

Ministry of Health and Family Welfare



3. Universalisation Women's Helpline Scheme

Brief Objective

The Scheme of Universalisation of Women Helpline is intended to provide 24 hours immediate and emergency response to women affected by violence through referral (linking with appropriate authority such as police, One Stop Centre, hospital) and information about women related government schemes programs across the country through a single uniform number - 181.



Benefits

181 is a toll-free 24-hours telecom service made available to women affected by violence seeking support and information.

It also provides information about the appropriate support services, government schemes and programmes available to the woman affected by violence, in her particular situation within the local area in which she resides or is employed.



Eligibility

Any woman or girl facing violence within public or private sphere of life or seeking information about women related programmes or schemes.



F. Decision Making and interpersonal skills among Women

14. Decision Making among Women at Household and Society

Objectives of the session:

In this session, the participants will learn about

- ✚ the meaning of decision making and participation of women in decision making
- ✚ ways to improve decision making among women

Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	10 min
II	Video show on “Decision making at home ”	15 min
III	Slide show on Gender equity and Gender equality; Concept of female sex ratio, literacy rate, child marriage and gender based violence	30 min
IV	Share experiences and feelings in a confidential group environment; Think about our own life experiences as women, and about ways in which society sometimes oppresses us.	15 min
V	Slide show on “Ways to achieve Gender Equality”	20 min
VI	Activity on “Equality of Work”	20 min
V	Discussion and Winding Up	10 min
	Total duration	120 min (2 hours)

Every human being has the right to participate in decisions that define her or his life. This right is the foundation of the ideal of equal participation in decision-making among women and men. This right argues that since women know their situation best, they should participate equally with men to have their perspective effectively incorporated at all levels of decision-making, from the private to the public

spheres of their lives, from the local to the global. Reducing gender inequality is one of the Sustainable Development Goals (SDGs), which states that women and girls, everywhere, must have equal rights and opportunity and gender equality is an important dimension of inclusive and sustainable development.

Participation of Women in Decision Making on Different Aspects

Decision making is regarded as an integral part of one's life. Individuals are required to make decisions on a daily basis. The decisions normally are classified into two categories, major and minor. Major decisions are the ones that have an impact upon the lives of the individuals to a major extent; these may be related to education, employment, housing, property, finances and so forth. On the other hand, minor decisions are the ones, which are trivial and do not have a great impact upon the lives of the individuals. The different aspects regarding which women make decisions have been stated as follows:

Household Responsibilities

Within the Indian society, the role of women in the implementation of household responsibilities is comprehensively recognized. Irrespective of their education, socio-economic background and overall personality, they need to possess adequate knowledge and be efficiently trained in terms of implementation of household responsibilities. The various areas that they need to take into account in the making of decisions in terms of household responsibilities are, cleaning, washing, preparation of meals, paying bills, purchase of items, health care, taking care of the needs of elderly individuals, child development and other tasks and activities.

Other important household responsibilities, in terms of which women need to make decisions, are decoration of the house, buying of domestic goods and getting the construction done. When women are the heads of the households, then they are the ones, who make the decisions in terms of household responsibilities. Whereas, when they are living with their spouses, then both husband and wife collaborate with each other in the making of decisions.

Family Members

Women are vested with the major responsibilities of taking care of the needs and requirements of their family members. These include, children and elderly members of the family. In terms of their family members, the decisions that are made by women are solely centred upon promoting their well-being. The function of child development is

comprehensive. In this case, mothers are required to make major decisions regarding their children, especially when they are young. These include, education, extra-curricular and creative activities, play activities, leisure and recreational activities, diet and nutrition, health care and so forth. When the child grows up and is to get engaged in employment opportunities or settle down, then too, mothers have a significant role to play. Adult children, who appreciate and respect their mothers, seek ideas and suggestions from them, when they are to get involved in any task or activity.

Financial Matters

Finances are regarded as an important aspect in terms of which women need to make decisions. When they have limited income, then they need to be cautious in terms of spending their finances. In such cases, women and other family members may just spend their finances on the essential items and services. On the other hand, wealthy women make spending of financial resources on the fulfilment of their needs as well as in promoting welfare of the family and community. The major decisions that they make in terms of financial matters are, making purchases of various items, health care and medical, travelling and tourism and so forth.

Career

Making a decision regarding career is regarded as the most important decision that is usually made once in the lifetime of the individuals. It is one of the most difficult decisions, on the basis of which ones entire life is centred. This decision is more than just making a selection of the job or an educational institution. It requires enthusiasm and motivation and these factors can be informed by the possession of knowledge. It is therefore, important to obtain the necessary information, before making any major career. Women too need to pay adequate attention towards their careers and make wise decisions. Women are getting enrolled in higher educational institutions to acquire good educational qualifications and develop their professional skills and abilities, so they are able to get engaged in good employment opportunities and enrich their career prospects. The careers which the individuals select, mainly depends upon their interests, skills and abilities. When making decisions regarding careers, individuals are required to take into consideration, number of factors, these are, family background, socio-economic status, and financial position, location of homes, and interests and abilities.

In some cases, when women make a selection of their careers, get enrolled in the program of study or get recruited within the employment setting, then it may happen that they do not feel satisfied and form the viewpoint that they have not made the correct career decision. In such cases, primarily, due to lack of abilities, they get compelled to leave and make another career decision. When women have made the decisions regarding their careers, then it is vital that they need to work towards them to their best abilities. They need to recognize this fact that they have invested time, diligence, creativity and monetary resources towards the selection of the career, therefore, they need to work wholeheartedly towards it. The different areas in which women choose their careers are, education, medical, administration, management, science, law, architecture, technology and so forth. When making career decisions, women need to ensure that their family members feel satisfied and pleased.

Social Activities

Within the Indian society, women, belonging to all age-groups and backgrounds, feel contented when they are to get engaged in social activities. The social activities are the activities that are organized, primarily for promoting well-being of the society. When the individuals get involved in any kind of social work, then they usually make use of resources on their own. There are number of social activities, but the participation of women in these activities, primarily depends upon their educational qualifications, financial position, skills and abilities.

Women, who are primarily home-makers, normally participate in social, religious and cultural activities. In most cases, these activities are not paid and they get engaged in these activities, to generate satisfaction among themselves. The social activities are of various types, women may carry out these activities by making provision of tuition classes, free of cost or donating various items, such as, food, clothes, stationary, bags to women and children, belonging to deprived and marginalized communities. Another aspect is participation in various social and religious functions, such as, birthdays, marriage ceremonies and so forth. The decisions made by the women in participation are normally influenced by their interests, abilities and health conditions. When they are healthy, then they would render an effective participation in various social activities.

Personal Interests

Every individual has the right to make decisions, relating to their personal lives. Personal interests are referred to the interests, which influence the personality traits of the individuals and daily routine activities. For instance, women, who belong to middle age groups and are engaged in full-time jobs, they may implement the household responsibilities, go to work, return home and get engaged in household chores. Whereas, women, who are home-makers may get engaged in the implementation of household responsibilities and look after the needs and requirements of the family members. In accordance to one's personal interests, women usually get engaged in number of activities. These include, reading, writing, cooking, embroidery, knitting, painting, pottery making, sports, physical activities, music, singing, dancing, social work, participation in religious activities, and so forth. Hence, decisions in terms of personal interests are normally made on the basis of one's curiosities and abilities.

15. Promoting Confidence, Self-esteem and Leadership among women

Objectives of the session:

In this session, the participants will learn about

- ✚ the meaning of Confidence, Self-esteem and Leadership
- ✚ ways to improve self-esteem and Leadership among women

Sl. No.	Particulars	Duration
I	Welcome the participants and revising earlier session	10 min
II	Video show on “Confidence building and self-esteem”	15 min
III	Slide show on “Promoting Confidence and Self Esteem and Leadership”	45 min
IV	Activity on “ Know yourself and Leadership”	40 min
V	Discussion and Winding Up	10 min
	Total duration	120 min (2 hours)

Self confidence

Self-confidence as an individual’s trust in his or her own abilities, capacities, and judgments, or belief that he or she can successfully face day to day challenges and demands.

Self-confidence also brings about more happiness. Typically, when you are confident in your abilities you are happier due to your successes. When you are feeling better about your capabilities, the more energized and motivated you are to take action and achieve your goals.

Self-confidence, then, is similar to self-efficacy in that it to focus on the individual’s future performance; however, seems to be based on prior performance, and so in a



tends
it
sense,

it also focuses on the past. Self-esteem is confidence in one's own worth or abilities.

CONFIDENCE BUILDING

Confidence and self –belief are both hugely important in virtually all aspects of our lives, through many of us aspire to have more of each, we often struggle to find them. Our confidence and the belief we have in ourselves (or lack of) shows in many ways; in our behaviour, our mood and even how we walk and talk. Individuals who lack confidence and self –belief will often find that various areas of their lives begin to feel the effects, with relationships, career, life style and state of mind all begin to suffer unless positive action is taken to build upon and improve these important qualities.

Confidence and self –belief:

If an individual doesn't believe in themselves, who else is going to? The good news for individuals suffering from low confidence and self-worth is that they are both things that can often be developed through confidence coaching. The first step is to acknowledge the current level of self –esteem and then find a way to build upon this until confidence and self-worth become deeply ingrained qualities.

Self –confidence and self –esteem are usually considered to be made up of a variety of factors, including social confidence, physical presence, status confidence, stage presence and peer independence. Your body language, your behaviour, how you speak and how you react to different situations can often portray to others how confident you are and how much belief you have in yourself. Those with confidence are generally more positive about themselves, whereas those lacking confidence often think negatively about themselves and could benefit from some confidence coaching.

If you are lacking confidence and don't have much self –belief you may feel:

- ✓ Shy and uneasy
- ✓ Uncertain of who you are and what you want
- ✓ Sense of worthlessness
- ✓ Negative thoughts about yourself and your abilities
- ✓ Uncertain of yourself
- ✓ Unable to relax and enjoy certain situations you'd like to
- ✓ Little sense of direction in your life

Alternatively, if you are full of confidence and self –belief you may feel:

- Comfortable facing new challenges
- At ease in social situations, and able to be yourself
- Excited about new opportunities
- Great sense of achievement
- Confident about your ideas and opinions
- Great enjoyment of life in general
- Respected by other people
- Sure of yourself and what you want

Self-esteem

Self-esteem encompasses beliefs about oneself (for example, "I am loved", "I am worthy") as well as emotional states, such as triumph, despair, pride, and shame. Self-esteem is how we value ourselves; it is how we perceive our value to the world and how valuable we think we are to others. Self –esteem affects our trust in others, our relationships, our work-nearly every part of our lives. Positive self –esteem gives us the strength and flexibility to take charge of our lives and grow for our mistakes without fear of rejection.

Following are some outward signs of positive self-esteem:

- Confidence
- Self-direction
- Non –blaming behaviour
- An awareness of personal strengths
- An ability to make mistake and learn from them
- An ability to accept mistakes for others
- Optimism
- An ability to solve problems
- An independent and cooperative attitude
- Feeling comfortable with a wide range of emotions
- An ability to trust others
- A good sense of personal limitations
- Good self-care

Low self esteem

Low self –esteem is a debilitating condition that keeps individuals from realizing their full potential. A person with low self –esteem feels unworthy, incapable, and incompetent.

Here are some signs of low self –esteem:-

- ✓ Negative view of life
- ✓ Perfectionist attitude
- ✓ Mistrusting others-even those who show signs of affection
- ✓ Blaming behaviour
- ✓ Fear of taking risks
- ✓ Feeling of being unloved and unlovable
- ✓ Dependence-letting others make decisions
- ✓ Fear of ridiculed
- ✓ How can you raise the low self –esteem

The following affirmations can help you to work toward a positive self-image:

- I respect myself and others
- I am lovable and likable
- I am confident and it shows
- I care about myself
- I am creating loving, healthy relationships
- I am a good friend to myself and others
- I accept myself just as I am
- I look great
- Life is good, and I like being a part of it

Leadership

Leadership encompasses the ability of an individual, group or organization to "lead", influence or guide other individuals, teams, or entire organizations.

Leadership captures the essentials of being able and prepared to inspire others. Effective leadership is based upon ideas—both original and borrowed—those are effectively communicated to others in a way that engages them enough to act as the leader wants them to act.

A leader inspires others to act while simultaneously directing the way that they act. They must be personable enough for others to follow their orders, and they must have the critical thinking skills to know the best way to use the resources at an organization's disposal.

Activities

1. Knowing about oneself

Activity overview:

Participants are given 15 minutes to find an object that represents some aspect of them. Participants then introduce themselves through the selected object.

Instructions:

1. Tell participants that they have 15 minutes to search the surrounding area, both outside and inside if appropriate, for an object they feel represents some of their characteristics or who they are.
2. After the 15 minutes are over, call participants back together.
3. Allow each participant a turn to say her name, show the object she selected and explain what it represents. For example, "My name is "X", I picked this rock because it is strong but smooth, like me."

2. Leadership quality

Objectives:

To enable participants to discover their leadership styles and qualities through hands on experience.

Requirements:

- One facilitator
- One blank sheet of paper per participant
- Pens or pencils for all participants
- Several old newspapers
- Enough art supplies for all participants including scissors, scotch tape, glue, markers or crayons. Optional inclusions could be scraps of cloth, leaves, stones, glitter, etc.

Activity overview:

Participants are divided into groups of three to four . Each woman takes a turn leading the group in a timed challenge, giving her the opportunity to explore her leadership style.

Instructions:

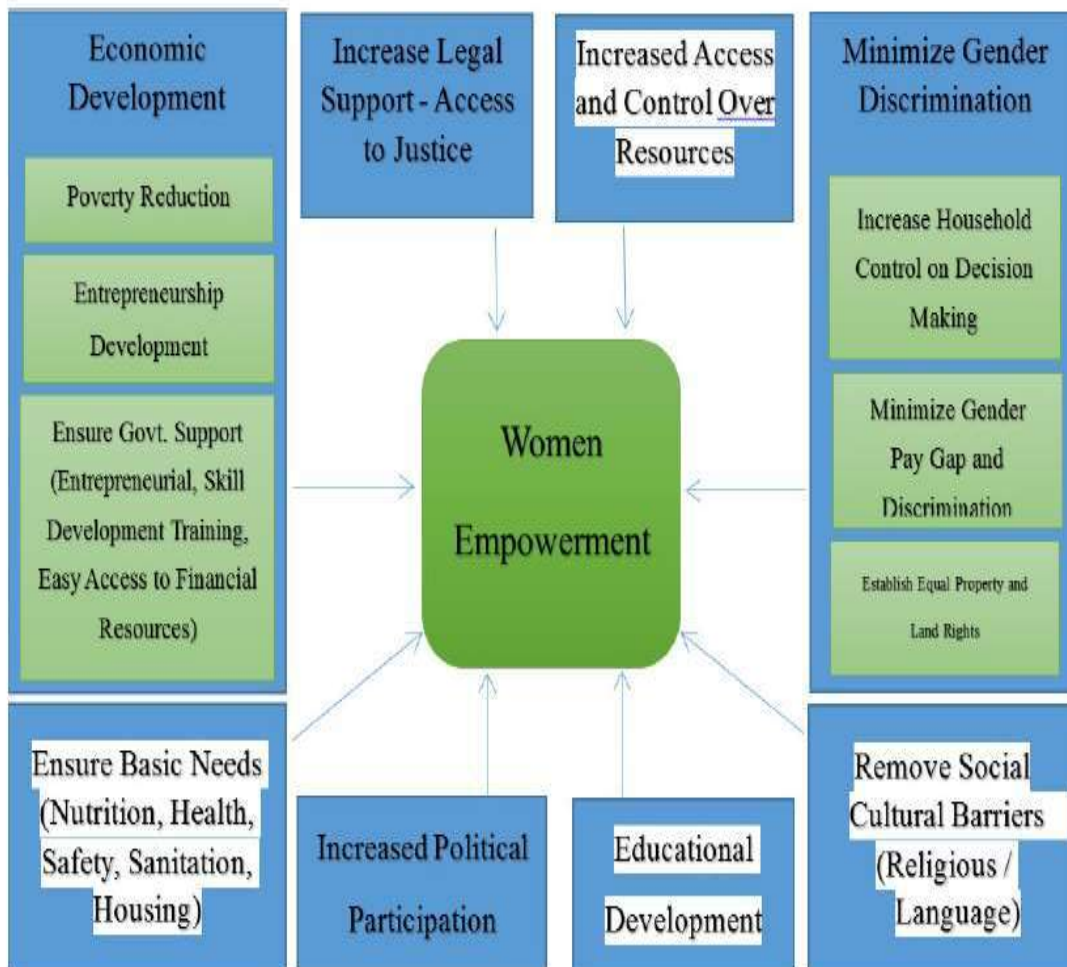
1. Hand out paper and pencils or pens to each participant.
2. Divide participants into teams of equal numbers if possible (either three or four)
3. Explain to the group that they will be given a series of challenges, and each challenge must be completed in 15 minutes. A different team member will lead each new challenge, and no team member should lead more than one challenge unless everyone else has had a turn. At the end of each challenge the winning teams, i.e. those who complete the challenge in the allotted time, will receive small prizes.
4. Let participants know that at the end of each challenge they will be given 5 minutes to evaluate the team leader for that challenge. The leader should also evaluate herself at this time. Encourage participants to list qualities that made the leadership effective and areas where the leadership could have been improved. These notes should be saved for the group discussion to follow the challenges.
5. When everyone understands the instructions tell the groups the first challenge and give them one minute to choose a leader, before you begin timing the challenge. All groups do the same challenge simultaneously. The groups who complete the tasks within the allotted timeframe can receive small prizes.
6. At the end of the activity when every participant has had an opportunity to lead her team, bring the group together in a circle to discuss what they learned.

▼ Give each participant a chance to hear her team mates' comments on her leadership style. Emphasise the importance of being respectful in comments.

Ask for both positive comments and comments on something the leader could improve.

▼ After listening to comments allow the participant in question to share what the leadership experience was like for her. What did she enjoy? What was difficult to deal with? What did she learn about leadership? What did she learn about herself? Were the leadership qualities she displayed with her team the same as she wrote down in the paper.

Strategic Women Empowerment Model



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ಬಾಲಕಿಯರ ಶಿಕ್ಷಣಕ್ಕಾಗಿ ಸರ್ಕಾರದ ಯೋಜನೆಗಳು



ಲೇಖಕರು

ಪ್ರಿಯಾ ರಮೇಶ ಹೆಗಡೆ

ಡಾ. ವಿನುತಾ ಯು. ಮುಕ್ತಾಮಠ

ಮಾನವ ವಿಕಾಸ ಹಾಗೂ ಕುಟುಂಬ ಅಧ್ಯಯನ ವಿಭಾಗ

ಸಮುದಾಯ ವಿಜ್ಞಾನ ಮಹಾವಿದ್ಯಾಲಯ

ಕೃಷಿ ವಿಶ್ವವಿದ್ಯಾಲಯ ಧಾರವಾಡ---580 005

ಜೂನ್, 2022

ಬಾಲಿಕಾ ಸಮೃದ್ಧಿ ಯೋಜನೆಯ ಪ್ರಯೋಜನಗಳು

ದಹಣ್ಣು ಶಿಶುವಿನ ಹತ್ಯೆಯನ್ನು ತಡೆಗಟ್ಟುವುದು ಮತ್ತು ಹೆಣ್ಣು ಮಗುವಿನ ಜನನಕ್ಕೆ ಸಂಬಂಧಿಸಿದ ಕಳಂಕವನ್ನು ಮುರಿಯುವುದು ಯೋಜನೆಯ ಉದ್ದೇಶಗಳಲ್ಲಿ ಒಂದಾಗಿದೆ. 2011 ರ ಜನಗಣತಿಯ ಪ್ರಕಾರ ಮಕ್ಕಳ ಲಿಂಗ ಅನುಪಾತ (Child Sex Ratio -CSR), 1000 ಪುರುಷರಿಗೆ 940 ಮಹಿಳೆಯರಿದ್ದಾರೆ. ಆದರೆ ಭಾರತದ ಕೆಲವು ರಾಜ್ಯಗಳಲ್ಲಿ ಪರಿಸ್ಥಿತಿ ಹೆಚ್ಚು ಭೀಕರವಾಗಿದೆ. ಆದ್ದರಿಂದ, ಜಾಗೃತಿ ಮೂಡಿಸಲು ಮತ್ತು ಹೆಣ್ಣು ಮಗುವಿನ ಜನನದ ಸುತ್ತಲಿನ ಸಂಪೂರ್ಣ ಕಳಂಕವನ್ನು ತೆಗೆದುಹಾಕಲು ಈ ರೀತಿಯ ಯೋಜನೆಗಳ ಅಗತ್ಯವಿದೆ. ಹುಟ್ಟುವ ಹೆಣ್ಣುಮಕ್ಕಳನ್ನು ಸಂತೋಷದಿಂದ ನೋಡದಿದ್ದಲ್ಲಿ, ಇಂತಹ ಯೋಜನೆಗಳು ಹೆಣ್ಣು ಮಕ್ಕಳನ್ನು ಹೊಂದಿರುವವರನ್ನು ಪ್ರೇರೇಪಿಸುವ ಒಂದು ಮಾರ್ಗವಾಗಿದೆ ಮತ್ತು ಹೆಣ್ಣುಮಕ್ಕಳಿಗೆ ಶಿಕ್ಷಣ ಮತ್ತು ಅವರ ಸ್ವಂತ ಕಾಲಿನ ಮೇಲೆ ನಿಲ್ಲಲು ಸಹಾಯ ಮಾಡುತ್ತದೆ.



ಈ ಯೋಜನೆಯು ಯಾವುದೇ ಹೆಣ್ಣು ಮಗು ಬಾಲ್ಯವಿವಾಹಕ್ಕೆ ಬಲಿಯಾಗದಂತೆ ಮತ್ತು ಅವಳು ಮದುವೆಯಾಗುವ ಮೊದಲು ವಿವಾಹದ ಕಾನೂನುಬದ್ಧ ವಯಸ್ಸನ್ನು ತಲುಪುವುದನ್ನು ಖಚಿತಪಡಿಸಿಕೊಳ್ಳುವ ಗುರಿಯನ್ನು ಹೊಂದಿದೆ.

ಈ ಯೋಜನೆಯು ಬಿವಿಎಸ್ ಅಡಿಯಲ್ಲಿ ನೋಂದಾಯಿಸಲ್ಪಟ್ಟ ಪ್ರತಿ ಹೆಣ್ಣು ಮಗುವನ್ನು ನೋಡಿಕೊಳ್ಳುತ್ತದೆ ಮತ್ತು ಅವರಿಗೆ ಆದಾಯ ಉತ್ಪಾದಿಸುವ ಚಟುವಟಿಕೆಗಳಲ್ಲಿ ತರಬೇತಿ ನೀಡಲು ಸಹಾಯ ಮಾಡುತ್ತದೆ, ಅದು ಅವರನ್ನು ಆರ್ಥಿಕವಾಗಿ ಸ್ವತಂತ್ರರನ್ನಾಗಿ ಮಾಡುತ್ತದೆ.

4. ಹದಿಹರೆಯದ ಬಾಲಕಿಯರ ಸಬಲೀಕರಣಕ್ಕಾಗಿ ರಾಜೀವ್ ಗಾಂಧಿ ಯೋಜನೆ (ಆರ್‌ಜಿಎಸ್‌ಇಎಜಿ)

ಹದಿಹರೆಯದ 11-18 ವರ್ಷ ವಯಸ್ಸಿನ ಬಾಲಕಿಯರ ಸಬಲೀಕರಣಕ್ಕಾಗಿ ರಾಜೀವ್ ಗಾಂಧಿ ಯೋಜನೆ (ಆರ್‌ಜಿಎಸ್‌ಇಎಜಿ) ಎಂಬ ಹೆಸರಿನ ಮತ್ತೊಂದು ರಾಷ್ಟ್ರೀಯ ಯೋಜನೆ ಯನ್ನು ಪರಿಚಯಿಸಲಾಯಿತು. 'ಸಬಲಾ' ಎಂದೂ ಕರೆಯುವ ಹುಡುಗಿಯರನ್ನು ಪೋಷಣೆ, ಆರೋಗ್ಯ ರಕ್ಷಣೆ ಮತ್ತು ಜೀವನ ಕೌಶಲ್ಯ ಶಿಕ್ಷಣದ ಮೂಲಕ ಸಬಲೀಕರಣಗೊಳಿಸಲು ಪರಿಚಯಿಸಲಾಯಿತು. ಮಹಿಳೆಯರು



ಪೌಷ್ಟಿಕಾಂಶದ ಕೊರತೆಯಿಂದ ಹೆಚ್ಚಿನ ಪ್ರಮಾಣದಲ್ಲಿ ಬಳಲುತ್ತಿದ್ದಾರೆ ಎಂದು ಗುರುತಿಸಿ, ಈ ಕೊರತೆಯನ್ನು ತಗ್ಗಿಸಲು, ಜೊತೆಗೆ ಹೆಣ್ಣುಮಕ್ಕಳಿಗೆ ಶಿಕ್ಷಣ ಸಂಬಂಧಿತ ಯೋಜನೆಗಳನ್ನು ಕೇಂದ್ರ ಸರ್ಕಾರವು ಆರಂಭಿಸಿತು, ಹೆಣ್ಣು ಮಕ್ಕಳಿಗೆ ವರ್ಷಕ್ಕೆ 300 ದಿನಗಳವರೆಗೆ ಆರೋಗ್ಯ ತಪಾಸಣೆ ಮತ್ತು ರಫರಲ್ ಸೇವೆಗಳ ಜೊತೆಗೆ ದಿನಕ್ಕೆ ಪೂರಕ ಪೋಷಣೆಯ ಸಾಕಷ್ಟು ಕ್ಯಾಲೋರಿಗಳು, ಪ್ರೋಟೀನ್ ಮತ್ತು ಸೂಕ್ಷ್ಮ ಪೋಷಕಾಂಶಗಳನ್ನು ನೀಡಲಾಗುತ್ತದೆ. ಪೋಷಣೆಯೇತರ ವಿಭಾಗದ ಅಡಿಯಲ್ಲಿ, ಸರ್ಕಾರವು ಹದಿಹರೆಯದ ಹುಡುಗಿಯರಿಗೆ ತರಬೇತಿಯನ್ನು ನೀಡುತ್ತದೆ. ವರದಿಗಳ ಪ್ರಕಾರ, ವರ್ಷಕ್ಕೆ ಸುಮಾರು 100 ಲಕ್ಷ ಹದಿಹರೆಯದ ಹುಡುಗಿಯರು ಈ ಯೋಜನೆಯಡಿಯಲ್ಲಿ ಪ್ರಯೋಜನ ಪಡೆಯುವ ನಿರೀಕ್ಷೆಯಿದೆ.

ಹೆಣ್ಣು ಮಕ್ಕಳಿಗಾಗಿ ಇರುವ ಸರ್ಕಾರದ ವಿದ್ಯಾರ್ಥಿ ವೇತನಗಳು

- ❖ ಏಐಸಿಟಿಇ ಪ್ರಗತಿ ವಿದ್ಯಾರ್ಥಿ ವೇತನ (ತಾಂತ್ರಿಕ ಹಾಗೂ ಡಿಪ್ಲೋಮಾ ಓದುವ ವಿದ್ಯಾರ್ಥಿನಿಯರಿಗೆ)
- ❖ ಇಂದಿರಾ ಗಾಂಧಿ ಸಿಂಗಲ್ ಗರ್ಲ್ ಚೈಲ್ಡ್ ವಿದ್ಯಾರ್ಥಿ ವೇತನ (ಪದವಿ ಹಾಗೂ ಸ್ನಾತಕೋತ್ತರ ಪದವಿ ವಿದ್ಯಾರ್ಥಿನಿಯರಿಗೆ)
- ❖ ಸಿಬಿಎಸ್‌ಇ ಸಿಂಗಲ್ ಗರ್ಲ್ ಚೈಲ್ಡ್ ವಿದ್ಯಾರ್ಥಿ ವೇತನ
- ❖ ವಿವೇಕಾನಂದ ಸಿಂಗಲ್ ಗರ್ಲ್ ಚೈಲ್ಡ್ ವಿದ್ಯಾರ್ಥಿ ವೇತನ (ಪಿಎಚ್‌ಡಿ ವಿದ್ಯಾರ್ಥಿನಿಯರಿಗೆ)
- ❖ ಕಲ್ಪನಾ ಚಾವ್ಲಾ ರಾಷ್ಟ್ರೀಯ ವಿದ್ಯಾರ್ಥಿ ವೇತನ
- ❖ ಸಿಬಿಎಸ್‌ಇ ಉಡಾನ್ ವಿದ್ಯಾರ್ಥಿ ವೇತನ

ಹಣಕಾಸಿನ ನೆರವು: ಕರ್ನಾಟಕ ವಿಜ್ಞಾನ ಮತ್ತು ತಂತ್ರಜ್ಞಾನ ಪೋಷಕ ಸೊಸೈಟಿ, ವಿದ್ಯುನ್ಮಾನ, ಮಾಹಿತಿ ತಂತ್ರಜ್ಞಾನ, ಜೈವಿಕ ತಂತ್ರಜ್ಞಾನ ಹಾಗೂ ವಿಜ್ಞಾನ ಮತ್ತು ತಂತ್ರಜ್ಞಾನ ಇಲಾಖೆ, ಕರ್ನಾಟಕ ಸರ್ಕಾರ

ಲೇಖಕರು

ಪ್ರಿಯಾ ರಮೇಶ ಹೆಗಡೆ, ಪಿಎಚ್‌ಡಿ ವಿದ್ಯಾರ್ಥಿನಿ

ಡಾ. ವಿನುತಾ ಯು. ಮುಕ್ತಾಮಠ, ಸಹಾಯಕ ಪ್ರಾಧ್ಯಾಪಕರು

ಕೃಷಿ ವಿಶ್ವವಿದ್ಯಾಲಯ ಧಾರವಾಡ---580 005

ಪ್ರತಿಗಳು: 100

ಬಾಲಕಿಯರ ಶಿಕ್ಷಣಕ್ಕಾಗಿ ಸರ್ಕಾರದ ಯೋಜನೆಗಳು

ಶಿಕ್ಷಣವು ಪ್ರತಿಯೊಬ್ಬರ ಜೀವನದ ಅವಿಭಾಜ್ಯ ಅಂಗವಾಗಿದ್ದು ಸಮುದಾಯದ ಆಧಾರವೆಂದು ಪರಿಗಣಿಸಲಾಗುತ್ತದೆ. ಇದು ಯಾವುದೇ ರಾಷ್ಟ್ರದಲ್ಲಿ ಆರ್ಥಿಕ ಬೆಳವಣಿಗೆಯನ್ನು ಉತ್ತೇಜಿಸುವ ತ್ವರಿತ ಮತ್ತು ಪರಿಣಾಮಕಾರಿ ವಿಧಾನಗಳಲ್ಲಿ ಒಂದಾಗಿದೆ. ಸಮಾಜದ ಏಳಿಗೆಯಲ್ಲಿ ಗಂಡು ಮತ್ತು ಹೆಣ್ಣು ಇಬ್ಬರ ಶಿಕ್ಷಣವೂ ಸರಿಸಮನಾದ ಪಾತ್ರವನ್ನು ವಹಿಸುತ್ತದೆ. "ಹೆಣ್ಣೊಂದು ಕಲಿತರೆ ಶಾಲೆಯೊಂದು ತೆರೆದಂತೆ", ಎನ್ನುವ ಮಾತಿನಂತೆ ಹೆಣ್ಣು ಮಕ್ಕಳ ಶಿಕ್ಷಣವು ಕುಟುಂಬದ ಶ್ರೇಯಸ್ಸಿಗೆ ಪೂರಕವಾಗಿದೆ. ಹೆಣ್ಣು ಮಕ್ಕಳಿಗೆ ಶಿಕ್ಷಣ ನೀಡದ ಹೊರತು ನಾವು ಅಭಿವೃದ್ಧಿ ಹೊಂದಿದ ರಾಷ್ಟ್ರವನ್ನು ಅಶಿಸಲು ಸಾಧ್ಯವಿಲ್ಲ. ಕೆಲವು ಸಮುದಾಯಗಳು ಹೆಣ್ಣು ಮಕ್ಕಳ ಶಿಕ್ಷಣದ ವಿಚಾರದಲ್ಲಿ ತಾರತಮ್ಯ ಮಾಡುತ್ತಿರುವುದು ಬೇಸರದ ಸಂಗತಿ. ಹೆಣ್ಣು ಮಕ್ಕಳಿಗೆ ಶಿಕ್ಷಣ ನೀಡುವುದರಿಂದ ಬಾಲ್ಯ ವಿವಾಹ, ಅಪೌಷ್ಟಿಕತೆ, ಮಹಿಳಾ ದೌರ್ಜನ್ಯ ಇತ್ಯಾದಿ ಸಮಸ್ಯೆಗಳು ಗಣನೀಯವಾಗಿ ಇಳಿಕೆಯಾಗುವುದಲ್ಲದೇ ಮಹಿಳಾ ಸಬಲೀಕರಣಕ್ಕೆ ಭದ್ರ ಬುನಾದಿಯಾಗುತ್ತದೆ. ಮಹಿಳಾ ಶಿಕ್ಷಣದ ಮಹತ್ವವನ್ನು ಅರಿತ ಕೇಂದ್ರ ಸರ್ಕಾರವು ಹಲವಾರು ಯೋಜನೆಗಳನ್ನು ಜಾರಿಗೊಳಿಸಿದೆ. ಅವುಗಳ ಕುರಿತಾಗಿ ಮಾಹಿತಿ ಇಲ್ಲಿದೆ.

1. ಬೇಟಿ ಬಚಾವೋ ಬೇಟಿ ಪಠಾವೋ ಯೋಜನೆ

ಹರಿಯಾಣದಲ್ಲಿ 22 ನೇ ಜನವರಿ 2015 ರಂದು ಭಾರತದ ಪ್ರಧಾನ ಮಂತ್ರಿ ಬೇಟಿ ಬಚಾವೋ ಬೇಟಿ ಪಠಾವೋ ಯೋಜನೆಗೆ ಚಾಲನೆ ನೀಡಿದರು. ಹೆಣ್ಣು ಮಕ್ಕಳ ಉಳಿವು, ರಕ್ಷಣೆ ಮತ್ತು ಶಿಕ್ಷಣ ಈ ಯೋಜನೆಯ ಧ್ಯೇಯೋದ್ದೇಶಗಳಾಗಿವೆ. ಕಳೆದ ಕೆಲವು ವರ್ಷಗಳಿಂದ ಕ್ಷೀಣಿಸುತ್ತಿರುವ ಲಿಂಗ ಅನುಪಾತದ ಸಮಸ್ಯೆಗಳನ್ನು ಪರಿಹರಿಸಲು, ಸಾಮಾಜಿಕ ಜಾಗೃತಿ ಮೂಡಿಸಲು ಮತ್ತು ಹೆಣ್ಣುಮಕ್ಕಳಿಗಾಗಿ ಅಭಿವೃದ್ಧಿಪಡಿಸಲಾದ ಕಲ್ಯಾಣ ಸೇವೆಗಳ ದಕ್ಷತೆಯನ್ನು ಹೆಚ್ಚಿಸಲು ಈ ಯೋಜನೆಯು ಗುರಿಯನ್ನು ಹೊಂದಿದೆ.



ಈ ಯೋಜನೆಯ ಫಲಾನುಭವಿಗಳು ಯಾರು?

ಬೇಟಿ ಬಚಾವೋ ಬೇಟಿ ಪಠಾವೋ ಯೋಜನೆ ಇಡೀ ದೇಶಕ್ಕೆ ಅನ್ವಯಿಸುತ್ತದೆ. ಆದಾಗ್ಯೂ, ಗರಿಷ್ಠ ವ್ಯಾಪ್ತಿಯನ್ನು ಹೊಂದಲು, ಈ ಯೋಜನೆಯನ್ನು 3 ಗುಂಪುಗಳಾಗಿ ವಿಂಗಡಿಸಲಾಗಿದೆ. ಇವು

- ಪ್ರಾಥಮಿಕ ಗುಂಪು (ಯುವ ಮತ್ತು ವಿವಾಹಿತ ದಂಪತಿಗಳು, ಗರ್ಭಿಣಿ ತಾಯಂದಿರು ಮತ್ತು ಪೋಷಕರು)
- ಮಾಧ್ಯಮಿಕ ಗುಂಪುಗಳು (ಭಾರತದ ಯುವಕರು, ಹದಿಹರೆಯದವರು, ಅಳಿಯಂದಿರು, ವೈದ್ಯರು, ಖಾಸಗಿ ಆಸ್ಪತ್ರೆಗಳು, ನರ್ಸಿಂಗ್ ಹೋಂಗಳು, ರೋಗನಿರ್ಣಯ ಕೇಂದ್ರಗಳು)
- ತೃತೀಯ ಗುಂಪುಗಳು (ದೇಶದ ಸಾಮಾನ್ಯ ಜನರು, ಧಾರ್ಮಿಕ ಮುಖಂಡರು, ಸ್ವಯಂಸೇವಾ ಸಂಸ್ಥೆಗಳು, ಮುಂಚೂಣಿಯ ಕಾರ್ಯಕರ್ತರು, ಅಧಿಕಾರಿಗಳು, ಮಾಧ್ಯಮ ಮತ್ತು ಮಹಿಳಾ ಸ್ವಸಹಾಯ ಗುಂಪುಗಳ ವಲಯ)

ಈ ಯೋಜನೆಯ ಪ್ರಯೋಜನಗಳನ್ನು ಪಡೆಯಲು ಅರ್ಹತೆಯ ಮಾನದಂಡವೇನು?

- 10 ವರ್ಷಕ್ಕಿಂತ ಕಡಿಮೆ ವಯಸ್ಸಿನ ಹೆಣ್ಣು ಮಗುವನ್ನು (ಭಾರತೀಯ) ಹೊಂದಿರುವ ಕುಟುಂಬ ಅರ್ಹವಾಗಿದೆ.
- ಹೆಣ್ಣು ಮಗುವನ್ನು ಹೊಂದಿರುವ ಕುಟುಂಬವು ಯಾವುದೇ ರಾಷ್ಟ್ರೀಕೃತ ಬ್ಯಾಂಕ್‌ನಲ್ಲಿ ಸುಕನ್ಯಾ ಸಮೃದ್ಧಿ ಖಾತೆಯನ್ನು (ಎನ್‌ಎನ್‌ಎ) ತೆರೆಯಬೇಕು.



ಈ ಯೋಜನೆಯನ್ನು ಪಡೆಯಲು ಅಪ್ಲಿಕೇಶನ್ ಪ್ರಕ್ರಿಯೆ ಏನು?

- ಹಂತ-1- ನೋಂದಾಯಿತ ಬ್ಯಾಂಕ್ ಅಥವಾ ಅಂಚೆ ಕಚೇರಿಗೆ ಭೇಟಿ ನೀಡಬೇಕು.
- ಹಂತ-2- ಬೇಟಿ ಬಚಾವೋ ಬೇಟಿ ಪಠಾವೋ ಯೋಜನೆಯ ಅರ್ಜಿ ನಮೂನೆಯನ್ನು ಸಂಗ್ರಹಿಸಿ ಮತ್ತು ಭರ್ತಿ ಮಾಡಬೇಕು.
- ಹಂತ-3- ಅಗತ್ಯ ದಾಖಲೆಗಳನ್ನು ಲಗತ್ತಿಸಿ ಮತ್ತು ಅರ್ಜಿ ನಮೂನೆಯನ್ನು ಸಲ್ಲಿಸಬೇಕು.

ಈ ಯೋಜನೆಗೆ ಅರ್ಜಿ ಸಲ್ಲಿಸಲು ಅಗತ್ಯವಿರುವ ದಾಖಲೆಗಳು ಯಾವುವು?

- ಹೆಣ್ಣು ಮಗುವಿನ ಜನನ ಪ್ರಮಾಣಪತ್ರ
- ಪಾಸ್‌ಪೋರ್ಟ್ ಅಳತೆಯ ಭಾವಚಿತ್ರ
- ಪೋಷಕರ ಗುರುತಿನ ಪುರಾವೆ (ಆಧಾರ್ ಕಾರ್ಡ್, ರೇಷನ್ ಕಾರ್ಡ್, ಇತ್ಯಾದಿ)
- ವಿಳಾಸದ ಪುರಾವೆ (ಪಾಸ್‌ಪೋರ್ಟ್, ನೀರು, ಚಾಲನಾ ಪರವಾನಗಿ, ದೂರವಾಣಿ, ಮಿಡ್ಯಾಟ್ ಇತ್ಯಾದಿಗಳಂತಹ ಯುಟಿಲಿಟಿ ಬಿಲ್‌ಗಳು)

2. ಸುಕನ್ಯಾ ಸಮೃದ್ಧಿ ಯೋಜನೆ

ಹೆಣ್ಣು ಮಕ್ಕಳ ಕಲ್ಯಾಣವನ್ನು ಉತ್ತೇಜಿಸುವ ಸಲುವಾಗಿ ಸುಕನ್ಯಾ ಸಮೃದ್ಧಿ ಯೋಜನೆ ಯನ್ನು (ಎಸ್‌ಎಸ್‌ಎ) 2015 ರಲ್ಲಿ ಪ್ರಾರಂಭಿಸಲಾಯಿತು. ಇದು ಹೆಣ್ಣು ಮಕ್ಕಳ ಭವಿಷ್ಯದ ಅಧ್ಯಯನ ಮತ್ತು ಮದುವೆಯ ವೆಚ್ಚಗಳಿಗಾಗಿ ಹೂಡಿಕೆ ಮಾಡಲು ಮತ್ತು ಹಣವನ್ನು ಉಳಿತಾಯ ಮಾಡಲು ಪೋಷಕರನ್ನು ಪ್ರೋತ್ಸಾಹಿಸುತ್ತದೆ.

ಯೋಜನೆ ಹೇಗೆ ಕೆಲಸ ಮಾಡುತ್ತದೆ?

ಮೊದಲ ಹೂಡಿಕೆಯಾಗಿ, 250 ರೂಪಾಯಿಗಳನ್ನು ಹೂಡಿಕೆ ಮಾಡಬೇಕು ಮತ್ತು ಅದರ ನಂತರ, ಹೂಡಿಕೆಗಳನ್ನು 150 ರೂಪಾಯಿಗಳ ಗುಣಕಗಳಲ್ಲಿ ಮಾಡಬೇಕು. ಇದು ವಾರ್ಷಿಕ ಹೂಡಿಕೆಯನ್ನು 1.5 ಲಕ್ಷಕ್ಕೆ ತರುತ್ತದೆ. ಪ್ರಕ್ರಿಯೆಯು ಮುಂದಿನ 15 ವರ್ಷಗಳವರೆಗೆ ಮುಂದುವರಿಯುತ್ತದೆ, ಅದರ ನಂತರ ಮೊತ್ತವು ಪಕ್ಕವಾಗುತ್ತದೆ ಮತ್ತು ಅದು ಹಿಂಪಡೆಯಲು ಸಿದ್ಧವಾಗಿರುತ್ತದೆ.

ಸುಕನ್ಯಾ ಸಮೃದ್ಧಿ ಯೋಜನೆಯಿಂದ ಪಡೆಯಬೇಕಾದ ಪ್ರಯೋಜನಗಳು

ಆದಾಯ ತೆರಿಗೆ ಕಾಯಿದೆಯ ಸೆಕ್ಷನ್ 80 ಸಿ ಅಡಿಯಲ್ಲಿ ತೆರಿಗೆಯಿಂದ ವಿನಾಯಿತಿ ಪಡೆದಿರುವ ಕಾರಣ ಈ ಯೋಜನೆಯು ಟ್ರಿಪಲ್ ವಿನಾಯಿತಿಯಿಂದ ರಕ್ಷಿಸಲ್ಪಟ್ಟಿದೆ. ಟ್ರಿಪಲ್ ವಿನಾಯಿತಿ ಅಡಿಯಲ್ಲಿ, ಹೂಡಿಕೆ ಮಾಡಿದ ಮೊತ್ತವು ತೆರಿಗೆ ಮುಕ್ತವಾಗಿರುತ್ತದೆ, ಗಳಿಸಿದ ಬಡ್ಡಿಯು ತೆರಿಗೆ ಮುಕ್ತವಾಗಿರುತ್ತದೆ ಮತ್ತು ಮೆಚ್ಯೂರ್ಡ್ ಮೊತ್ತವು ತೆರಿಗೆ ಮುಕ್ತವಾಗಿರುತ್ತದೆ.

ದೇಶದ ಹಲವು ಭಾಗಗಳಲ್ಲಿ ಹೆಣ್ಣು ಮಗುವಿನ ಭವಿಷ್ಯ ಇನ್ನೂ ಮದುವೆಗೆ ಸೀಮಿತವಾಗಿದೆ. ಈ ಯೋಜನೆಯು ಪೋಷಕರಿಗೆ ಮದುವೆಯ ವೆಚ್ಚಕ್ಕಾಗಿ ಹಣವನ್ನು ಸಂಗ್ರಹಿಸಲು ಸಹಾಯ ಮಾಡುತ್ತದೆ ಅದರೊಂದಿಗೆ ಹೆಣ್ಣು ಮಗುವಿನ ಶಿಕ್ಷಣದ ವೆಚ್ಚವನ್ನು ನೋಡಿಕೊಳ್ಳುತ್ತದೆ.

ಈ ಯೋಜನೆಯ ನಮೂನೆಯು ಭಾರತೀಯ ಅಂಚೆ ಕಚೇರಿಯ ಯಾವುದೇ ಶಾಖೆಯಲ್ಲಿ ಅಥವಾ ಕೇಂದ್ರ ಸರ್ಕಾರದಿಂದ ಅನುಮೋದಿಸಲ್ಪಟ್ಟ ಯಾವುದೇ ವಾಣಿಜ್ಯ ಬ್ಯಾಂಕ್‌ಗಳಲ್ಲಿ ಸುಲಭವಾಗಿ ಲಭ್ಯವಿದೆ.

3. ಬಾಲಿಕಾ ಸಮೃದ್ಧಿ ಯೋಜನೆ

ಬಾಲಿಕಾ ಸಮೃದ್ಧಿ ಯೋಜನೆಯು ಸಮಾಜದ ಆರ್ಥಿಕವಾಗಿ ದುರ್ಬಲ ವರ್ಗಗಳಲ್ಲಿ ಹೆಣ್ಣುಮಕ್ಕಳನ್ನು ಬೆಂಬಲಿಸುವ ಕೇಂದ್ರ ಸರ್ಕಾರದ ಮತ್ತೊಂದು ಯೋಜನೆಯಾಗಿದೆ. ಈ ಯೋಜನೆಯು ಪ್ರಾಥಮಿಕ ಮತ್ತು ಪ್ರೌಢಶಾಲೆಗಳಲ್ಲಿ ಹೆಣ್ಣು ಮಕ್ಕಳ ದಾಖಲಾತಿ ಮತ್ತು ಧಾರಣೆ ಕ್ಷೇತ್ರವಾಗುತ್ತದೆ.

ಇದು ಹೆಣ್ಣು ಮಗುವಿನ ಏಳಿಗೆಯ ಗುರಿಯನ್ನು ಹೊಂದಿದೆ ಮತ್ತು ಅವರಿಗೆ ಉತ್ತಮ ಗುಣಮಟ್ಟದ ಶಿಕ್ಷಣವನ್ನು ಒದಗಿಸುತ್ತದೆ. ಬಾಲಿಕಾ ಸಮೃದ್ಧಿ ಯೋಜನೆಯ ಪ್ರಯೋಜನಗಳನ್ನು ಪಡೆಯಲು, ಹೆಣ್ಣು ಮಗು ಬಡತನ ರೇಖೆಗಿಂತ ಕೆಳಗಿರುವ (ಬಿಪಿಎಲ್) ಕುಟುಂಬಕ್ಕೆ ಸೇರಿರಬೇಕು.

ಬಾಲಿಕಾ ಸಮೃದ್ಧಿ ಯೋಜನೆಯು ಹೆಣ್ಣು ಮಗುವಿನ ಹೆರಿಗೆಯ ನಂತರ ತಾಯಿಗೆ 500 ರೂ. ಚೊತೆಗೆ ಮಗುವಿನ ಶಿಕ್ಷಣಕ್ಕಾಗಿ ವಾರ್ಷಿಕ ವಿದ್ಯಾರ್ಥಿವೇತನವನ್ನು ಒದಗಿಸುತ್ತದೆ. ಗ್ರಾಮೀಣ ಪ್ರದೇಶದಲ್ಲಿ ಬಡತನ ರೇಖೆಗಿಂತ ಕೆಳಗಿರುವ ಕುಟುಂಬಗಳು ಸ್ವರ್ಣ ಜಯಂತಿ ಗ್ರಾಮ ಸ್ವರೋಚಗಾರ್ ಯೋಜನೆಯಡಿ ನಿಗದಿಪಡಿಸಿದ ಮಾನದಂಡಗಳ ಪ್ರಕಾರ ಪ್ರಯೋಜನಗಳನ್ನು ಪಡೆಯುತ್ತವೆ. 1 ರಿಂದ 3 ನೇ ತರಗತಿಯ ಬಾಲಕಿಯರಿಗೆ ರೂ. 300, ಪ್ರತಿ ತರಗತಿಗೆ, 4 ಮತ್ತು 5 ನೇ ತರಗತಿಯ ವಿದ್ಯಾರ್ಥಿಗಳಿಗೆ ಕ್ರಮವಾಗಿ ರೂ. 500 ಮತ್ತು ರೂ. 600, 6 ರಿಂದ 7 ನೇ ತರಗತಿಯ ವಿದ್ಯಾರ್ಥಿಗಳಿಗೆ ರೂ. 700, 8ನೇ ತರಗತಿ ವಿದ್ಯಾರ್ಥಿಗಳಿಗೆ ರೂ. 800 ಮತ್ತು 9 ಮತ್ತು 10 ನೇ ತರಗತಿಯಲ್ಲಿ ವಿದ್ಯಾರ್ಥಿನಿಯರಿಗೆ 1000 ರೂ. ಗಳನ್ನು ನೀಡಲಾಗುತ್ತದೆ. ಈ ಯೋಜನೆಯು ವಿದ್ಯಾರ್ಥಿನಿಯರಿಗೆ ಅವರ ಶಾಲಾ ಶಿಕ್ಷಣದ ಅವಧಿಯಲ್ಲಿ ಪ್ರಯೋಜನವನ್ನು ನೀಡುತ್ತದೆ ಮತ್ತು ಎಲ್ಲರಿಗೂ ಶಿಕ್ಷಣವನ್ನು ಉತ್ತೇಜಿಸಲು ಉದ್ದೇಶಿಸಿದೆ. ಹೆಣ್ಣುಮಕ್ಕಳು ಯಾವುದೇ ಹಣಕಾಸಿನ ಸಮಸ್ಯೆಯಿಂದಾಗಿ ಸಾಕಷ್ಟು ಶಾಲಾ ಶಿಕ್ಷಣವನ್ನು ಹೊಂದುವುದನ್ನು ನಿರ್ಬಂಧಿಸಬಾರದು, ಕನಿಷ್ಠ ಮಾಧ್ಯಮಿಕ ಹಂತದವರೆಗೆ ಶಿಕ್ಷಣವನ್ನು ಪೂರೈಸಬೇಕೆನ್ನುವುದು ಈ ಯೋಜನೆಯ ಧ್ಯೇಯೋದ್ದೇಶವಾಗಿದೆ.



4. ಪ್ರಧಾನ ಮಂತ್ರಿ ದಕ್ಷತಾ ಔರ್ ಕುಶಾಲತ ಸಂಪನ್ ಹಿತಗೃಹಿ ಯೋಜನೆ



ಪ್ರಧಾನ ಮಂತ್ರಿ ದಕ್ಷತಾ ಔರ್ ಕುಶಾಲತ ಸಂಪನ್ ಹಿತಗೃಹಿ ಯೋಜನೆ (Pradhan Mantri Dakshata Aur Kushalta Sampann Hitgrahi-PM DAKSH) ಯನ್ನು 2020-21 ರಲ್ಲಿ ಭಾರತ ಸರ್ಕಾರದ ಸಾಮಾಜಿಕ ನ್ಯಾಯ ಮತ್ತು ಸಬಲೀಕರಣ ಸಚಿವಾಲಯ

(MoSJ&E) ಹಿಂದುಳಿದ ವರ್ಗಗಳ ಕೌಶಲ್ಯಕ್ಕಾಗಿ ರಾಷ್ಟ್ರೀಯ ಕ್ರಿಯಾ ಯೋಜನೆಯ ಭಾಗವಾಗಿ ಪ್ರಾರಂಭಿಸಿತು, ಪರಿಶಿಷ್ಟ ಜಾತಿಗೆ ಸೇರಿದ ವ್ಯಕ್ತಿಗಳು, ಹಿಂದುಳಿದ ವರ್ಗಗಳು, ಆರ್ಥಿಕವಾಗಿ ಹಿಂದುಳಿದ ವರ್ಗಗಳು,, ಡಿ-ನೋಟಿಫೈಡ್, ಅಲೆಮಾರಿ ಮತ್ತು ಅರೆ ಅಲೆಮಾರಿ ಬುಡಕಟ್ಟು ಜನಾಂಗಗಳಿಗೆ ಸೇರಿದವರು, ತ್ಯಾಜ್ಯ ತೆಗೆಯುವವರು ಸೇರಿದಂತೆ ನೈರ್ಮಲ್ಯ ಕಾರ್ಯಕರ್ತರು ಈ ಯೋಜನೆಯ ಲಾಭವನ್ನು ಪಡೆದುಕೊಳ್ಳಬಹುದು.

ಉದ್ದೇಶ: ಪ್ರಧಾನ ಮಂತ್ರಿ ದಕ್ಷತಾ ಔರ್ ಕುಶಾಲತ ಸಂಪನ್ ಹಿತಗೃಹಿ ಯೋಜನೆ ಮುಖ್ಯ ಉದ್ದೇಶಗಳೇನೆಂದರೆ ಯುವಕರಿಗೆ ಅಲ್ಪಾವಧಿಯ ಮತ್ತು ದೀರ್ಘಾವಧಿಯ ಕೌಶಲ್ಯಗಳನ್ನು ಒದಗಿಸುವ ಮೂಲಕ ಕೌಶಲ್ಯ ಮಟ್ಟವನ್ನು ಹೆಚ್ಚಿಸುವುದು, ನಂತರ ವೇತನ/ಸ್ವಯಂ-ಉದ್ಯೋಗದಲ್ಲಿ ಸಹಾಯ ಮಾಡುವುದು. ಮೇಲಿನವುಗಳಲ್ಲದೆ, ಕುಶಲಕರ್ಮಿಗಳ ಕೌಶಲ್ಯ ಮಟ್ಟವನ್ನು ಅಪ್‌ಲಿಫಿಂಗ್/ ರಿಸ್ಕಿಲ್ಲಿಂಗ್ ಕಾರ್ಯಕ್ರಮಗಳ ಮೂಲಕ ಹೆಚ್ಚಿಸುವುದು ಮತ್ತು ಅವರ ಅಭ್ಯಾಸ ವೃತ್ತಿಗಳಲ್ಲಿ ಅವರ ಆದಾಯವನ್ನು ಹೆಚ್ಚಿಸಲು ಅನುವು ಮಾಡಿಕೊಡುವುದು.

ಯೋಜನೆಯ ಪ್ರಮುಖ ಲಕ್ಷಣಗಳು: ಪ್ರಧಾನ ಮಂತ್ರಿ ದಕ್ಷತಾ ಔರ್ ಕುಶಾಲತ ಸಂಪನ್ ಹಿತಗೃಹಿ ಯೋಜನೆ ಅಡಿಯಲ್ಲಿ ನಾಲ್ಕು ವಿಧದ ಕೌಶಲ್ಯ ಅಭಿವೃದ್ಧಿ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮಗಳಿವೆ; (i) ಉನ್ನತ-ಕೌಶಲ್ಯ/ಮರು-ಕೌಶಲ್ಯ, (ii) ಅಲ್ಪಾವಧಿಯ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮಗಳು, (iii) ದೀರ್ಘಾವಧಿಯ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮಗಳು, ಮತ್ತು (iv) ಉದ್ಯಮಶೀಲತೆ ಅಭಿವೃದ್ಧಿ ಕಾರ್ಯಕ್ರಮ.

ಪ್ರಶಿಕ್ಷಣಾರ್ಥಿಗಳಿಗೆ ಉಚಿತ ತರಬೇತಿ, ಸರ್ಕಾರದಿಂದ 100% ಅನುದಾನ.

- ಅಲ್ಪಾವಧಿ ಮತ್ತು ದೀರ್ಘಾವಧಿಯ ತರಬೇತಿಯಲ್ಲಿ 80% ಮತ್ತು ಅದಕ್ಕಿಂತ ಹೆಚ್ಚಿನ ಹಾಜರಾತಿ ಹೊಂದಿರುವ ಪ್ರಶಿಕ್ಷಣಾರ್ಥಿಗಳಿಗೆ ಪ್ರತಿ ತಿಂಗಳಿಗೆ ರೂ.1,000/- ರಿಂದ ರೂ.1,500/- ವರೆಗೆ ಸ್ಟೆಪೆಂಡ್ ಒದಗಿಸಲಾಗುತ್ತದೆ.
- ವೇತನ ಪರಿಹಾರವಾಗಿ ಪ್ರತಿ ಪ್ರಶಿಕ್ಷಣಾರ್ಥಿಗಳಿಗೆ ರೂ.3000/- ಒದಗಿಸಲಾಗುತ್ತದೆ. ಪ್ರಧಾನ ಮಂತ್ರಿ ದಕ್ಷತಾ ಔರ್ ಕುಶಾಲತ ಸಂಪನ್ ಹಿತಗೃಹಿ ಯೋಜನೆಯ ಪ್ರಕಾರ ರೂ. 2500/- ಮತ್ತು ಅಪ್‌ಲಿಫಿಂಗ್/ ರಿಸ್ಕಿಲ್ಲಿಂಗ್ ಕಾರ್ಯಕ್ರಮಗಳಲ್ಲಿ 80% ಮತ್ತು ಅದಕ್ಕಿಂತ ಹೆಚ್ಚಿನ ಹಾಜರಾತಿ ಹೊಂದಿರುವ ಪ್ರಶಿಕ್ಷಣಾರ್ಥಿಗಳಿಗೆ ಸಾಮಾನ್ಯ ವೆಚ್ಚದ ನಿಯಮಗಳ ಪ್ರಕಾರ ರೂ. 500/-)

- ತರಬೇತಿ ಮತ್ತು ಮೌಲ್ಯಮಾಪನವನ್ನು ಯಶಸ್ವಿಯಾಗಿ ಪೂರ್ಣಗೊಳಿಸಿದ ನಂತರ ತರಬೇತಿ ಪಡೆದ ಅಭ್ಯರ್ಥಿಗಳಿಗೆ ಪ್ರಮಾಣೀಕರಣವನ್ನು ನೀಡಲಾಗುತ್ತದೆ.

- ತರಬೇತಿ ಪಡೆದ ಅಭ್ಯರ್ಥಿಗಳಿಗೆ ಮೌಲ್ಯಮಾಪನ ಮತ್ತು ಪ್ರಮಾಣೀಕರಣದ ನಂತರ ಉದ್ಯೋಗವನ್ನು ಒದಗಿಸಲಾಗುತ್ತದೆ.

ಅರ್ಹತೆ: ಈ ಕೆಳಗಿನ ಯಾವುದೇ ವರ್ಗಕ್ಕೆ ಸೇರಿದ 18-45 ವರ್ಷ ವಯಸ್ಸಿನ ಅಭ್ಯರ್ಥಿಗಳು ಪ್ರಧಾನ ಮಂತ್ರಿ ದಕ್ಷತಾ ಔರ್ ಕುಶಾಲತ ಸಂಪನ್ ಹಿತಗೃಹಿ ಯೋಜನೆಯ ಅಡಿಯಲ್ಲಿ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮಕ್ಕೆ ಅರ್ಜಿ ಸಲ್ಲಿಸಬಹುದು:

- ಪರಿಶಿಷ್ಟ ಜಾತಿಗಳಿಗೆ ಸೇರಿದ ವ್ಯಕ್ತಿಗಳು - ವಾರ್ಷಿಕ ಆದಾಯದ ಮಿತಿಯಿಲ್ಲ
- ವಾರ್ಷಿಕ ಕುಟುಂಬದ ಆದಾಯ 3.00 ಲಕ್ಷ ರೂ.ಗಿಂತ ಕಡಿಮೆ ಇರುವ ಇತರೆ ಹಿಂದುಳಿದ ವರ್ಗಗಳು (Other Backward Classes-OBC)
- ವಾರ್ಷಿಕ ಕುಟುಂಬದ ಆದಾಯ ರೂ.1.00 ಲಕ್ಷಕ್ಕಿಂತ ಕಡಿಮೆ ಇರುವ ಆರ್ಥಿಕವಾಗಿ ಹಿಂದುಳಿದ ವರ್ಗಗಳು (Economically Weaker Section- EWS)
- ಡಿ-ನೋಟಿಫೈಡ್, ಅಲೆಮಾರಿ ಮತ್ತು ಅರೆ ಅಲೆಮಾರಿ ಬುಡಕಟ್ಟು (Denotified Tribes-DNT) ಜನಾಂಗದವರಿಗೆ ವಾರ್ಷಿಕ ಆದಾಯದ ಮಿತಿ ಇಲ್ಲ
- ತ್ಯಾಜ್ಯ ತೆಗೆಯುವವರು ಸೇರಿದಂತೆ ನೈರ್ಮಲ್ಯ ಕಾರ್ಯಕರ್ತರು - ವಾರ್ಷಿಕ ಆದಾಯದ ಮಿತಿ ಇಲ್ಲ

ಅರ್ಜಿ ಸಲ್ಲಿಸುವುದು ಹೇಗೆ: ಕೌಶಲ್ಯ ಅಭಿವೃದ್ಧಿ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮಗಳ ಪ್ರಚಾರವನ್ನು ಕಾಲಕಾಲಕ್ಕೆ ಸ್ಥಳೀಯ ಪತ್ರಿಕೆಗಳು ಅಥವಾ ಯಾವುದೇ ಇತರ ಮುದ್ರಣ ಅಥವಾ ವಿದ್ಯುನ್ಮಾನ ಮಾಧ್ಯಮಗಳಲ್ಲಿ ಜಾಹೀರಾತು ಮೂಲಕ ಮಾಡಲಾಗುತ್ತದೆ. ಆಸಕ್ತ ಅಭ್ಯರ್ಥಿಗಳು ಕೌಶಲ್ಯ ಅಭಿವೃದ್ಧಿ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮಗಳಲ್ಲಿ ದಾಖಲಾತಿಗಾಗಿ ಪೋರ್ಟಲ್ನಲ್ಲಿ ನೋಂದಾಯಿಸಿಕೊಳ್ಳಬೇಕು.

ನೋಂದಣಿಗಾಗಿ ಲಿಂಕ್ <https://pmdaksh.dosje.gov.in/student> ಆಗಿದೆ.

ಹಣಕಾಸಿನ ನೆರವು: ಕರ್ನಾಟಕ ವಿಜ್ಞಾನ ಮತ್ತು ತಂತ್ರಜ್ಞಾನ ಪ್ರೋತ್ಸಾಹಕ ಸೊಸೈಟಿ, ವಿದ್ಯುನ್ಮಾನ, ಮಾಹಿತಿ ತಂತ್ರಜ್ಞಾನ, ಜೈವಿಕ ತಂತ್ರಜ್ಞಾನ ಹಾಗೂ ವಿಜ್ಞಾನ ಮತ್ತು ತಂತ್ರಜ್ಞಾನ ಇಲಾಖೆ, ಕರ್ನಾಟಕ ಸರ್ಕಾರ

ಲೇಖಕರು

ಪ್ರಿಯಾ ರಮೇಶ ಹೆಗಡೆ, ಪಿಎಚ್‌ಡಿ ವಿದ್ಯಾರ್ಥಿನಿ
ಡಾ. ವಿನುತಾ ಯು. ಮುಕ್ತಾಮರ, ಸಹಾಯಕ ಪ್ರಾಧ್ಯಾಪಕರು
 ಕೃಷಿ ವಿಶ್ವವಿದ್ಯಾಲಯ ಧಾರವಾಡ - 580 005
ಪ್ರತಿಗಳು:100

ಕೃಷಿ ವಿಶ್ವವಿದ್ಯಾಲಯ, ಧಾರವಾಡ



ಮಹಿಳಾ ಸಬಲೀಕರಣಕ್ಕಾಗಿ ಇರುವ ಸರ್ಕಾರದ ಯೋಜನೆಗಳು



ಲೇಖಕರು

ಪ್ರಿಯಾ ರಮೇಶ ಹೆಗಡೆ
ಡಾ. ವಿನುತಾ ಯು. ಮುಕ್ತಾಮರ

ಮಾನವ ವಿಕಾಸ ಹಾಗೂ ಕುಟುಂಬ ಅಧ್ಯಯನ ವಿಭಾಗ
 ಸಮುದಾಯ ವಿಜ್ಞಾನ ಮಹಾವಿದ್ಯಾಲಯ
 ಕೃಷಿ ವಿಶ್ವವಿದ್ಯಾಲಯ ಧಾರವಾಡ---580 005

ಜೂನ್, 2022

ಇತ್ತೀಚಿನ ದಿನಮಾನಗಳಲ್ಲಿ ಮಹಿಳೆಯರು ರಾಜಕೀಯ, ಶಿಕ್ಷಣ, ಮಾಧ್ಯಮ, ಕಲೆ, ಸಾಂಸ್ಕೃತಿಕ, ಸೇವಾ ವಿಭಾಗಗಳು, ವಿಜ್ಞಾನ ಮತ್ತು ತಂತ್ರಜ್ಞಾನ ಇತ್ಯಾದಿ ಎಲ್ಲಾ ರಂಗಗಳಲ್ಲಿಯೂ ತಮ್ಮನ್ನು ತೊಡಗಿಸಿಕೊಂಡಿದ್ದಾರೆ. ಕಳೆದ ಕೆಲವು ವರ್ಷಗಳಲ್ಲಿ, ಭಾರತವು ಮಹಿಳಾ ಉದ್ಯಮಶೀಲತೆಯಲ್ಲಿ ದಾಖಲೆಯ ಬೆಳವಣಿಗೆಯನ್ನು ಸಾಧಿಸುತ್ತಿದೆ ಮತ್ತು ಹೆಚ್ಚಿನ ಮಹಿಳೆಯರು ಈ ದಿಕ್ಕಿನಲ್ಲಿ ತಮ್ಮ ವೃತ್ತಿಯನ್ನು ಮುಂದುವರಿಸುತ್ತಿದ್ದಾರೆ. ಭಾರತದಲ್ಲಿ, ಸುಮಾರು 8 ಮಿಲಿಯನ್ ಮಹಿಳೆಯರು ತಮ್ಮದೇ ವ್ಯವಹಾರಗಳನ್ನು ಪ್ರಾರಂಭಿಸಿದ್ದಾರೆ. ಇದಲ್ಲದೆ, ಭಾರತದಲ್ಲಿ ಕಾರ್ಪೊರೇಟ್‌ನ ಹಿರಿಯ ನಿರ್ವಹಣಾ ಹುದ್ದೆಗಳಲ್ಲಿ ಮಹಿಳೆಯರು 24% ಪಾಲನ್ನು ಹೊಂದಿದ್ದಾರೆ.

ಭಾರತೀಯ ಸಂವಿಧಾನವು ಲಿಂಗ ತಾರತಮ್ಯದ ವಿರುದ್ಧ ಹಾಗೂ ಮಹಿಳೆಯರಲ್ಲಿಗೂ ಸಮಾನ ಅವಕಾಶ ಕಲ್ಪಿಸುವ ನಿಟ್ಟಿನಲ್ಲಿ ಹಲವಾರು ಕಾನೂನು, ನಿಯಮಗಳನ್ನು ಜಾರಿಗೊಳಿಸಿದೆ. ಮಹಿಳಾ ಕಲ್ಯಾಣಕ್ಕಾಗಿ ಹತ್ತು ಹಲವು ಯೋಜನೆಗಳನ್ನು, ಸವಲತ್ತುಗಳನ್ನು ರೂಪಿಸಿದೆ. ಕೇಂದ್ರ ಹಾಗೂ ರಾಜ್ಯ ಸರ್ಕಾರಗಳೂ ಸಹ ಮಹಿಳೆ ಮತ್ತು ಮಕ್ಕಳ ಅಭಿವೃದ್ಧಿ ಯೋಜನೆಗಳನ್ನು ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ಅನುಷ್ಠಾನಕ್ಕೆ ತಂದಿವೆ. ಭಾರತ ಸರ್ಕಾರವು 2001 ನೇ ಇಸ್ವಿಯನ್ನು ಮಹಿಳಾ ಸಬಲೀಕರಣ ವರ್ಷ ಎಂದು ಘೋಷಿಸಿದೆ.

ಈ ನಿಟ್ಟಿನಲ್ಲಿ ಕೇಂದ್ರ ಸರ್ಕಾರವು ಮಹಿಳಾ ಸಬಲೀಕರಣಕ್ಕಾಗಿ ಅನೇಕ ಯೋಜನೆಗಳನ್ನು ಜಾರಿಗೊಳಿಸಿರುತ್ತದೆ. ಅವುಗಳ ವಿವರ ಹೀಗಿದೆ.

1. ಮಹಿಳಾ ಉದ್ಯಮಿಗಳಿಗಾಗಿ ಉದ್ಯಮ ಸಖಿ ಪೋರ್ಟಲ್

ಉದ್ಯಮ ಸಖಿ: ಇದು ಮೈಕ್ರೋ, ಸಣ್ಣ ಮತ್ತು ಮಧ್ಯಮ ಉದ್ಯಮಗಳ ಉಪಕ್ರಮದ ಸಚಿವಾಲಯ ಆರಂಭಿಸಿರುವ ಸಾಮಾಜಿಕ ಅಸಮಾನತೆಗಳನ್ನು ಪರಿಹರಿಸಲು ಕಡಿಮೆ-ವೆಚ್ಚದ ಉತ್ಪನ್ನಗಳು ಮತ್ತು ಸೇವೆಗಳ ಸುತ್ತ ಸುತ್ತವ ವ್ಯಾಪಾರ ಮಾಡಿಗಳನ್ನು ರಚಿಸುವ ಸಾಮಾಜಿಕ ಉದ್ಯಮಶೀಲತೆಯನ್ನು ಪ್ರೋತ್ಸಾಹಿಸುವ ಜಾಲವಾಗಿದೆ.



ಉದ್ದೇಶ : ಉದ್ಯಮ ಸಖಿ ಮಹಿಳಾ ಉದ್ಯಮಿಗಳನ್ನು ಪ್ರೋತ್ಸಾಹಿಸಲು ಮತ್ತು ಅವರ ಹಿತಾಸಕ್ತಿಗಳಿಗೆ ಸಹಾಯ ಮಾಡಲು, ಸಲಹೆ ನೀಡಲು, ಸಹಾಯ ಮಾಡಲು ಮತ್ತು ರಕ್ಷಿಸಲು ಪ್ರಯತ್ನಿಸುತ್ತದೆ. ಇದು ಸ್ಪರ್ಧಾತ್ಮಕ ಉದ್ಯಮವನ್ನು ಸಂರಕ್ಷಿಸುತ್ತದೆ ಮತ್ತು ನಮ್ಮ ರಾಷ್ಟ್ರದ ಒಟ್ಟಾರೆ ಆರ್ಥಿಕತೆಯನ್ನು ಕಾಪಾಡಿಕೊಳ್ಳಲು ಮತ್ತು ಬಲಪಡಿಸಲು ಸಹಾಯ ಮಾಡುತ್ತದೆ.

ಉದ್ಯಮ ಸಖಿ ಭಾರತೀಯ ಮಹಿಳೆಯರಿಗೆ ವ್ಯವಹಾರಗಳನ್ನು ಪ್ರಾರಂಭಿಸಲು, ನಿರ್ಮಿಸಲು ಮತ್ತು ಬೆಳೆಯಲು ಸಹಾಯ ಮಾಡುತ್ತದೆ. ಉದ್ಯಮದಲ್ಲಿನ ಮಹಿಳಾ ಉದ್ಯಮಿಗಳು ಆರ್ಥಿಕ ಚೇತರಿಕೆ ಮತ್ತು ಶಕ್ತಿಗೆ, ರಾಷ್ಟ್ರದ ಭವಿಷ್ಯವನ್ನು ನಿರ್ಮಿಸಲು ಮತ್ತು ಇಂದಿನ ಜಾಗತಿಕ ಮಾರುಕಟ್ಟೆಯಲ್ಲಿ ಭಾರತವನ್ನು ಸ್ಪರ್ಧಿಸಲು ಸಹಾಯ ಮಾಡಲು ನಿರ್ಣಾಯಕ ಎಂದು ಇದು ಗುರುತಿಸುತ್ತದೆ.

ಒದಗಿಸುವ ಸೇವೆಗಳು

- ಉದ್ಯಮ ಸಖಿ ಪ್ರಾಥಮಿಕವಾಗಿ ಅದರ ಪ್ರೋಗ್ರಾಮ್‌ಮ್ಯಾಟಿಕ್ ಕಾರ್ಯಗಳ ಮೂಲಕ ಸಹಾಯವನ್ನು ಒದಗಿಸುತ್ತದೆ:

- ವಾಣಿಜ್ಯೋದ್ಯಮ ಕಲಿಕೆಯ ಪರಿಕರಗಳು ಉದಾ. ವ್ಯಾಪಾರ ಯೋಜನೆಯನ್ನು ಸಿದ್ಧಪಡಿಸುವುದು.
- ಇನ್ಯುಬೇಶನ್ ಸೌಲಭ್ಯ
- ನಿಧಿ ಸಂಗ್ರಹಕ್ಕಾಗಿ ತರಬೇತಿ ಕಾರ್ಯಕ್ರಮಗಳು ಸಲಹೆಗಾರರನ್ನು ಒದಗಿಸುವುದು
- ಒಬ್ಬರಿಂದ ಒಬ್ಬರಿಗೆ ಹೂಡಿಕೆದಾರರ ಭೇಟಿ ಮಾರುಕಟ್ಟೆ ಸಮೀಕ್ಷೆ ಸೌಲಭ್ಯವನ್ನು ಒದಗಿಸುವುದು
- ಕಲಿಕೆ ಮತ್ತು ಅಭಿವೃದ್ಧಿ (ಶಿಕ್ಷಣ, ಮಾಹಿತಿ, ತಾಂತ್ರಿಕ ನೆರವು ಮತ್ತು ತರಬೇತಿ)

ಉದ್ಯಮ ಸಖಿ ಸೇವೆಗಳನ್ನು ಜಾಲತಾಣದಲ್ಲಿ ಪಡೆಯಬಹುದು.
<http://www.udyamsakhi.org/index.php>

2. ಮಹಿಳಾ ಸಮೃದ್ಧಿ (ಮಹಿಳೆಯರಿಗಾಗಿ ಮೈಕ್ರೋ ಫೈನಾನ್ಸ್ ಯೋಜನೆ)

ಉದ್ದೇಶ: ನಿಗದಿಪಡಿಸಿರುವ ಅರ್ಹತೆ ಹೊಂದಿರುವ ಮಹಿಳಾ ಉದ್ಯಮಿಗಳಿಗೆ ಮೈಕ್ರೋ ಫೈನಾನ್ಸ್ ಒದಗಿಸುವುದು.



- ಅರ್ಹತೆ**
- ಹಿಂದುಳಿದ ವರ್ಗಗಳಿಗೆ ಸೇರಿದ ಮಹಿಳೆಯರು, ಕಾಲಕಾಲಕ್ಕೆ ಕೇಂದ್ರ ಸರ್ಕಾರ/ರಾಜ್ಯ ಸರ್ಕಾರಗಳು ಸೂಚಿಸಿದಂತೆ.
 - ಅರ್ಜಿದಾರರ ಕುಟುಂಬದ ವಾರ್ಷಿಕ ಆದಾಯ ರೂ. 3.00 ಲಕ್ಷಕ್ಕಿಂತ ಕಡಿಮೆಯಿರಬೇಕು.
 - ಸ್ವ-ಸಹಾಯ ಗುಂಪುಗಳಲ್ಲಿ 60% ಸದಸ್ಯರು ಹಿಂದುಳಿದ ವರ್ಗಗಳಿಂದ ಮತ್ತು ಉಳಿದ 40% ಸದಸ್ಯರು ಪರಿಶಿಷ್ಟ/ ಅಂಗವಿಕಲರು/ ಅಲ್ಪಸಂಖ್ಯಾತರು ಇತ್ಯಾದಿ ಇತರ ದುರ್ಬಲ ವರ್ಗದಿಂದ ಇರಬಹುದು.

ಪ್ರಮುಖ ಅಂಶಗಳು

1. ಪ್ರತಿ ಸ್ವ-ಸಹಾಯ ಗುಂಪುಗಳಿಗೆ ಗರಿಷ್ಠ ಸಾಲದ ಮಿತಿ: ರೂ.15.00 ಲಕ್ಷ
2. ಪ್ರತಿ ಫಲಾನುಭವಿಗೆ ಗರಿಷ್ಠ ಸಾಲದ ಮಿತಿ: ರೂ.1, 25,000/-
3. ಒಂದು ಸ್ವ-ಸಹಾಯ ಗುಂಪಿನಲ್ಲಿ ಮಹಿಳೆಯರ ಗರಿಷ್ಠ ಸಂಖ್ಯೆ: 20

ಅನುಷ್ಠಾನ: ಮಹಿಳಾ ಫಲಾನುಭವಿಗಳಿಗೆ ನೇರವಾಗಿ ಅಥವಾ ಸ್ವ-ಸಹಾಯ ಗುಂಪುಗಳ ಮೂಲಕ ಹಣಕಾಸು ಒದಗಿಸುವ ಮೂಲಕ ಗ್ರಾಮೀಣ ಮತ್ತು ನಗರ ಪ್ರದೇಶಗಳಲ್ಲಿ ಚಾನಲ್ ಪಾಲುದಾರರು ಈ ಯೋಜನೆಯನ್ನು ಜಾರಿಗೊಳಿಸಬೇಕು.

ಹಣಕಾಸು ಮಾದರಿ: ರಾಷ್ಟ್ರೀಯ ಹಿಂದುಳಿದ ವರ್ಗಗಳ ಹಣಕಾಸು ಅಭಿವೃದ್ಧಿ ನಿಗಮ ಸಾಲ: 95%

ಚಾನಲ್ ಪಾಲುದಾರ/ಫಲಾನುಭವಿ ಕೊಡುಗೆ: 05%

ಬಡ್ಡಿ ದರ: ರಾಷ್ಟ್ರೀಯ ಹಿಂದುಳಿದ ವರ್ಗಗಳ ಹಣಕಾಸು ಅಭಿವೃದ್ಧಿ ನಿಗಮ ದಿಂದ ಚಾನಲ್ ಪಾಲುದಾರರಿಗೆ : ಪ್ರತಿ ವರ್ಷಕ್ಕೆ 1%

ಚಾನಲ್ ಪಾಲುದಾರರಿಂದ ಸ್ವ-ಸಹಾಯ ಗುಂಪು (SHG)/ ಫಲಾನುಭವಿಗಳಿಗೆ: ಪ್ರತಿ ವರ್ಷಕ್ಕೆ 4%

ಮರುಪಾವತಿ: ಸಾಲವನ್ನು 4 ವರ್ಷಗಳೊಳಗೆ ತ್ರೈಮಾಸಿಕ ಕಂತುಗಳಲ್ಲಿ ಮರುಪಾವತಿಸಬೇಕು (ಆರು ತಿಂಗಳ ಅಸಲು ಮರುಪಾವತಿಯ ಮೇಲಿನ ಮೊರಟೋರಿಯಂ ಅವಧಿಯನ್ನು ಒಳಗೊಂಡಂತೆ).

ಹೆಚ್ಚಿನ ಮಾಹಿತಿಗಾಗಿ ಟೋಲ್ ಫ್ರೀ ನಂ.18001023399 ಅನ್ನು ಸಂಪರ್ಕಿಸಬಹುದು.

3. ಮಹಿಳೆಯರಿಗೆ ಹೊಸ ಸ್ಪರ್ಧೆಮಾ ಯೋಜನೆ

ಉದ್ದೇಶಗಳು: ಅವಧಿ ಸಾಲದ ಅಡಿಯಲ್ಲಿ ಹಿಂದುಳಿದ ವರ್ಗಗಳ ಮಹಿಳೆಯರಲ್ಲಿ ಸ್ವಯಂ ಅವಲಂಬನೆಯ ಮನೋಭಾವವನ್ನು ಬೆಳೆಸುವುದು.



ಅರ್ಹತೆ: ಕೇಂದ್ರ/ರಾಜ್ಯ ಸರ್ಕಾರಗಳು ಕಾಲಕಾಲಕ್ಕೆ ಸೂಚಿಸಿದಂತೆ ಹಿಂದುಳಿದ ವರ್ಗಗಳಿಗೆ ಸೇರಿದ ಮಹಿಳೆಯರು ಈ ಯೋಜನೆಯಡಿ ಸಾಲ ಪಡೆಯಲು ಅರ್ಹರಾಗಿರುತ್ತಾರೆ.

ಅರ್ಜಿದಾರರ ಕುಟುಂಬದ ವಾರ್ಷಿಕ ಆದಾಯ. 3.00 ಲಕ್ಷ ರೂ.ಗಿಂತ ಕಡಿಮೆಯಿರಬೇಕು.

ಪ್ರಮುಖ ಅಂಶಗಳು: ರಾಷ್ಟ್ರೀಯ ಹಿಂದುಳಿದ ವರ್ಗಗಳ ಹಣಕಾಸು ಅಭಿವೃದ್ಧಿ ನಿಗಮ (National Backward Classes Finance & Development Corporation -NBCFDC) ಯ "ಹೊಸ ಸ್ಪರ್ಧೆಮಾ" ಯೋಜನೆಯ ಅಡಿಯಲ್ಲಿ ರೂ.3.00 ಲಕ್ಷಕ್ಕಿಂತ ಕಡಿಮೆ ಕುಟುಂಬದ ವಾರ್ಷಿಕ ಆದಾಯ ಹೊಂದಿರುವ ಹಿಂದುಳಿದ ವರ್ಗಗಳಿಗೆ ಸೇರಿದ ಮಹಿಳೆಯರು ಸಾಲ ಸೌಲಭ್ಯವನ್ನು ಪಡೆಯಬಹುದು.

ಫಲಾನುಭವಿ ಮಹಿಳೆಯರು ರೂ.2,00,000/- ವರೆಗಿನ ಪ್ರಾಚೀನಗಳಲ್ಲಿ ಸ್ವಂತವಾಗಿ ಯಾವುದೇ ಮೊತ್ತವನ್ನು ಹೂಡಿಕೆ ಮಾಡುವ ಅಗತ್ಯವಿಲ್ಲ.

ಸಾಮಾನ್ಯ ಸಾಲ ಯೋಜನೆಗೆ ಹೋಲಿಸಿದರೆ ಈ ಯೋಜನೆಯ ಸಾಲದ ಮೊತ್ತದ ಮೇಲಿನ ಬಡ್ಡಿ ದರ ಕಡಿಮೆಯಿದೆ ಗರಿಷ್ಠ ಸಾಲದ ಮೊತ್ತ: ರೂ. 2.00 ಲಕ್ಷ (ಪ್ರತಿ ಫಲಾನುಭವಿಗೆ)

ಹಣಕಾಸಿನ ಮಾದರಿ: ರಾಷ್ಟ್ರೀಯ ಹಿಂದುಳಿದ ವರ್ಗಗಳ ಹಣಕಾಸು ಅಭಿವೃದ್ಧಿ ನಿಗಮ ಸಾಲ: 95% ಚಾನಲ್ ಪಾಲುದಾರರ ಕೊಡುಗೆ : 05%

ಬಡ್ಡಿ ದರ: ರಾಷ್ಟ್ರೀಯ ಹಿಂದುಳಿದ ವರ್ಗಗಳ ಹಣಕಾಸು ಅಭಿವೃದ್ಧಿ ನಿಗಮ ದಿಂದ ಚಾನಲ್ ಪಾಲುದಾರರಿಗೆ : ಪ್ರತಿ ವರ್ಷಕ್ಕೆ 2%

ಚಾನಲ್ ಪಾಲುದಾರರಿಂದ ಫಲಾನುಭವಿಗೆ : ಪ್ರತಿ ವರ್ಷಕ್ಕೆ 5%

ಮರುಪಾವತಿ: ಸಾಲವನ್ನು 8 ಗರಿಷ್ಠ ವರ್ಷಗಳಲ್ಲಿ ತ್ರೈಮಾಸಿಕ ಕಂತುಗಳಲ್ಲಿ ಮರು ಪಾವತಿಸಬೇಕು (ಮೊರಟೋರಿಯಂ ಅವಧಿ ವಸೂಲಾತಿಯ ಆರು ತಿಂಗಳ ಅವಧಿಯನ್ನು ಒಳಗೊಂಡಂತೆ).

ಹೆಚ್ಚಿನ ಮಾಹಿತಿಗಾಗಿ ಟೋಲ್ ಫ್ರೀ ನಂ.18001023399 ಅನ್ನು ಸಂಪರ್ಕಿಸಬಹುದು.

EMPOWERMENT AND HEALTH STATUS OF HALAKKI VOKKALIGA AND KUNBI TRIBAL WOMEN: A STUDY IN UTTARA KANNADA DISTRICT OF KARNATAKA

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ABSTRACT

The present study was conducted under the aegis of University of Agricultural Sciences, Dharwad during the year 2019-22 on 230 Halakki Vokkaliga and 230 Kunbi tribal women in the age group between 20-50 years. The objectives of the study were to assess and situationally analyse the empowerment and health status of Halakki Vokkaliga and Kunbi women; to study the relationship between selected factors with empowerment and health status using QUAN-qual mixed research method. An intervention package was developed to improve the empowerment knowledge of Kunbi women and its efficacy was tested. Qualitative method employing ethnographic case study was conducted. The respondents were drawn randomly from the fourteen villages of Halakki Vokkaliga and twenty two villages of Kunbi communities residing in Uttara Kannada district. The total sample included 460 women from both the communities. Self-structured general questionnaire, Empowerment status questionnaire by Rashid and Gao (2014), PGI-2 health questionnaire by Wig *et al.* (1978), Reproductive health practice scale by Hassan MK (2002), Nutritional status assessment and Socio-economic status scale by Aggrawal *et al.* (2005) were the tools used for the study.

Results revealed that, nearly forty per cent of the Halakki Vokkaliga and Kunbi women were in medium level (42.60 % and 38.27 %) of empowerment followed by low and high level. Significant difference was observed between empowerment status of Halakki Vokkaliga and Kunbi women, where Halakki Vokkaliga women were better compared to Kunbi women. More than sixty per cent of Halakki Vokkaliga and Kunbi women had better general health, reproductive health and normal nutritional status. Halakki Vokkaliga women had better reproductive health compared to Kunbi women. Higher education, working other than agriculture labourer/housewife, higher socio-economic status, husband's higher education and occupation were positively and significantly correlated with empowerment status and health status of both Halakki Vokkaliga and Kunbi women. Education, occupation, socio-economic status, husband's education, SHG enrolment, media usage and mobile usage frequency were the significant predictors of empowerment status and they contributed to 43 per cent and 44 per cent variance among Halakki Vokkaliga and Kunbi women respectively. Education, socio-economic status, husband's education, age at marriage, age at first pregnancy and type of delivery were the significant predictors of health status of Halakki Vokkaliga and Kunbi women. On the basis of the results, an educational package to improve the empowerment knowledge of Kunbi women was developed and the efficacy of the package was tested on 36 Kunbi women. Intervention programme proved to be effective in enhancing women's knowledge in educational, economic, social, political - legal, autonomy and decision-making dimensions of empowerment.