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A Comprehensive Review of Women's Education and Health in an Indian Context

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Abstract: The lives of women throughout the world have improved considerably as a result of the current trend of globalisation, especially those in developing countries. Nevertheless, women are still disadvantaged in many areas, including education, employment, health, etc. Today, we often discuss women's empowerment without considering why it is necessary. To find answers, we must examine the historical situation of women, learn the history of Indian feminism and identify the major problems facing Indian women today, such as health and education. This systematic literature review examines the historical trajectory and current challenges related to women's empowerment in India, with a focus on women's health and education. Guided by the PRISMA (Preferred Reporting Items for Systematic Reviews guidelines, the review analyses peer-reviewed journals and scholarly publications from 2000 to 2023. This research synthesises statistical data and empirical evidence to offer actionable insights designed to improve the status of women's health and education. The findings highlight significant regional disparities and emerging trends in policy adoption, laying the groundwork for potential future reforms.

Keywords: *Women in Health and Education, Rural and Urban Perspectives.*

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I. INTRODUCTION

Over the past two decades, Indian society has undergone significant changes that have impacted the landscape of women's empowerment. While historical narratives often focus on women's socio-political achievements, the current scenario reveals persistent challenges, particularly in women's health and education. Empowerment in India must be understood in the dual context of historical legacies and contemporary policy frameworks, highlighting both improvements and gaps in maternal health services, higher education participation, and workforce representation. Geographically, India is a large and unique country. The issues concerning Indian women, however, paint a different picture. Women of all classes and backgrounds, whether peasant farmers or professionals, have a range of responsibilities, including household maintenance and child rearing. Women from rural and urban areas have different lifestyles, which come with different sets of obstacles and responsibilities. Compared to rural women, urban women feel more empowered, educated, and independent. Women can transform the social, economic, educational and political landscape, and indeed, women in India require such enhanced social powers. Educated women make it possible for them to determine the movement, economic self-sufficiency, political involvement, public address, and the informed exercise of rights. Women have historically and continue to be the most important change agents in the Indian educational system. Women who are educated are now viewed as the drivers of national development, social transformation and economic progress. The patriarchal norms and social barriers severely restricted women's access to education. Reformers such as Savitribai Phule have pioneered girls' education and challenged deep-rooted prejudices (Khan et al., 2020). The government gave priority to women's literacy, introducing policies and programmes to increase girls' enrollment and retention, hiring female teachers, and removing gender bias from the curriculum (Mandal, 2021). Initiatives such as Beti Bachao Beti Padhao and scholarships further bridge the gender gaps, although these gaps continue to persist, especially in rural and marginalised communities (Mittal, 2021). Traditionally, women's roles in health are limited by gender norms, low education and limited decision-making power, resulting in poorer health outcomes and limited access

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to health care (Gorski et al., 2017; Shukla, 2020). In recent decades, the empowerment of women, especially in decision-making, education and social independence, has been strongly associated with improvements in health, nutrition and access to health care. Community women's groups and self-help groups are particularly effective in improving the health, nutrition and knowledge of mothers and children (Desai et al., 2020; Pradhan et al., 2023). Caste, tribe and regional differences continue to affect women's empowerment and health outcomes. Gender norms and socio-cultural prejudices still restrict women's autonomy and access to resources, especially in marginalised communities (Shukla, 2020).

➢ *Women's Role in Indian Education*

Table 1 Women's Role in Indian Education

Era/Initiative	Key Developments & Impact	Citations
Pre-Independence	Reformers like Savitribai Phule started girls' schools.	(Khan et al., 2020).
Post-Independence	Government policies boost female literacy and teacher recruitment.	(Mandal, 2021).
21st Century	National campaigns and scholarships focus on empowerment and leadership.	(Mittal, 2021).

In India, from the independence era, the journey of women's education started with reforms like Savitribai Phule, followed by post-independence policies promoting literacy and female teacher recruitment. In the 21st century, national campaigns and scholarships emphasise women's empowerment and leadership.

II. METHODOLOGY

The present review adheres to the PRISMA guidelines to ensure methodological rigour. A systematic search was conducted across multiple databases, including PubMed, Scopus, Web of Science, and Google Scholar. The search terms used combined keywords related to "women's empowerment", "women's health", "women's education", "maternal health", "higher education participation", "workforce representation", "rural", "urban" and "India". The inclusion criteria were:

- Articles published between 2000 and 2023.
- Peer-reviewed journals and scholarly publications.
- Studies and reviews that provided statistical data or empirical evidence.
- Comparative research focusing on rural and urban settings as well as different Indian states.
- Publications available in the English language.

III. REVIEW OF LITERATURE

➢ *Women's Education in an Indian Perspective*

- *Maternal Health*

The literature review revealed substantial progress and considerable disparities in maternal health in India. Studies indicated improvements in maternal mortality ratios (MMR) over the past two decades. The maternal mortality inter-agency group (MMEIG) provides global estimates of MMR. According to the United Nations MMEIG 2020 report "Maternal mortality trends 2000-2020", India's MMR fell from 384 in 2000 to 103 in 2020, while the global MMR fell from 339 in 2000 to 223. The average annual reduction rate (ARR) of global MMR between 2000 and 2020 was 2.07%, while India's MMR decreased by 6.36%, higher than the global decline (World Health Organisation, 2023). However, the decline was not uniform across states. Southern states, such as Kerala and Tamil Nadu, reported significantly lower MMRs compared to northern and central states like Uttar Pradesh and Bihar. India's MMR dropped from around 398 per 100,000 live births in 1997–1998 to 103 in 2017–2019, representing a decline of over 74% (Kumar & Metilda, 2022). States like Kerala (MMR ~43) and Tamil Nadu have achieved much lower MMRs, while states such as Assam (MMR ~215), Uttar Pradesh, and Bihar remain high-risk areas. Bihar and Assam are identified as persistent hotspots for maternal mortality, with higher spatial risk compared to other states (Kumar & Metilda, 2022). Empirical evidence suggests that maternal health services in urban areas are more accessible and of higher quality compared to those in rural regions. In general, we expect women to live longer than men, but this does not necessarily guarantee better quality of life. Deep research has shown that women are more sick and disabled throughout their lifetime than men (Ginter & Simko, 2013). Because of biological factors, women are more likely to be exposed to sexually transmitted infections (STIs), including human immunodeficiency virus (HIV), than men (Ramjee & Daniels, 2013). Malnutrition affects millions of women because they lack calories, proteins, vitamins, minerals, and other diseases and social status. Indian mothers and their children are at risk of dying of malnutrition, a serious health problem. The proper nutrition of any individual, especially women, is an essential cornerstone for maintaining health (Paul et al., 2011).

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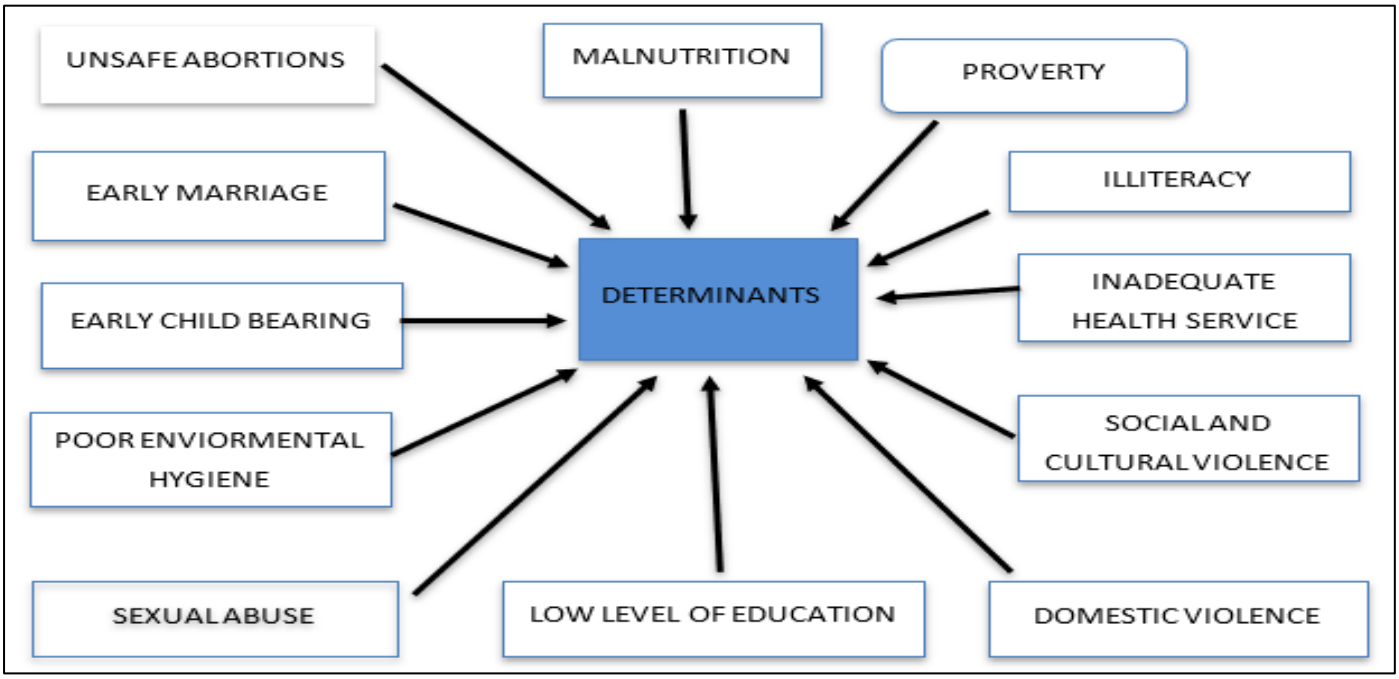

Fig 1 Factors that Determine the Health Concerns of the Women
Source: DOI: 10.15406/mojpb.2017.05.00162

Babys born in malnourished women are exposed to many complications, including cognitive impairments, short life expectancy, reduced infection resistance, and high risk of disease and death during their lifetime. Due to women's genetic biology, low social status, poverty, and lack of education, women are more likely to develop food disorders than men (Raj et al., 2015). The world's two most common nutritional deficiencies among women are iron and anemia. Approximately 80% of pregnant women in India suffer from anemia due to iron deficiency (Rao et al., 2010). In India, maternal mortality is consistently high compared to many developing countries. Between 1992 and 2006, India accounted for about 20% of the worldwide maternal mortality due to social and economic and cultural constraints and access to health care (Dharmalingam et al., 2010). In India, maternal mortality is 57 times higher than in the United States. India's maternal mortality rate is lower than in Bangladesh and Nepal, and higher than in Pakistan and Sri Lanka (World Health Organization and UNICEF 2003).

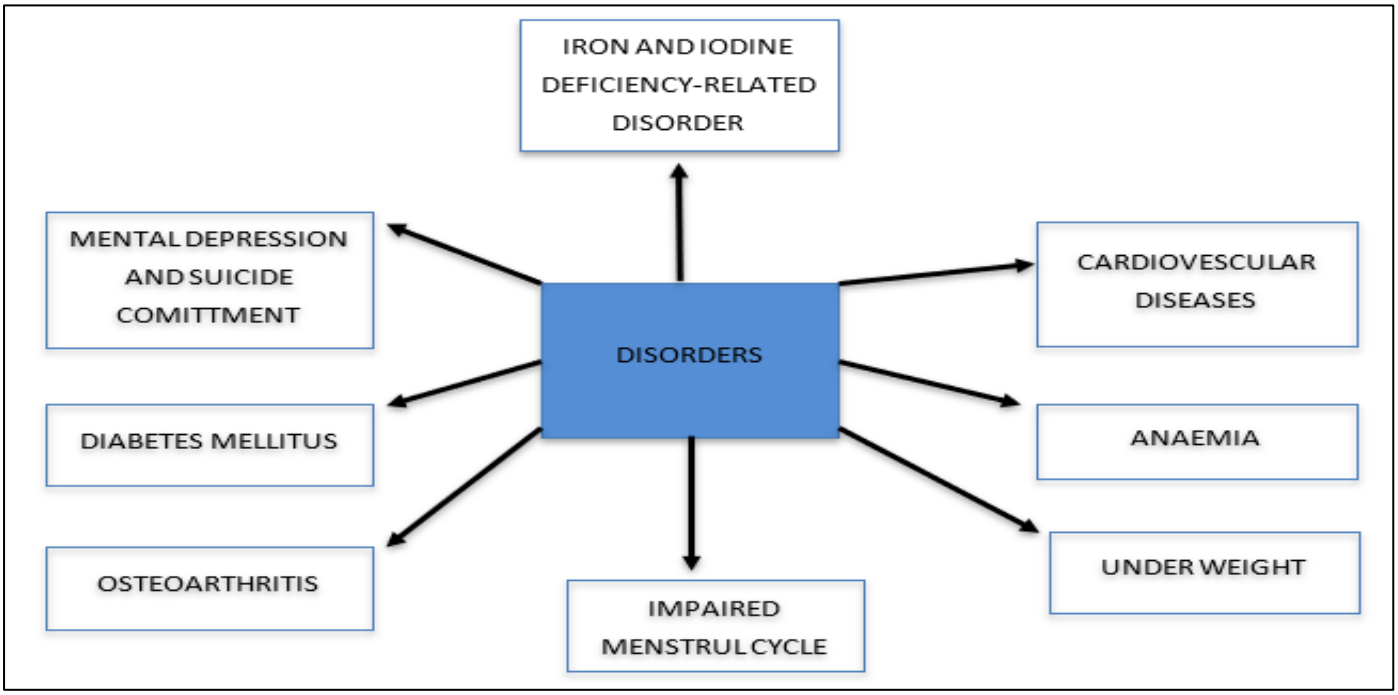

Fig 2 Disorders Associated with Malnutrition in Women.
Source: DOI: 10.15406/mojpb.2017.05.00162

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Cardiovascular diseases are the main cause of increased female mortality in India due to differences in health care access between sexes (Krishnan, 2012). Surprisingly, men visit hospitals more often than women to treat their illnesses. Furthermore, Indian women are more likely to suffer from mental depression than Indian men (Bohra et al., 2015). More Indian women commit suicide than men, directly attributed to depression, anxiety, gender discrimination and domestic violence (Halder et al., 2015).

- *Impact of Maternal Education on Health Outcomes*

Higher maternal education is consistently linked to lower infant mortality rates and maternal mortality rates. Better-educated mothers are more likely to understand and attend to health problems, and to seek and utilise health services like antenatal and postnatal care, thus improving health outcomes for mothers and infants. Mothers with higher education are more likely to access health services, including immunisation, antenatal care (ANC), and postnatal care (PNC). There is, however, a concerning gap in access to these services among low-educated and illiterate mothers, which leads to poorer health outcomes (Singh et al., 2016). There is higher illiteracy and lower socio-economic status these women have, the greater the infant and maternal mortality rate. With education typically comes a higher socioeconomic status, which improves access to health services. Also, urban centres where education levels are higher are known to have better urban health outcomes and better access to health facilities than rural areas (Singh et al., 2016).

- *Impact of Janani Suraksha Yojana (JSY)*

Maternal education, socioeconomic status, and policy interventions like Janani Suraksha Yojana (JSY) are key factors influencing antenatal care utilisation and maternal health outcomes in India. Higher education and socioeconomic status consistently predict better utilisation of maternal health services, while JSY has increased institutional deliveries and reduced disparities; however, challenges remain in awareness, quality, and regional implementation. JSY has led to a substantial rise in institutional deliveries, especially among disadvantaged groups, and has reduced out-of-pocket expenses for families (Gupta et al., 2012; Lim et al., 2010). The program has helped reduce socioeconomic inequalities in maternal care utilisation, though the poorest and least educated women do not always benefit the most (Modugu et al., 2012). Success varies by state and region, with better outcomes in areas with strong outreach and health infrastructure. In some regions, low awareness, mismanagement, and lack of accountability limit effectiveness (Lim et al., 2010).

- *Determinants of Antenatal Care Utilisation*

Utilisation of antenatal care and institutional delivery services is greatly influenced by the education and wealth of a woman. There is a widening gap between the rich and the poor as well as between educated and uneducated women, although this gap seems to have closed since the introduction of the Janani Suraksha Yojana (JSY) program. Even with this progress in other regions, the poorest regions still face inequitable access to these services (Jain et al., 2016; Randive et al., 2014; Kumar et al., 2015; Dhakne & Phalke, 2019). Higher literacy rates and exposure to health information through media are linked to increased awareness and use of maternal health services, contributing to improved outcomes (Gebremedhin et al., 2022).

➢ *Higher Education Participation*

The disparity between male and female literacy rates has always existed, though it differs depending on the area and demographic. At various educational levels, disparities can be seen. Compared to the primary level, they are higher at the secondary level.

Early marriage, lack of female role models, and traditional gender roles limit the perceived value of education for girls. Parental attitudes are generally positive, but practical constraints often override aspirations (Nayak & Kumar, 2022; Mete et al., 2023). Many tribal schools suffer from poor infrastructure, including dilapidated buildings, a lack of classrooms, and insufficient teaching staff. Single-teacher schools and predominantly male teachers can further discourage attendance (Mohanty et al., 2019). Positive peer interactions, competent teachers, and culturally relevant curricula can help retain girls in school, while negative experiences or lack of support increase dropout risk (Nayak & Kumar, 2022). According to Chaudhuri and Roy (2006), discrimination against girls can take the form of reduced educational funding or the decision not to enrol them in school. Parents don't want to spend a lot of money on girls' education because of the dominant social and cultural norms (Mohanty, 2006). At the primary level, poor retention and lower completion rates continued, with the issue being more severe for SC and ST girls (Govinda & Bandyopadhyay, 2008). A girl's education is influenced by a number of factors. According to Kambhapati (2008), families with educated mothers spend more on their daughters' education. Because their boys will assist them financially in their later years and inherit the property, parents seek to educate their sons (Bose, 2012).

➢ *Health and Education: Key Insights*

Table 2 Health and Education: Key Insights

Area	Key Findings	Citations
Nutrition	Higher empowerment is linked to better nutrition (e.g., lower iron deficiency, improved diet diversity).	(Gupta et al., 2019).
Workforce	Employment (e.g., through government schemes) increases women's economic power, reduces violence, and improves health.	(Rodriguez, 2022).
Education	Education is a powerful driver of empowerment, increasing self-confidence, decision-making, and workforce participation. Female literacy and higher education rates remain below those of men, especially in rural areas.	(Mondal, 2023).

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Empowerment improves women's health through better nutrition, education, and employment. Education and workforce participation enhance confidence, reduce inequality, and improve well-being, especially in rural areas.

➢ *Major Educational Barriers for Women*

Table 3 Major Educational Barriers for Women

Barrier Type	Description	Citations
Socio-cultural Norms	Traditional beliefs prioritise boys' education, early marriage, and restrict girls' mobility.	(Chavan, 2020).
Dropout & Retention Issues	High dropout rates due to domestic responsibilities, early marriage, and lack of support.	(Yadav & Singh, 2020).
Infrastructure Deficits	Lack of nearby schools, poor facilities (e.g., toilets), unsafe travel, and inadequate resources.	(Ali & Shafeeq, 2021).
Economic Constraints	Poverty, limited family resources, and parental preference for investing in sons' education.	(Jamatia, 2023; Yadav & Singh, 2020).
Discrimination & Exclusion	Caste, class, religion, and disability further limit access, especially for marginalised groups.	(Rahiman, 2023).

These challenges lead to high dropout rates and limited access, especially for marginalised groups.

➢ *Workforce Representation*

One important measure of social and economic empowerment for women is their employment status. The systematic review uncovered evidence that although there has been an increase in female labour force participation, the overall percentage remains low compared to men. The period between 2000 and 2023 witnessed gradual improvements in workforce representation in sectors such as information technology, education, and healthcare. The quality of employment for women is generally better in urban areas, but participation rates are higher in rural areas, mainly because of the nature of available work.

- *Key Factors Influencing Participation*

Rural women participate more due to the necessity of contributing to family agriculture or informal work, but these jobs are often unpaid or low-paid and lack benefits (Sanghi et al., 2015). Urban jobs are more likely to be formal and better paid, but fewer women access them due to social expectations, safety concerns, and the need for proximity and flexibility (Fernandez, 2023). Both rural and urban women face restrictions from marriage, caste, religion, and household responsibilities, but these are often more pronounced in urban settings where job opportunities require travel or longer hours (Chatterjee & Sircar, 2021). Higher education can reduce rural participation (as educated women may not find suitable jobs locally) but is associated with better job quality in urban areas (Narayan, 2023).

- *Current Status and Barriers*

Female literacy rates in India remain below those of males, with girls facing higher dropout rates, especially in rural and marginalised communities. Factors such as poverty, geographic isolation, and traditional beliefs continue to hinder access to education for many girls (Mondal, 2023; Mandal, 2021; Karan, 2017). Deep-rooted patriarchal structures restrict women's autonomy, limit their access to education and economic independence, and reinforce traditional gender roles. These norms are especially strong in rural and marginalised communities, where family honour and social expectations dictate what is considered "respectable" work for women, often discouraging them from pursuing higher education or professional careers (Pervin & Mokhtar, 2023). Other difficulties that women have in the rural sector include a lack of information about job opportunities for education and training, restricted access to real estate and land, as well as financial and non-financial services. The goals of initiatives like Mahila Shakti Kendra, Beti Bachao Beti Padhao, and Sukanya Samriddhi Yojana are to support females' financial empowerment and education (Hasan & Parveen, 2020).

IV. DISCUSSION

A review of recent literature between 2000 and 2023 reveals a broad and developing picture of women's empowerment in India. Although there is improvement in maternal health and access to higher education, these improvements are not equitably shared. The literature review suggests that the enhancement of socio-economic policies coupled with high-level government policies and their implementation has improved maternal health; however, the uneven geographic distribution of health services remains a considerable challenge. The rural-urban divide is a recurring theme in the literature. Urban regions are served with relatively more advanced health and educational facilities, which also employ more women. However, rural regions, despite higher levels of informal employment, do not offer the same informal safety net or career progression opportunities. This gap highlights the importance of comprehensive policies that go beyond infrastructural development to include socio-cultural barriers. Moreover, the inter-state comparison reveals that uniform policies are not effective. Policies must be designed based on state-level resources and societal and governance contexts. For instance, the explained features of improved maternal mortality rates and maternal health education within specific states, along with the observed outcomes, included an efficient allocation of public health services, focused public health campaigns, and grassroots-level health interventions. All reviewed literature pointed towards the importance of women's

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economic empowerment in improving the overall status of women. Improved access to education increases chances of employment and economic mobility. All reviewed literature highlighted the relationship between education, economic independence, and improved participation of women in both familial and public governance structures. However, there are still underlying issues to address. Gender stereotypes and cultural frameworks continue to restrict women's economic and social opportunities even in urban areas. There is an urgent need to address the change in societal mindset as reflected in organisational structures, education, and general gender roles. There is a need for legal frameworks that go beyond the simple allocation of resources to include gender sensitisation, anti-discrimination legislation, and the promotion of women in leadership roles within all governance structures. From the findings of the review, it is evident that actions aimed at enhancing women's health and education involve the expansion of maternal health services in the neglected areas, the implementation of inclusive educational policies, and the revision of gender equitable workplace policies. As an example, the role of community health workers in remote regions could drastically expand the availability of maternal health services. At the same time, scholarship funds, as well as mentorship programs, could motivate the pursuit of higher education among underrepresented populations.

V. CONCLUSION

In conclusion, this comprehensive review of the literature has offered a thorough examination of the main obstacles Indian women encounter in reaching the best possible health and educational results. Significant advancements have been made in the areas of workforce representation, higher education participation, and maternal health improvements over the last 20 years. Nonetheless, persistent sociocultural barriers and regional differences underscore the need for targeted policy interventions.

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