Demography India
A Journal of Indian Association of Study of Population
Journal Homepage: https://demographyindia.iasp.ac.in/

The Paradigm Shift in Women's Empowerment Through Health and Nutrition in Baiga Tribe

Suruchi Sharma[1]* and K.L Sharma[2]

Abstract

The empowerment of women has become central to all development policies and efforts. There should be updated policies and assessments regarding women's health, as the times are changing and so are the dietary habits and morbidities. This paper analyses the empowerment of women through health and nutrition interventions. Nutrition and health are closely related. The study delves into the tools and agency that are now provided for the well-being of women, as a healthy woman means that she will be able to take care of herself and her family. In recent years, there has been an enormous paradigm shift with regard to women's empowerment via health and nutrition. The purpose of this study is to investigate the transformational shifts in tactics and techniques that have enabled this transition. It digs into the growth of empowerment frameworks, looking at how health and nutrition initiatives have aided women's empowerment. Women play a pivotal role in society, as their well-being is directly proportional to the well-being of families and communities. The paper demonstrates the multifaceted influence of improved health and nutritional outcomes on baiga women's empowerment by evaluating many research and efforts. It also addresses the obstacles and opportunities to sustaining this paradigm shift.

Keywords

Adolescent Girls, Menstrual Hygiene, Menstrual Knowledge, Management

* *Corresponding Author*
[1] *Ph.D Scholar, Jaipur National University, Jaipur, India. Email: suruchi.1023@gmail.com*
[2] *Pro-Vice Chancellor, Jaipur National University, Jaipur, India*

Introduction

The issue of empowering women is not a new discourse rather it has always been out there from Millennium Development Goals (MDG3), which included the promotion of gender equality. Though the efforts towards it have upscaled in contemporary times. When women were first granted rights, it was observed that women's empowerment has always been linked with reproductive rights. The conversation on female empowerment led policy makers worldwide to address issues of reproduction and childbirth. This shows that their rights were restricted to these areas alone. More often than not, nutritional conversations about women are centered around new mothers. However, in the present times it should be all women who can decide what nutrients they need for themselves as well as for their babies if any at all. Food does not empower her directly but through different program elements which will be discussed hereafter; they provide a number of things aimed at empowering them while ensuring that they remain healthy always. These projects offer them with means plus instrumentalities required so that females may have decision-making powers over their own lives especially when it comes to prioritizing personal well-being vis-à-vis family health care needs.

In India, the empowerment of women is on the rise, as it has been realized that empowering women will transform lives. The policies in India are up and running, and a special effort has been made to level empowerment at grassroots levels. Empowerment in tribal settings is a multifaceted concept, as these societies function differently. The difference is so vast that there should be a different lens when studying the tribal setting.

In the tightly knit fabrics of India's tribal variety, the Baiga tribe stands out as a separate cultural entity located in the country's core. The Baiga tribe, identified for its rich cultural legacy, has a distinct social structure that carefully integrates traditions, rituals, and communal relationships. The Baiga people demonstrate living in close-knit communal groups. Examining the various threads of their cultural fabric is critical for understanding the environment in which transformations in women's empowerment via health and nutrition occur. In the Baiga tribe, women undertake a diverse array of responsibilities. Historically, Baiga women have been pivotal as primary nurturers and caregivers, bearing the crucial role of safeguarding the health and nutritional well-being of their families and communities. Unravelling the historical narratives reveals the tenacity, knowledge, and adaptive strategies used by Baiga women to manage the complex terrain of health and nutrition, frequently in the face of shifting cultural and societal standards.

The change in health trends is not a recent phenomenon; rather it can be observed from precolonial to colonial to contemporary times. In this scenario, a paradigm shift is noted, providing an answer to the issue of women's empowerment is fundamental for realising human rights are crucial for ensuring lasting and sustainable development outcomes. In contemporary times, it is perceived that massive attempts are made to ensure improvement in the status of women. The participation of women in household decisions is the most important feature when talking about the empowerment of women.

The story does not end here, as it is not participation but the final say in household decisions that matter. So, a woman having a final say in household decisions can be considered to be empowered in the true sense.

The Nexus of Empowerment: Exploring Women's Agency and Autonomy

Women's empowerment is a comprehensive term that includes their sense of power, self-assurance, and capacity to control their lives. Within this framework, the notions of agency and autonomy are essential in understanding the broad spectrum of women's empowerment. Women are often provided with agencies and other resources to help them empower themselves in the healthcare sector. These resources can include access to educational materials, training programmes, and support networks that enable women to make informed decisions about their health and well-being. By empowering women in this way, healthcare agencies can help reduce gender disparities in health outcomes and ensure that all individuals have equal access to high-quality care.

With the increase in life expectancy all over the globe, there are various factors that affect the health of a woman. These factors include access to healthcare facilities, social factors like education, employment, income, marital status, and cultural and economic factors. It is hence important to take these into consideration when planning policies for women to pave the way for their empowerment. Autonomy refers to the ability to make major life decisions, such as financial decisions or health-related acts, without relying on a spouse or an extended family member, such as a mother-in-law. The agency includes the management of both social and material resources, allowing people or groups to wield influence and take action in order to pursue and get what they value.

Heckert et al. (2019) observed that nutrition programs have helped empower women, especially in areas like making purchasing decisions and communicating openly with their spouses. They concluded that empowering women could be a key pathway for nutrition-focused programs to reduce child wasting. The authors suggested that efforts to improve child nutrition should actively include strategies to strengthen women's empowerment. They also highlighted the importance of further research to better understand how empowering women directly impacts child nutrition.

Corroon et al. (2013) found that when women feel empowered, they are more likely to make proactive choices about their health, including using modern contraception, giving birth in a medical facility, and having a skilled professional by their side during delivery. Empowerment, in this sense, directly supports better family planning and maternal health practices.

The growing literature finds that women have more bargaining power and control over resources when they have separate accounts, higher education, and higher income. The study also finds that increasing women’s share of expenditure improves child nutrition and education outcomes. The study suggests that policies that enhance women’s empowerment and agency can have positive impacts on household welfare and development.

Empowerment of women means dismantling societal barriers, and challenges and promoting women's agency and autonomy. Through various studies, it has been observed that through women's empowerment, women were able to make better decisions about their health and nutrition. Nutrition programmes often aim to improve women's empowerment.

The Baiga tribe is one of the most primitive tribes that exist in central India. Empowerment among Baiga tribal women refers to the process of fostering their autonomy, agency, and capacity to make choices, enabling them to actively participate in decision-making regarding their health, education, livelihoods, and overall well-being within their community. This includes initiatives aimed at providing them with access to resources, education, healthcare, and opportunities to amplify their voice and influence within their societal structure. The intervention that has taken place to ensure autonomy and empowering Baiga tribal women is the introduction of ASHAs. It is a well-known fact that tribal societies are reluctant to use modern medicine. It cannot be stated that modern medicine is superior to the primitive knowledge that is held by tribal groups and passed down from generation to generation. The introduction of healthcare services at grassroots levels has helped the tribal women look further into caring for their well-being. The final goal of the empowerment of females is the expansion of women's agency to feel empowered in a true sense.

One of the most backward tribes in central India happens to be the Baiga tribe. The term empowerment with regard to Baiga tribal women implies that they should be supported in developing independence, initiative and the ability to choose so as to participate actively in making decisions about their health care, education among others aspects of life within the community where they live; this involves also such things as giving them access rights over resources, schooling facilities for girls as well boys etc., increasing opportunities which could enable them to speak out louder or have more impact on decision-making processes within different levels and structures of society. Among other things, it meant bringing closer healthcare services at the grassroots which enabled them to discover more about looking after themselves better. The ultimate aim behind female empowerment is to broaden women's agency towards feeling empowered indeed i.e., having power over oneself as a woman. The women are engaged as agents of change in combating hunger, educating the community about nutrition and nutritional foods, and promoting reproductive health.

Material and Methods

Study Area

The study was carried out in Dindori district, located in Madhya Pradesh, India. This region is predominantly inhabited by the Baiga tribe, locally referred to as Baigachak. Situated in the eastern part of Madhya Pradesh, Dindori borders the state of Chhattisgarh. Covering an area of around 7470 square kilometres, the district is recognized for its substantial Baiga population, classified as a Particularly Vulnerable Tribal Group (PVTG).

Study Design

The study used a community-based ethnographic technique that focused on Baiga

tribal women, as indicated by the title: "The Paradigm Shift in Women's Empowerment Through Health And Nutrition In Baiga Tribe". Data was collected in the villages of Bauna and Cheetalpani in Dindori district, which have large Baiga populations. Women from these communities were the primary subjects of data gathering. To provide a representative sample of the community, participants were picked at random.

Data Collection Methods

A descriptive research design was employed, utilizing a quantitative approach through a cross-sectional study. Data were gathered using a self-reported, self-administered questionnaire. The research methodology was multifaceted, incorporating several qualitative techniques to gain a comprehensive understanding of the paradigm shift in women's empowerment through health and nutrition in the Baiga tribe:

Focus Group Discussions (FGDs): Twenty-seven women participated in FGDs, divided into three groups. The women aged from 15 years to 60 years. These sessions were structured to encourage open and detailed exploration of their experiences and strategies regarding health, nutrition, and empowerment, emphasizing communal perspectives and shared coping strategies.

Semi-structured Interviews: Complementing the FGDs, 111 interviews were conducted with women from the selected villages. These interviews provided a platform for personal narratives and in-depth experiences, enriching the qualitative data. The interviews, focused solely on Baiga women, included both open and closed-ended questions to delve deeply into their experiences and perceptions of health, nutrition, and empowerment.

Participant Observation: To enhance the authenticity and validity of the data, extensive participant observation was carried out. This involved residing within the Baiga community and participating in their daily activities, offering firsthand insights into their practical strategies for health, nutrition, and empowerment.

In-depth Interviews with ASHA Workers: Specific interviews were conducted with local ASHA workers to understand the health-related aspects of nutrition and the unique challenges faced by the women in the community.

Case Studies: Individual case studies were created to investigate specific instances related to health, nutrition, and empowerment, providing detailed contextual analysis that enriched the overall research findings.

This study uses a thorough assessment of secondary sources to investigate the multidimensional link between women's empowerment, health, and nutrition. The technique is based mostly on a careful review and synthesis of existing literature, which includes academic papers, scholarly articles, reports, and books from disciplines as diverse as sociology, public health, gender studies, and nutrition sciences. The paper uses electronic databases, networks, and snowballing techniques to collect relevant literature, and includes both published and gray sources.

Result

Village Distribution: The sample consists of 111 Baiga women, with a slight majority from Bauna village (55%) and the remaining from Cheetalpaani (45%). This near-equal distribution ensures that the findings are representative of the Baiga community across these two villages.

Age Distribution: The age distribution of the respondents is predominantly within the younger age groups. A significant proportion (91%) of the sample falls within the 17-30 age range. This highlights a youthful demographic, which is essential for understanding the health and nutrition needs of young women in the Baiga community.

Age at Marriage: The age at which the respondents got married indicates early marriage is prevalent. The data reveals that 93.7% of the respondents were married by the age of 18, underscoring the cultural norm of early marriage within the Baiga tribe. This early marriage trend has significant implications for health and educational interventions targeted at young women.

House Type: The housing conditions are primarily traditional. The overwhelming majority live in kaccha houses, reflecting the economic constraints and traditional lifestyle prevalent in the community.

Number of Rooms: The number of rooms in the respondents' homes indicates limited living space. Most households have only one or two rooms, suggesting crowded living conditions that may impact health and well-being.

Family Members Count: The family sizes are generally large. A significant proportion of households (76.5%) have four to eight members, highlighting the extended family structure common in the Baiga community.

Main Water Source for Household: Water sources are divided between. The majority rely on wells for their water supply, which could have implications for water quality and accessibility.

All respondents use open spaces for sanitation, indicating a lack of proper toilet facilities and posing significant health risks.

The reliance on traditional fuels points to limited access to cleaner cooking technologies, impacting indoor air quality and health.

The demographic and household characteristics of Baiga women provide several critical insights into their living conditions and lifestyles. The majority of the sample consists of young women, with a significant proportion aged between 17 and 30 years. Early marriage is a prevalent norm within this community, with 93.7% of the women marrying by the age of 18. This trend of early marriage has substantial implications for health and educational interventions targeting young women.

Living conditions among the Baiga women are largely traditional. Most households reside in kaccha (mud) houses (95.5%), reflecting economic constraints and a traditional lifestyle. Only a small fraction live in pakka (brick) or semi-pakka houses.

Table 1 Demographic and Household Characteristics of Baiga Women

Variable	Category	Frequency	Percent (%)
Village	Bauna	61	55
	Cheetalpaani	50	45
Age	17-20	29	26.1
	21-25	34	30.6
	26-30	38	34.2
	31-40	10	9.1
Age at Marriage	15-16	38	34.2
	17-18	66	59.5
	19-25	7	6.3
House Type	Kaccha	106	95.5
	Pakka	2	1.8
	Semi Pakka	3	2.7
Number of Rooms	1	60	54.1
	2	22	19.8
	3	28	25.2
	4	1	0.9
Family Members Count	01-03	23	20.7
	04-05	44	39.6
	06-08	41	36.9
	09-10	3	2.7
Main Water Source for Household	Well	74	66.7
	Other	37	33.3
Type of Toilet Facility	Open Space	111	100
Cooking Fuel Type	Straw/Shrubs/Grass	110	99.1
	Dung Cakes	1	0.9

Source- Author's calculation

The number of rooms per household is generally limited, with the majority having one or two rooms, indicating crowded living conditions that could negatively impact health and well-being.

Family sizes tend to be large, with 76.5% of households comprising four to eight members. This extended family structure, combined with limited living space, highlights the need for interventions aimed at improving housing conditions.

The main water source for 66.7% of the households is wells, while the remaining 33.3% rely on other sources. Sanitation facilities are notably inadequate, with all respondents using open spaces for sanitation. This lack of proper toilet facilities poses significant health risks.

Cooking practices predominantly involve the use of traditional fuels, with 99.1% of households using straw, shrubs, or grass, and 0.9% using dung cakes. The reliance on these fuels points to limited access to cleaner cooking technologies, affecting indoor air quality and health.

These findings underscore the urgent need for targeted interventions in health, nutrition, and education, especially focusing on young married women. Improving housing conditions, enhancing access to clean water and sanitation facilities, and transitioning to cleaner cooking fuels are essential steps toward improving the overall well-being of the Baiga community. By understanding these demographic and household characteristics, policymakers and practitioners can design more effective programs that address the specific needs and challenges faced by Baiga women. These targeted interventions will ultimately contribute to their empowerment and improved quality of life.

Table 2 Descriptive Statistics for Health Checkup Attendance

Pair	Mean	N	Std. Deviation	Std. Error Mean
Number of Medical Checkups	2.459	111	1.2489	0.1185
Total Checkups Attended	2.414	111	1.2393	0.1176

Source- Author's calculation

Table 2. presents the number of medical checkups and total checkups attended by the participants. It includes the mean, standard deviation, and standard error mean for each variable, which provides an overview of the central tendency and dispersion of the data. The average number of medical checkups attended was slightly higher (mean = 2.459) compared to the total checkups attended (mean = 2.414), although both had similar standard deviations (1.2489 and 1.2393 respectively). This similarity in means and variances indicates that the frequency of attending medical checkups is almost equivalent to the total number of health-related visits, suggesting a consistent health-seeking behavior among the study participants.

Table 3 Correlation Between Number of Medical Checkups and Total Checkups Attended

Pair	N	Correlation
Number of Medical Checkups & Total Checkups Attended	111	0.957

Source- Author's calculation

Table 3 displays the Pearson correlation coefficient between the number of medical checkups and total checkups attended, which quantifies the strength and direction of the linear relationship between these variables. The correlation coefficient of 0.957 ($p < 0.001$) indicates a very strong positive relationship between the number of medical checkups and the total checkups attended. This high correlation suggests that as the number of medical checkups increases, the total checkups attended also increases, reinforcing the notion that engagement in medical checkups is a major component of overall health checkup behavior.

Women's empowerment and gender equality go hand in hand. This is why governments all over the globe have worked hard to narrow the gap. Women's empowerment leads to longer birth intervals, late marriage, fewer unintended pregnancies, and miscarriages. The recent trend in public policy is inclined towards promoting gender equity. It is crucial to acknowledge the significant correlation between women's empowerment and nutrition. When women are empowered, they are granted increased access to education, healthcare, and economic opportunities, subsequently leading to improved nutritional outcomes for both themselves and their families. Furthermore, proper nutrition can further contribute to women's empowerment by enhancing their health, energy levels, and productivity. Through investment in women's empowerment and nutrition, a positive cycle of progress can be established, benefiting individuals, families, and communities alike.

Women's empowerment has traditionally been related to their reproductive health, but the current trend reveals that it is no longer restricted to that. The empowerment of Baiga tribal females can be observed in their household decision-making, and resource allocation, there is autonomy in social and domestic matters. The final say is that of Baiga women when it comes to child-related decisions. What is unique about this tribe can be seen through the dynamics of power relations in them. There is abuse present, but it is usually done by females to males. The attitude towards gender roles is such that it is mostly men who stay at home and cook, while females go to the forest to hunt and collect. The Baiga tribal women are empowered through nutritional and healthcare programmes, but the empowerment of their mobility still needs some work. Like men who travel to other states for work, the females would rather stay due to the language barrier. There is a need for women's freedom of movement or mobility.

To precisely gauge women's empowerment, it's crucial to use a combination of universal indicators aligned with international gender equality and rights, as well as locally defined indicators that align with sociocultural interpretations.

Discussion

The factors that are usually considered in the empowerment of women are social, economic, and political. Many studies have found that a positive correlation exists between the empowerment of women and lower fertility rates. According to a literature review conducted as part of this study, each article uses a different definition for measuring female empowerment. The choice made by females when it comes to their families is significant. Frequently in India, women are given almost no control over what happens with their bodies; this decision rests mostly with husbands and/or other relatives on the husband's side who may have influence over matters such as family planning which would affect her ability or desire for children. In most cases, though not all, this power dynamic shifts only after women attain some degree of economic independence. This may be achieved through education, employment opportunities beyond traditional sectors like agriculture, or the gradual accumulation of wealth. Once economically empowered, women are better able to negotiate on these issues without being entirely dependent on any single individual.

In distinct studies, feminist social demographers propose that the women's empowerment issue consists of various multidisciplinary dimensions. It is also mentioned that progress in one dimension does not necessarily mean progress in another dimension too. For instance, a woman might be well aware of her rights in terms of political and economic aspects and has empowerment in household decisions, but might not have much say in healthcare decisions. The lack of agency in women, even in one aspect cannot be upheld as empowerment in the true sense. Heckert et al. (2019) examined four dimensions of women's empowerment—purchasing decisions, healthcare decisions, family planning, and spousal communication—and identified a positive relationship between these factors and child nutrition. Their findings suggest that empowering women can significantly improve child health outcomes, but they also emphasize the importance of providing adequate resources to support these empowerment efforts for the best possible impact.

Pierre Pratley (2016) identifies various health-related tools and services available to women, including policies on antenatal care, skilled birth attendance, contraceptive access, child mortality reduction, complete vaccination, nutritional support, and protection from violence. Evidence shows that women's empowerment is strongly and positively associated with improved maternal and child health outcomes.

A study in Burkina Faso examined the relationship between women's empowerment, agricultural practices, and child nutrition. Findings showed that increased empowerment, specifically in household decision-making and family planning, contributed to a reduction in child wasting. This suggests that pathways focused on enhancing women's empowerment can play a significant role in lowering child mortality rates (Heckert et al., 2019).

A qualitative study conducted in India by Pradhan et al. (2023), explores the role of self-help groups (SHGs) in improving women's empowerment and community-based health

and nutrition interventions. The study focuses on the SWABHIMAAN intervention programme, which aims to improve the nutrition of girls and women before conception, during pregnancy, and after childbirth. A study done by Pratley P. (2016) shows that there is a positive association between women's empowerment and maternal and child health. This shows that empowering women is a viable strategy to improve women's health. The convergence of these studies suggests that women's empowerment, while multi-faceted, has a consistently positive impact on health outcomes when support structures, such as health services and resources, are in place. However, true empowerment requires progress across all dimensions; partial empowerment does not equate to full agency and can leave significant gaps in healthcare and overall well-being. Empowerment programs must thus address multiple dimensions simultaneously and ensure resource provision to foster sustainable improvements in both maternal and child health.

Numerous studies suggest a strong link between women's empowerment and improved health outcomes, especially in maternal and child health. When women have greater autonomy over healthcare decisions, they are more likely to make informed choices that benefit both their own well-being and that of their families. With all the policies in place, the tools and agency have been provided to women to achieve the same. The major challenge that remains is that whenever gender equality is talked about it always winds up in maternal and child health discourse.

Another challenge is that discussions around women's empowerment often lack clear parameters, with the focus frequently shifting primarily to maternal health. There has been a shift in the key areas of women's empowerment, including financial independence, attitudes towards domestic violence, control over their partners, and decision-making. Efforts to empower women span across various domains such as healthcare, education, employment development, gender-based violence, and political participation at global, national, and local levels (like the Panchayat). However, a significant gap remains between legislative reforms and their effective implementation. Empowerment is often measured and operationalized through proxy indicators, as direct observation of these processes can be challenging.

In the Baiga tribe, women are seen as empowered in a unique way, as they are often left to fend for themselves due to the frequent absence of husbands. Women have mastered the skills necessary for surviving in the forest, enabling them to live independently without relying on a male companion, unlike men in the tribe, who cannot easily do the same. The polyamorous nature of the tribe allows women to change partners if their husbands do not adequately care for them, further highlighting their autonomy. Baiga women possess significant independence, having both a strong voice in their community and physical resilience.

Indicators of empowerment typically include factors such as education, labor market participation, marriage and kinship structures, land ownership, social norms, health, and autonomy in decision-making. In the Baiga

tribe, while women are not educated, this is reflective of the tribe as a whole, where formal education is uncommon. Unlike men, who often travel to other states for work, Baiga women tend to find local work, such as in construction. They have the freedom to choose whether to work or stay at home. However, staying at home doesn't mean being confined to domestic chores; women actively engage in foraging for wood and food to sustain their households. Baiga women also have significant autonomy over their bodies, with sterilization decisions primarily made by the women themselves. Although the Baigas are a traditional tribe with little trust in modern medicine, there has been a notable shift, providing women with access to healthcare, health education, and community support. This increased access has improved their ability to care for themselves and their children. The introduction of ASHAs (Accredited Social Health Activists) has significantly influenced their views on health and well-being.

In the Baiga tribe, women's empowerment manifests in a unique way. Unlike mainstream narratives where economic independence is often emphasized, Baiga women demonstrate autonomy over their bodies and household decisions without the traditional markers of empowerment like formal education or salaried employment. Their ability to navigate the forest for survival, make decisions regarding family planning, and shift partners based on caregiving abilities reflects a form of empowerment deeply rooted in their cultural context. However, while Baiga women enjoy significant autonomy, this should not obscure the lack of access to modern healthcare and education, which are critical to improving long-term wellbeing. This example underscores the complexity of defining empowerment across different social and cultural landscapes.

Conclusion

In recent years, our understanding of women's health and nutrition has evolved significantly. Women are no longer seen as passive recipients of healthcare but should be empowered to take control of their own well-being. Providing women with knowledge about healthy living is crucial, enabling them to make informed decisions about their bodies. This, in turn, helps reduce gender disparities in health outcomes and ensures that everyone receives equitable medical treatment.

There has been increasing attention on women's rights in relation to health and nutrition, emphasizing the need for institutions to equip women with the skills necessary for self-care. However, empowering women requires a global commitment that goes beyond written equality; societies worldwide must actively respect and implement these values.

While many studies confirm a positive correlation between women's empowerment and outcomes such as lower fertility rates, improved child nutrition, and better maternal health, the definition of empowerment remains inconsistent across research, making it difficult to draw universal conclusions. The case of the Baiga tribe underscores the complexity of empowerment, illustrating how autonomy in non-traditional forms such as control over family planning and household decisions can coexist with limited access to formal education and healthcare. This example serves as a reminder that

empowerment looks different in varying cultural and social contexts.

This paper aims to contribute valuable insights to policymakers, researchers, and practitioners working in gender-focused health systems. By sharing these findings, we hope to support the ongoing effort to improve health outcomes through the empowerment of women.

Conflict of Interests-The authors declare that there is no conflict of interests regarding the publication of this paper.

Acknowledgments- Authors wish to thank all the Baiga community who voluntarily participated in the present study

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