From Paper to Practice: A Study on Health-System Bias and Exclusions in Assessing SRHR in India

Aashi Sahu, Anshim, Ritika Jindal, Swastika Kar

Abstract

This paper attempts to investigate the gap between reproductive health policies in India and their grassroots implementation. Special focus is given to marginalized women, mainly those from Dalit and tribal backgrounds. Although there are various legal frameworks such as the Janani Suraksha Yojana (JSY) and the Medical Termination of Pregnancy (MTP) Act amendments, deep rooted impediments continue to restrict women's access to sexual and reproductive health rights (SRHR). Most mainstream literature focuses on service outreach metrics but fails to look into the intersectional realities of caste, class, age, and geography in health-system interactions.

Methodologically, this paper builds on the qualitative approach with content analysis of policy documents, review of secondary data, and semi-structured interviews with women. Alongside, this paper explores the lacuna in SRHR. Primary focus is given to institutional bias, provider's attitudes, and lack of infrastructure that result in denial or delay of services. Emphasizing lived experiences and examining the state's accountability in ensuring bodily autonomy, the research aims to offer a nuanced critique of India's reproductive health landscape. The paper concludes with policy recommendations targeting both structural reforms and sensitization frameworks to make reproductive rights meaningfully accessible to marginalized women.

Keywords: reproductive health policies, marginalized women, intersectional realities, policy recommendations

Introduction & Background

The foundation of bodily autonomy and gender equality is formed by sexual and reproductive health rights (SRHR). Central to human rights lies SRHR, which not only encompasses access to healthcare services but also the right to make informed choices about one's body (United Nations Population Fund [UNFPA], 2022). In India, the government's unwavering commitments towards women's reproductive health can be witnessed through several legal and policy initiatives. The schemes include, Janani Suraksha Yojana (JSY), the Medical Termination of Pregnancy (MTP) Act along with its 2021 amendments, and other maternal healthcare schemes (Ministry of Health and Family Welfare [MoHFW], 2021). In spite of these initiatives, there exists stark disparities in the implementation of these rights, especially for women from marginalized backgrounds, including adolescents, Dalits, and tribal communities. Recent policy evaluations suggest that while India has improved certain reproductive health indicators such as reduced maternal mortality and increased institutional deliveries, qualitative aspects of care remain deeply compromised (Chatterjee, 2020). This discrepancy is particularly evident in the gap between high-level policy commitments and the

lived experiences of women at the grassroots level. Studies increasingly reveal that social determinants such as caste, class, age, and geography play a crucial role in determining access to reproductive healthcare (Deshpande, 2022). Women from Dalit and tribal backgrounds often face layered marginalization in the form of institutional discrimination, infrastructural deficits, provider apathy, and limited awareness about their reproductive rights (Raj et al., 2023).

Moreover, healthcare providers' attitudes and systemic biases frequently result in the denial or delay of services like safe abortion, contraception, and maternal care (Kumar & Rai, 2021). In many instances, services provided under schemes like JSY tend to reduce women to mere statistical targets, sidelining their autonomy and preferences. The focus on numerical achievements in public health metrics has diverted attention away from more complex, intersectional issues of dignity, agency, and consent in reproductive healthcare delivery (Chatterjee, 2020). Consequently, the promise of universal reproductive rights remains an illusion for large sections of marginalized women in India.

Problem Statement & Research Objectives

This paper addresses these critical gaps by adopting a qualitative inquiry into how reproductive health policies are implemented in practice. Using content analysis of policy documents, a review of secondary literature, and semi-structured interviews with affected women and healthcare providers; it investigates how systemic biases, infrastructural shortcomings, and socio-cultural barriers collectively obstruct marginalized women from accessing dignified reproductive care. In doing so, the study confronts a central paradox: despite the presence of progressive reproductive health policies in India, marginalized women, particularly adolescents, Dalits, and tribal women continue to experience systemic exclusions that undermine their reproductive autonomy. By highlighting the disconnect between policy narratives and lived experiences, the paper aims to bridge this gap in scholarly discourse and policy evaluation, contributing towards a more grounded understanding of reproductive rights that goes beyond numerical outreach to address structural and attitudinal inequalities within India's healthcare system.

Thematic Literature Review

It makes more sense from a theoretical standpoint to conduct a thorough investigation of SRHR-related impediments. Intersectionality theory, as pioneered by Kimberlé Crenshaw (1989), explains how multiple social identities (such as race, caste, gender, class, and religion) overlap to create complex yet unique experiences of discrimination and privilege. In the Indian context, this perspective is crucial for understanding why policies focused solely on gender or caste fail to address the compounded disadvantages faced by Dalit, tribal, and rural women. Laws and health programs frequently overlook these intertwined barriers while resulting in policies that do not effectively reach those who experience multiple forms of exclusion. An intersectional lens thus pushes for policy frameworks and interventions that are attuned to the specific circumstances of people at the margins and demands for a systematic recognition of how layered oppression functions within existing legal, institutional, and cultural settings.

Bodily contestation theory addresses the power struggles around who has the authority to make decisions regarding bodies while focusing on how autonomy, rights, and agency are regulated by social norms, legal systems, and institutional practices. In the context of reproductive and sexual health, this literature emphasizes on the ongoing battles between individual autonomy and societal/institutional constraints (such as legal requirements, medical gatekeeping, and moral policing). Contemporary analyses show that, despite improvements like the MTP Act and related legal reforms, genuine bodily autonomy for Indian women remains hindered by patriarchal structures, stigma, and the discretionary power of providers. Ultimately, this theory calls attention to the need for legal and policy reforms that secure real agency and dignity to ensure that individuals (especially women and marginalized groups) are empowered to make informed decisions about their own bodies free from coercion or undue interference.

The literature study deconstructs the intricacy of SRHR by focusing on four main and connected issues.

- **Legal and Institutional policy and framework** - There are still many gaps in its implementation that keep the people from fully benefiting from the initiatives, despite India's significant contributions to legal and policy frameworks, including the incorporation of the Right of Health under Article 21 and multiple rulings that made SRHR a crucial topic to concentrate on. Kapoor (2024) criticizes the MTP (Regulation) Act as being burdensome and doctor-centric, often requiring the consent of the spouse or family even if it is legal. The Government of India's Surrogacy Bill is criticized by Jakhar (2025) for upholding strict traditional norms by prohibiting unmarried and LGBTQ+ individuals from becoming parents. Women in India are still viewed as a means of population control, particularly in rural areas where sterilization camps are prevalent, according to the CREA Shadow Report (2018). It also mentions the ongoing issue of responsibility in society, which hinders community involvement and the opportunity to discuss their rights and the violence they encounter.

- **Multiple layers of Marginalization** - Including the underprivileged in the benefits will help India reach SDG 5 because not everyone in India has access to reproductive rights, particularly the LGBTQ+ community, Adivasi or tribal people, religious minorities, adolescents, and those who are poor. In her research, Narang (2024) highlighted that pervasive identity differentiation (caste, creed, religion, etc.) will eventually make it more challenging for the general public to benefit from government initiatives. Tribal women may face discrimination and judgment even when they receive care, or they may have trouble traveling to hospitals. LGBTQ+ people, adolescents, and single people are also denied access to abortion services because of their nonconformity with the "ideal family" model. The CHJS (2015) states that research hardly ever discusses caste-related data or gender-sensitive topics, including their difficulties. It is therefore difficult for the government, service providers, and legislators to find answers and fill in the gaps.

- **Patriarchal control and Gender norms** - There is still social stigma associated with discussing abortion, menstruation, and other sexual health issues in public. Women continue to be reluctant to discuss these difficulties in their families due to a number of societal constraints, which prevents them from participating in government-sponsored programs. Narang (2024)

asserts that the patriarchal and social conventions around women date back to ancient times, when women were viewed as mothers, caregivers, and the moral pillars of the household. In some ways, these standards are still reflected in current policies, which prioritize motherhood and population control over bodily autonomy and choice. According to Khanna et al. (2022), women in urban areas frequently experience early marriages and rigid gender roles, which in some ways prevents them from evaluating SRHR. Despite the fact that abortion, menstruation, and other health services are safe and legal, women are reluctant to use them due to family pressure and fear of being judged. A Bollywood movie called Jayesh Bhai Jordaar also explores the same theme of social conventions and patriarchal control. In order to have a son, his wife has to undergo several abortions, and there are numerous other restrictions placed on women, such as the prohibition against using scented soaps to prevent male arousal. This demonstrates that patriarchal control is not just common in rural areas but also in impoverished urban areas.

- **Unawareness of SRHR** - Lack of knowledge on SRHR remains a hurdle in spite of numerous legal attempts. Sharma (2025) asserts that in spite of numerous government-introduced policies, such as Beti Padhao and Beti Bachao, as well as numerous laws, a lack of public communication and other social norms causes a problem as it prevents women from accessing the services designed to help them. Grown et al. (2005) state that women can be made aware of SRHR through community involvement, education, counseling, and infrastructure improvements. When these elements are absent, women's sexual and reproductive health suffers.

Methodological Overview

Review Question
What is the influence of health-system biases and gender norms on women's access to sexual and reproductive health rights (SRHR) in India?

Review Objective
To investigate how reproductive health policies intersect with social hierarchies like caste, age, and geography, and how these intersections contribute to the denial of bodily autonomy and access to sexual and reproductive health rights (SRHR).

Review Design
This study employs a systematic review design with qualitative, quantitative and intersectional research approach to examine the gap between reproductive health policies and their ground-level implementation in India, specifically for marginalized women such as Dalits, Adivasis, and adolescents. The research focuses on how social hierarchies, institutional mechanisms, and policy frameworks interact to impact access to sexual and reproductive health rights (SRHR).

The study is based on both primary and secondary data. Primary data has been collected through semi-structured interviews administered via digital platforms (Google Forms). These were shared with women from represented and underrepresented communities. The use of both open-ended and close-ended questions is intended to obtain both personalized narratives and specific factual

information regarding individuals' access to and experiences with reproductive healthcare services. Although conducted remotely, this method allows for the collection of qualitative and quantitative data in a manner that is adaptable and sensitive to diverse contextual realities. The study also conducted a document review of key policies and legal frameworks such as the Janani Suraksha Yojana (JSY), the Medical Termination of Pregnancy (MTP) Act, and other related schemes. Using content analysis, these documents have been examined for the ways in which they construct eligibility, access, and entitlements – particularly in relation to caste, age, marital status, and geographic location.

A review of secondary literature has been undertaken to understand the broader academic and policy discourse on SRHR in India. This include research articles, survey data, and reports by government and non-governmental organizations. It focuses on identifying structural gaps, provider-level biases, and areas that remain under-researched. All collected data has been analyzed through thematic analysis that are aimed at identifying recurring patterns and issues related to systemic exclusion, delay, or denial of services. The analysis is informed by feminist grounded theories (like bodily contestation theory) as key theoretical frameworks for enabling a critical understanding of how reproductive rights are shaped by social structures and state institutions.

This methodological diversity ensures a comprehensive analysis of the interplay between gender norms and health outcomes.

Core Findings

6.1 Sexual Health Policies

The Government of India has implemented a range of policies to address sexual health and reproductive rights, with a particular focus on ensuring better, affordable healthcare for the impoverished, rural, and marginalized communities, including women.

Building on the success of the first two National Health Policies (1983 and 2002), the 2017 policy was reintroduced to reinforce and expand the government's role in healthcare—covering areas such as health financing, technology, medical education, disease prevention, and human capital investment (Ministry of Health & Family Welfare, Government of India, 2017). A major goal of this policy is to provide free primary healthcare services, especially in maternity, child, and adolescent health, by optimizing existing resources (World Health Organization: WHO, 2019). It sets targets to reduce maternal and infant mortality, increase life expectancy from 67.5 to 70 years by 2025, and improve disease prevention and awareness (Dahiya, 2018). By 2022, the maternal mortality rate dropped from 130 per 100,000 live births in 2017 to 97, and the infant mortality rate declined from 39 to 23 per 1,000 live births during the same period (Agrawal et al., 2024).

In 1966, the Shantilal Shah Committee recommended liberalizing abortion laws to reduce maternal deaths due to unsafe abortions. This led to the Medical Termination of Pregnancy (MTP) Bill, introduced in 1969 and enacted in 1971. The Act mandates that abortions must be conducted in government-approved facilities (legal Service India, n.d.).

While the MTP Act has helped reduce unsafe abortions, barriers remain for poor and marginalized women. A report by the Centre for Reproductive Rights reveals that India still performs 8,000 unsafe abortions annually (Diamondstein, 2021). Unsafe abortions account for approximately 15,000 maternal deaths annually—about 8.9% of all such deaths. Only 25% of organized-sector abortion clinics are government-owned, with the remainder in the private sector. In Jharkhand, 82% of women are unaware that abortion is legal (Kohli, 2008), and around 190,000 adolescents undergo unsafe abortions without proper medical care, as 78% of procedures occur outside regulated facilities (Seth, 2022).

The healthcare workforce shortage also affects service delivery. There is only one government physician for every 10,189 people, compared to the WHO recommendation of one per 1,000. Only 1,351 obstetricians and gynaecologists serve rural community health centres (Banerjee, 2022). While institutional deliveries increased from 39% in 2005 to 79% in 2015, 21% of births still occur at home (Mishra et al., 2021). The National Rural Health Mission (NRHM), launched in 2005, aims to provide affordable, accessible healthcare in rural areas. Since 1990, India has seen an 83% reduction in maternal mortality, surpassing the global decline of 45% (Ministry of Health & Family Welfare-Government of India, n.d.). The Accredited Social Health Activist (ASHA) program, also part of NRHM, engages over a million trained volunteers to provide maternal care, immunization, and family planning services (Kuldeep, 2025).

The Janani Suraksha Yojana (JSY), also launched in 2005, seeks to reduce maternal and infant mortality by offering financial incentives for institutional deliveries (Pillai, 2024). Despite its reach, disparities persist. Mothers from marginalized backgrounds often face economic and social barriers in accessing hospital care. SC/STs represent 37.6% of JSY beneficiaries, compared to 61.8% from non-SC/ST groups (Mishra, Veerapandian, et al., 2021). The 2015–16 report from the National AIDS Control Organization (NACO) indicates that transgender individuals have the second-highest HIV prevalence among high-risk groups at 8.82%, largely due to systemic discrimination and limited access to healthcare.

In 2013, the Ministry of Health & Family Welfare launched the Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH+N) strategy. It aims to reduce maternal and child mortality through improvements in infrastructure, human resources, and cross-sectoral collaboration (Ministry of Health & Family Welfare-Government of India, n.d.).

6.2 Reproductive Rights of Women

Reproductive rights form a crucial subset of human rights. For robust SRHR outcomes, states must ensure the availability and accessibility of quality public health facilities. However, India's public healthcare system faces significant challenges, including inadequate infrastructure, insufficiently trained personnel, and low investment. Despite improvements, rising costs due to private sector dominance hinder access for the poor and marginalized.

The Indian judiciary has progressively recognized reproductive autonomy as part of personal liberty under Article 21 of the Constitution. In the landmark Puttaswamy judgment, the Supreme Court

upheld a woman's right to make reproductive choices. Similarly, in Suchitra Srivastava v. Chandigarh Administration, the court affirmed a woman's right to bodily autonomy, dignity, privacy, and choice in pregnancy decisions (Mathur, n.d.). The 2017 ruling further recognized health as a fundamental right under Article 21, reaffirming reproductive autonomy and access to abortion. The Surrogacy (Regulation) Bill, 2020 restricts surrogacy to altruistic arrangements for Indian couples, aiming to eliminate exploitation in commercial surrogacy. Meanwhile, the Protection of Children from Sexual Offences (POCSO) Act, 2012 safeguards minor girls' reproductive rights by ensuring legal abortion access in cases of abuse. According to NFHS-5, rural maternal mortality stands at 114 per 100,000 live births, compared to 87 in urban areas. About 20% of rural women lack access to safe abortion and modern contraception. Teenage pregnancies are recorded at 7.1% nationally (rural: 9.3%, urban: 4.2%) (Chandra, 2025). NFHS-3 data shows that 16% of girls aged 15–19 are mothers, and 46% were married before age 18. In Jharkhand, one in four teenage girls is already a parent. Alarmingly, 35% of Indian women report experiencing physical or sexual violence, and 54% believe spousal abuse is justified (Chowdhury, 2021)

Interpretation & Analysis

7.1 The analysis reveals the complex reality of underprivileged women, adolescents, and gender-diverse communities accessing India's reproductive health system through the use of feminist and rights-based lenses;

7.1.1 Policy Intent vs Ground-level realities:

Structural deficits persist despite India's SRHR policy's intention to be inclusive, equity-oriented and rights-based. As Dr. Ritu Priya (Prof, JNU) argues, "health policy in India often gets trapped between technocratic planning and political inaction, leading to a disconnect between community needs and service design." On the brighter side, The National Health Policy 2017, NRHM, and initiatives like RMNCAH+N emphasize accessibility and affordability, however, the darker side paints the picture of implementation gaps and structural loopholes.

7.1.2 Unsafe abortions and Legal illiteracy:

Despite having progressive laws like the Medical Termination of Pregnancy (MTP) Act, India paradoxically leads the world in unsafe abortions. Every year, unsafe abortions result in over 15,000 maternal fatalities, exposing a more serious lack of knowledge and access. The fact that 82% of Jharkhand women did not know that abortion was allowed illustrates both the lack of legal knowledge and the part that sociocultural silence plays in stifling female sexuality. Even in cases where laws are in place, feminist scholars such as Shivani Nag and Flavia Agnes contend that bureaucratic gatekeeping, stigma, and patriarchy prevent women from freely exercising their rights.

7.1.3 The ASHA program

The Accredited Social Health Activists (ASHAs) have significantly contributed to rising institutional deliveries, better immunization coverage, family planning awareness, and early

detection of illnesses like TB and malaria.The model, despite being people-centric, has limitations in the nature of workers having minimal pay, precarious job security, and overwhelming responsibilities. ASHAs are not treated as formal employees but as "volunteers," receiving performance-based incentives instead of fixed wages.

Ravi Duggal notes that "ASHAs have become the backbone of India's public health, yet the state treats their labor as dispensable and voluntary."

7.1.4 Public- Private Divide:

Nowhere is the dichotomy between the public and private sector more evident than in the domain of sexual and reproductive health rights (SRHR) in India. This divide is not just about infrastructure, but also about ideology and priorities. Private sector expansion has not led to equitable health delivery, it has rather made healthcare less affordable, especially in reproductive health domains. The current scenario reflects upon how India's healthcare narrative is increasingly shaped by market logics rather than social justice imperatives.

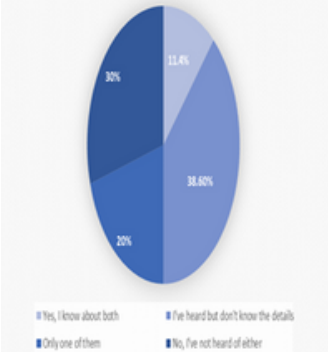
7.2. Thematic Analysis of the Primary Data: "Understanding Access to Sexual and Reproductive Health: A Ground-Level Reality Check" (a questionnaire)

The responses obtained from the structured questionnaire offer vital information about the knowledge levels, lived experiences, and structural obstacles that people, especially women and marginalized groups face when trying to access sexual and reproductive health (SRH) services.

Key demographics: Out of all the primary respondents, a dominant 79.5% fall within the 18–25 age group, indicating that young adults are the primary participants in this survey. The same numerical estimate, i.e. 79.5% is reflected in the gender group analysis wherein women are dominating the survey. More than 90% of the respondents belong to the urban geographical region as opposed to around only 6.8% belonging to the rural. The data showed state diversity with 25% people belonging to Delhi, and the rest from states like Assam (2.3%), Uttar Pradesh (13.6%), West Bengal (18.2%), Punjab (9.1%), etc. 83.7% respondents were un-married or single while the rest were married, showing the dominance of a younger group of individuals.

Theme-1: Awareness of Reproductive Health Rights

As per the questionnaire, while 45.5% of respondents felt 'well-informed' about reproductive health rights, a slightly higher 50% reported being only 'somewhat aware', reflecting limited understanding or incomplete information. A marginal section remained unaware or uncertain about key SRHR terms.



Theme-2: Awareness of Reproductive Health Schemes

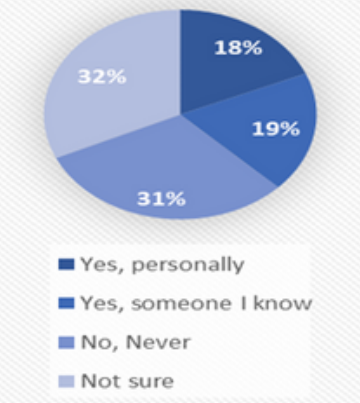
When asked about the awareness of government schemes related to reproductive health like Janani Suraksha Yojana (JSY) or the MTP Act, response statistics are as follows; As is clearly evident from the chart, only 11.4% of respondents demonstrate full awareness, despite the fact that reproductive health programs like the MTP Act and JSY have been in place for years.

A gap between policy and practice is evident in the remaining majority, who are either completely ignorant or only slightly informed. These findings show under-utilization of maternal health schemes among youth and marginalized groups.

Theme-3: Silence and Stigma in conversations on reproductive health

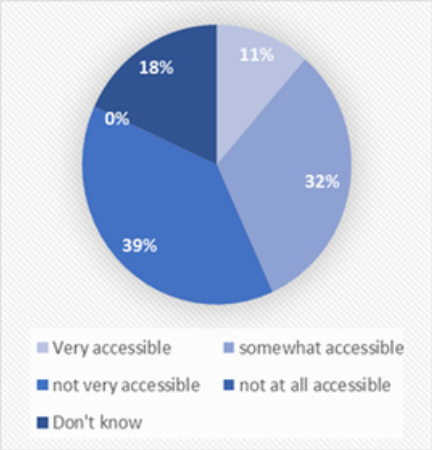
There is overall openness which is emerging but hesitancy still prevails. A combined 56.8% (somewhat + mostly comfortable) shows a moderate shift towards comfort in discussing sexual and reproductive health (SRH). Only 1 in 4 (25%) feel 'Very Comfortable' when talking about such issues. This suggests that a strong psychological or social barrier still exists.

There is dominance of responses in favour of 'somewhat comfortable' (40.9%) indicating social ambivalence. The 'not comfortable' section remains marginalized which portrays a positive picture and emerging confidence.



Theme-4: Judgement in care

A significant minority have personally experienced judgment or awkwardness from healthcare providers. This suggests a breach of medical neutrality and professional decorum in patient care. High "Not Sure" Responses (32%) Signal Ambiguity and Mistrust or a reluctance to report negative experiences due to internalized shame or power dynamics with healthcare providers. Just one-third had a clearly positive experience which suggests that safe and respectful SRH consultation is not a universal norm.



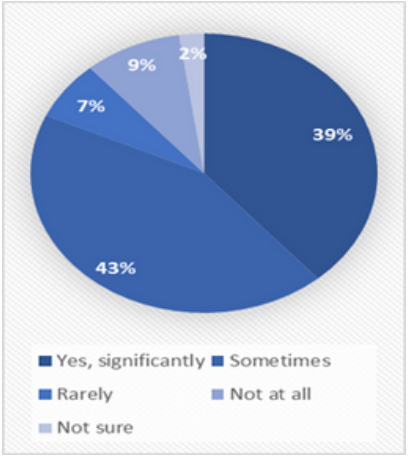
Theme-5: Accessibility of Reproductive health services

The vast majority (70.4%) are classified as "somewhat" or "not very accessible." This suggests inconsistent or unreliable access to public reproductive healthcare services, suggesting that although there may be availability in theory, actual use is hampered by obstacles like stigma, lack of privacy, poor quality, and distance. This small minority (11.4%) reflects a stark gap between public health service provision and lived experience.

While 0% report a complete absence of services, this may point to basic infrastructure being present, but failing in quality, outreach, or cultural acceptability.

Theme-6: Informal gatekeepers

Young people clearly gravitate toward digital spaces because of their simplicity, privacy, and relatability, as seen by the fact that more than 3/4 (77.3%) of them rely on the internet and social media. But there is a chance that this will lead to misinformation. There is a near-Complete Absence of Family as a Source (0%). This reflects upon the lack of openness in Indian families with regards to Sexual and Reproductive Health. It also suggests that the inter-generational transfer is broken probably due to shame or discomfort. The schools and teachers have played a marginal role (11.4%) which exposes a critical policy-practice gap in formal schooling.



Lastly, the fact that none of the respondents identified health professionals as their main source of SRH information is concerning.

Theme-7: Influence of regional and social identities

The majority of the respondents believe that the bias exists (81.8%- combining 'Yes' and 'Sometimes'). This is consistent with research demonstrating that underprivileged groups experience worse treatment, longer wait times, or the denial of respectful medical attention. The fact that so few people (9.1%) deny any discrimination highlights the fact that healthcare equity is still viewed as an ideal rather than a reality.

Certain biases (such as tone, neglect, or language) are subtle or covert, and not all users may notice them right away.

Theme-8: Attitudes Toward Unmarried Women Seeking SRHR Services

Judgement is the Norm: a clear majority (56.8%) believe that women are treated with judgement. This represents ingrained moral and social prejudices in healthcare environments, where the sexual agency of unmarried women is frequently vilified. Barely 1 in 4 respondents think such women will be treated with dignity and support, highlighting a serious trust deficit in the public healthcare system. This also points to fragmented positive experiences.

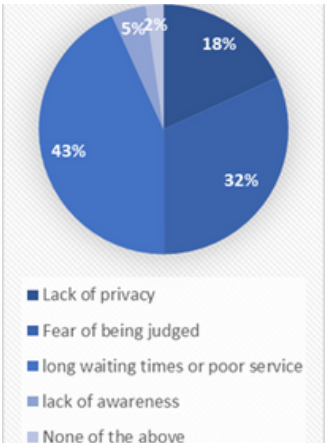
A small segment (6.8%) is unaware of how unmarried women are treated. This indicates social silence around these experiences.

Theme-9: Navigating access of legal abortion

Even in cases where abortion is legal, the absence (0%) of a "very easy" response is concerning since it draws attention to structural inefficiencies or obstacles in obtaining abortion services. While over half the respondents believe it's possible (59.1%), they also acknowledge hurdles such as repeated consultations, judgmental staff, or delays. One-third (34.1%) believe that legal abortion is difficult to obtain in government hospitals, perhaps as a result of a lack of qualified gynecologists and physicians' fear of legal ramifications. Lastly, a tiny but significant minority (6.8%) feels that access to legal abortions in governmental contexts is virtually nonexistent. This impression could result from instances of discrimination by providers, misinterpretations of gestation, or denials based on marital status.

Theme-10: Understanding Deterrents to Public SRHR Services

The largest group (43.2%) points to systemic inefficiencies in the delivery of public healthcare by citing lengthy wait times or subpar service. This reflects structural constraints in the system of service delivery. Almost one out of three (32%) respondents said that healthcare providers' critical views are a hindrance. This is consistent with other research showing that young or single women are deterred from visiting public health facilities by the stigma associated with premarital sex, contraception, and abortion.



Concerns regarding privacy are significant (18.2%)- Particularly in small towns or rural settings where communities are close-knit, women are afraid of being exposed in public waiting areas or having their anonymity violated.

7.3 Stakeholder Mapping

Stakeholder mapping serves as a critical tool to identify, analyze, and engage the diverse actors whose interests, influence, and actions shape the trajectory and outcomes of the research issue at hand.

Stakeholder	Role/ Description	Interest in SRHR	Nuances
Women and adolescent girls	Primary beneficiaries	**High** – seek autonomy, information, and access	Often **silenced by stigma**, caste, age, and marital status; lack of awareness is a key barrier
Healthcare providers (Doctors, ANMs, ASHA workers)	Service delivery frontline	**Medium to High** – dependent on training, norms, incentives	May carry personal/community biases; lack gender-sensitization; but **crucial actors for reform**
Ministry of Health and Family welfare (MoHFW)	olicy-maker and implementer of National Health missions	**High** – responsible for ensuring universal SRHR access	**Key driver of programs** like Family Planning, but often lacks gender-transformative lens

Traditional and Religious Leaders	Custodians of social/gender norms in communities	**Medium**	Often **uphold patriarchal norms** **that restrict access** to contraception, abortion, sexuality education
Civil Society and NGOs	Advocates for rights-based approaches nd community empowerment	**High**	**Bridge the gap** between policy and practice; push for accountability, work on stigma, and build awareness
Judiciary and legal institutions	Enforcers of constitutional rights	**Medium**	**Landmark rulings** (e.g., abortion rights) uphold SRHR; but access to justice remains unequal
Marginalized Sub-groups (LGBTQ+, SC/ST, Disabled, etc.)	Face compounded barriers in access	**High**	Structural exclusion worsens with intersecting identities; **often underrepresented in policymaking**

Policy And Practice Recommendations

Despite all constitutional guarantees and progressive reforms, big gaps still exist between what is promised and what women actually receive. In light of these systemic gaps, it becomes necessary to translate reproductive rights from legal and policy frameworks into accessible, actionable, and accountable services on the ground. The following policy recommendations are organized across three key domains, targeted to move beyond the current failures in implementation and intersectional inequalities:-

8.1 Legal and Institutional Accountability

The intersectional approach, as theorized by Kimberlé Crenshaw, recognized how overlapping identities influence access to rights. (Crenshaw, 1991) Integrating some principles would align Indian policy more closely with the reproductive justice framework which will view reproductive rights not just as access to services but the freedom to make decisions about one's body, family, and future. (Ross & Solinger, 2017) While reproductive health is part of the right to life under Article 21 of the Indian Constitution, it still requires stronger legal backing and better systems to protect these rights in real life (Srivastava v. Chandigarh, 2009).

India should bring a separate reproductive law that specifically protects the reproductive rights of women regardless of a woman's caste, marital status, or background. This law should give women the legal right to decide whether they want to have children, when to have them, and how to manage their fertility. (Nisha Ranjan, 2025) Access rules should be revised under the MTP Act. While the 2021 amendment extended abortion access for some women up to 24 weeks of pregnancy, decisions still heavily depend on doctors. (MTP Act, 2021) The law should trust women to make independent choices without needing multiple medical approvals (except in emergencies). Additionally, it should be made sure that all national laws and policies follow treaties like the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

and the International Covenant on Economic, Social and Cultural Rights (ICESCR) alongwith setting up clear ways to check and fix any violations of maternal and reproductive rights. (UNHRC, 2024) To ensure this, independent monitoring and feedback systems should be set up with teams (including health experts, legal professionals, and members of civil society) at district or state levels that check whether hospitals and Primary Health Centres (PHCs) are following laws and policies related to sexual and reproductive health. The bodily contestation theory emphasizes how women's bodies are sites of social and political control. (Bordo, 1993) Accordingly, policies must shift from provider-centric models to ones that prioritise women's bodily autonomy in order to ensure their right to make informed and independent decisions about contraception, abortion, and maternal care free from any coercion or paternalistic interference. Judicial activism should be encouraged to actively protect sexual and reproductive health (SRH) rights. Public interest litigations (PILs) and past cases can help ensure that marginalized women are not denied essential services. Each state should appoint a dedicated SRH ombudsperson to handle complaints (particularly from adolescents) who seek care without parental consent or face caste-based discrimination in healthcare.

8.2 Health System Strengthening and Service Delivery

According to NFHS-5 (2020–21), only about 56.5% of currently married women (15–49 years) use modern contraceptive methods and knowledge about emergency contraception remains alarmingly low. (IIPS & ICF, 2021) These gaps illustrate the systemic failure to guarantee reproductive agency, especially among young and rural women. To change this:

PHCs (Primary Health Centres) and smaller clinics should be equipped to offer not only pregnancy care, but provide full reproductive services i.e. safe abortion services, contraception, treatment of infections, and health education. (WHO, 2022) Medication abortion (using pills to terminate early pregnancies) should be made available at these centres as it doesn't require advanced tools or hospitalization. For women who can't travel due to distance, cost, or restrictions, healthcare workers should deliver monthly door-to-door check-ups, especially in rural and tribal areas.

Sexual and reproductive health (SRH) should be integrated into the Universal Health Coverage (UHC) agenda through a 'progressive universalism' approach that prioritizes those most at risk, such as young, poor, Dalit, and tribal women, rather than merely extending services uniformly to middle-class populations. (WHO, 2022) Many healthcare providers such as Auxiliary Nurse Midwives (ANMs) or Accredited Social Health Activists (ASHAs) need training to be more empathetic and informed to understand the unique needs of adolescents or Dalit and tribal women. It should include respect for consent, privacy, and non-judgmental care. There should be regular social audits and public meetings to check how well things are working. Civil society groups should be involved in reviewing gaps and making sure SPARSH (Sensitization, Prevention and Redressal of Sexual Harassment) rules are followed in healthcare. (MoHFW, 2021)

Additionally, as seen during the COVID-19 pandemic, sexual and reproductive health services were often stopped. The government should stay prepared during emergencies and treat these as essential services even during crises to prevent more maternal deaths or unwanted pregnancies.

(Ministry of Health, 2020) Most importantly, financial incentives should be directed with enough safeguards to ensure that care remains voluntary and of high quality. The government should allocate dedicated funds to set up adolescent-friendly SRH centers within Primary Health Centres (PHCs) that offer confidential services for menstruation, STIs, contraception, and mental health. To improve access to safe abortion, trained Registered Medical Practitioners (RMPs) at PHC level should be allowed to prescribe Medication Abortion (MA) drugs under the MTP Rules. This step would significantly reduce stigma and eliminate the need for women to travel long distances for basic reproductive care.

8.3 Community Engagement and Rights-Based Education

A key challenge is the normalisation of shame and silence around reproductive health in India particularly among unmarried women and gender minorities. Addressing this requires a cultural shift where bodily autonomy is not perceived as immoral but rather as essential to individual dignity and democracy.

Many women and adolescents do not know their reproductive rights or are afraid to ask for services because of social stigma. Rights-based education should be started by introducing Comprehensive Sexuality Education (CSE) in schools and community learning centres. This means teaching about puberty, consent, menstrual health, contraception, and gender equality in age-appropriate ways which should be available to both girls and boys. (UNESCO, 2024) Awareness campaigns should be introduced in regional languages by using radio, TV, social media, and local public meetings to tell women about their rights under laws like the MTP Act, while also clarifying that unmarried women and rape survivors can legally access abortions. (MoHFW, 2021) Safe spaces should be created to report abuse or denial wherein healthcare centres should put up clear information about complaint systems in local languages. If a woman is denied care or treated badly, she should know whom to contact and how to get help.

Rather than being utopian visions, these policies are doable within the infrastructure already available. For instance, expanding medication abortion pills is low-cost and can be done at the PHC level. District health offices already run monitoring visits which can be improved to focus on rights and treatment quality. Training and awareness programs already exist and they only need to include topics like consent, discrimination and inequality. (WHO, 2022) By focusing on real-life challenges, these suggestions help bridge the gap between paper policies and women's actual experiences. Most importantly, they make bodily autonomy and dignity a real part of India’s public health system and not just legal promises.

Limitation and Implementation Challenges - While the proposed reforms are based on systems that already exist, putting them into action will need strong political support, enough funding, and better training, especially in rural areas where the health system is already stretched. Additionally, any changes in the law must take into account the possibility of social and cultural resistance. This is the reason it is equally important to invest in spreading awareness, educating people about their rights and involving communities in the process.

Conclusion

This paper investigates critically the ongoing discrepancy in the execution of India's reproductive health policies at the local level. Systemic barriers based on caste, class, gender, and geography still affect marginalized groups, especially Dalit, tribal women, and adolescents, even in the face of progressive legal frameworks like the Medical Termination of Pregnancy (MTP) Act and programs like Janani Suraksha Yojana (JSY). In India, health policy frequently "gets trapped between technocratic planning and political inaction," as Dr. Ritu Priya points out, leading to inefficient service delivery. The authors point out that unsafe abortions continue to be a serious problem, contributing to over 15,000 maternal fatalities every year, primarily as a result of stigma and legal illiteracy (Shivani Nag & Flavia Agnes).

The study highlights the disparity between public and private sectors in reproductive healthcare, where social justice is subordinated to market-driven goals, resulting in unequal access. The results of primary surveys show a general lack of knowledge of schemes, prejudice against unmarried women, and obstacles such provider bias and privacy concerns.

To close the gap between policy and practice, it is suggested that rights-based education, institutional reforms, and enhanced legal responsibility be taken up. A case for a change toward empowering women's bodily autonomy, comprehensive sexuality education, and sensitive healthcare delivery, citing Kimberlé Crenshaw's intersectionality paradigm, is made. In order to ensure that everyone has meaningful access to sexual and reproductive health rights, the paper advocates for a comprehensive, inclusive strategy.

References

Ajaz, M., & Dar, M. A. (2024). Reproductive rights in India: A comprehensive analysis of laws and policies. International Journal of Legal Science and Innovation, 6(3), 379–396. https://ijlsi.com/wp-content/uploads/Reproductive-Rights-in-India-A-Comprehensive-Analysis-of-Laws-and-Policies.pdf

Ghose, A., Inamdar, P., & Bagchi, P. (2022). Reproductive health of women in India: A sociological and legal overview. International Journal of Health Sciences, 6(S4), 11917–11927. https://sciencescholar.us/journal/index.php/ijhs/article/download/11422/8689/8804

Sharma, S. (2015). Reproductive rights and women's health in India: A new prospective. Indian Socio-Legal Journal. 4. Sen, G., & Govender, V. (2015). Sexual and reproductive health and rights in changing health systems. Global Public Health, 10(2), 228–242. https://ir.nbu.ac.in/server/api/core/bitstreams/b025783d-a063-43c5-8371-25d483c58db1/content

Sen, G., & Govender, V. (2015). Sexual and reproductive health and rights in changing health systems. Global Public Health, 10(2), 228–242. https://idl-bnc-idrc.dspacedirect.org/server/api/core/bitstreams/9305fcd0-d04a-4fd4-9643-8360487cc134/content

Das, S. (2025). Reproductive health rights of women in India. Journal of Emerging Technologies and Innovative Research (JETIR), 12(3), 495–500. https://www.jetir.org/papers/556835.pdf

World Health Organization. (2023). Achieving gender equality and sexual and reproductive health and rights (SRHR). In HRP annual report 2022. World Health Organization. https://www.jstor.org/stable/resrep56762.13

Ministry of Health and Family Welfare (MoHFW), Government of India. (2017). National Health Policy 2017. [https://main.mohfw.gov.in]

Banerjee, A. (2022). All India Rural Health Statistics 2021–22.[Ministry of Health and Family Welfare]

Duggal, R. (2014). "The Political Economy of Health Care in India: Toward a Rights-Based Approach". Social Scientist, 42(11–12), 17–25.

Seth, A. (April 28, 2022). Sexual and Reproductive Health Rights (SRHR) in India. The Times of India. [https://timesofindia.indiatimes.com/blogs/nonpartisan-perspectives/sexual-and-reproductive-health-rights-srhr-in-india-part-1/]

UNFPA India. (10 July 2025). An Analysis of Sexual and Reproductive Health Inequities in India: Big Push to Leave No One Behind. [https://india.unfpa.org/en/publications/analysis-sexual-and-reproductive-health-inequities-india-big-push-leave-no-one-behind]

Banerjee, S. (2022, November 9). Battleground Body: Sexism and the right to safe abortions in

India. https://science.thewire.in/health/safe-abortion-access-sexism/

Chowdhury, Dr. (2021). REPRODUCTIVE RIGHTS OF THE INDIAN WOMEN: AN ANALYSIS. In Women's Rights are Human Rights: Role of Non-State Actors. Patna Women's College Publications.

Dahiya, H. (2018). NATIONAL HEALTH POLICY OF INDIA. International Journal of Recent Scientific Research, 9(7(B)), 27842–27844.

Diamondstein, M. (2021, September 27). Abortion in India: Report reveals widespread legal barriers and recommends ways to improve access. Center for Reproductive Rights. [https://reproductiverights.org/report-barriers-india-abortion-access/#:~:text=A%20recent%20fact-finding%20report%20by%20the%20Center%20for,account%20for%208-10%25%20of%20maternal%20deaths%20in%20India]

Ghose, A., Inamdar, P., & Bagchi, P. (2022). Reproductive health of women in India. International Journal of Health Sciences, 11917–11927.

Kohli, N. (2008, August 9). Most unsafe abortions in India | Latest News India - Hindustan Times. Hindustan Times. [https://www.hindustantimes.com/india/most-unsafe-abortions-in-india/story-UhtYsSeiNpCwMaO4TO3pjI.html?]

Kuldeep. (2025, March 12). ASHA: Inspiring change in rural healthcare in India. Raj Medical. [https://rajmedical.co.in/accredited-social-health-activist-asha/]

Mishra, P. S., Kumar, P., & Srivastava, S. (2021). Regional inequality in the Janani Suraksha Yojana coverage in India: a geo-spatial analysis. International Journal for Equity in Health, 20(1). https://doi.org/10.1186/s12939-020-01366-2

Mishra, P. S., Veerapandian, K., & Choudhary, P. K. (2021). Impact of socio-economic inequity in access to maternal health benefits in India: Evidence from Janani Suraksha Yojana using NFHS data. PLoS ONE, 16(3), e0247935. https://doi.org/10.1371/journal.pone.0247935

Narang, M. (2024). Reclaiming Rights: Analysis of sexual and reproductive health rights from global and Indian perspectives. INTERNATIONAL JOURNAL OF HUMAN RIGHTS LAW REVIEW, 3(6), 53–59.

Pillai, N. (2024, July 1). Janani Suraksha Yojana Scheme – Eligibility, Benefits & More. Impact Guru. [https://www.impactguru.com/info/janani-suraksha-yojana-jsy/]

Release of SDG India Index 2023-24. (n.d.). [https://www.pib.gov.in/PressReleaseIframePage.aspx?PRID=2032857]

Seth, A. (2022a, April 28). Sexual and Reproductive Health Rights (SRHR) in India [Part 1]. Times of India Voices. [https://timesofindia.indiatimes.com/blogs/nonpartisan-perspectives/sexual-and-reproductive-health-rights-srhr-in-india-part-1/]

Chatterjee, S. (2020). Reproductive justice in India: A review of policies and practices. Indian Journal of Gender Studies, 27(2), 231–250.

Deshpande, M. (2022). Caste, class and reproductive health: Examining intersectional inequalities in India. Economic & Political Weekly, 57(12), 40–47.

Kumar, R., & Rai, P. (2021). Healthcare provider bias and its impact on reproductive health services in rural India. Social Science & Medicine, 289, 114373.

Ministry of Health and Family Welfare. (2021). The Medical Termination of Pregnancy (Amendment) Act, 2021. Government of India.

Raj, A., Dasgupta, A., Silverman, J. G., & Gupta, J. (2023). Addressing health-system barriers to reproductive autonomy for Dalit and tribal women in India. The Lancet Global Health, 11(5), e622–e630.

United Nations Population Fund. (2022). State of world population 2022: Seeing the unseen.