AMERICAN JOURNAL OF YOUTH AND WOMEN EMPOWERMENT (AJYWE)

ISSN: 2835-3250 (ONLINE)

VOLUME 5 ISSUE 1 (2026)

PUBLISHED BY
E-PALLI PUBLISHERS, DELAWARE, USA

American Journal of Youth and Women Empowerment (AJYWE)

Volume 5 Issue 1, Year 2026
ISSN: 2835-3250 (Online)
DOI: https://doi.org/10.54536/ajywe.v5i1.8075
https://journals.e-palli.com/home/index.php/ajywe

Spatial Inequalities in Reproductive Healthcare Access and Women's Bodily Autonomy in India

Seema Mehra Parihar[1*], Mohammed Baber Ali[1], Deepak Dhaked[1], Yuvraj Singh Sikarwar[1], Vyom Sharma[1]

Article Information

Received: April 19, 2026
Accepted: July 01, 2026
Published: June 30, 2026

Keywords

Bodily Autonomy, Family Planning, Government Policy, India, Institutional Delivery, Maternal Health, Nfhs, Regional Disparities, Reproductive Healthcare, Women's Empowerment

ABSTRACT

Reproductive health services and bodily autonomy represent two closely related domains which play a significant role in the determination of health conditions and gender relations within the Indian society. In this context, the purpose of the paper is to explore the situation with reproductive health in India and critically evaluate the impact of government policies on women's bodily autonomy. Based on the findings revealed in the documents prepared by recognized sources (WHO, UNFPA, NITI Aayog, Ministry of Health and Family Welfare, the World Bank, and other academic publications), this paper will take a descriptive-analytical approach to consider the main indicators of reproductive health in various Indian states. The questions which will be examined in this paper include: (i) trends in using maternity services (antenatal, delivery, and postpartum care); (ii) the role of key programs implemented by the government (National Health Mission, Janani Suraksha Yojana, Pradhan Mantri Surakshit Matritva Abhiyan, and Medical Termination of Pregnancy Act); (iii) the correlation between access to medical help and decision-making opportunities; and (iv) differences in reproductive health among the best performing and the worst performing areas of India. Another important observation is the marked increase in the proportion of institutional deliveries from 39% in NFHS-3 to 89% in NFHS-5 and up to 90.6% in NFHS-6, along with the increase in the percentage of four or more antenatal visits from 51% to 59% in the transition from NFHS-4 to NFHS-5 and further to approximately 72% in NFHS-6. It is also true that there are some structural disparities, as states like Bihar and Nagaland lag behind states such as Kerala and Tamil Nadu in almost all reproductive health parameters. Moreover, 71% of currently married women in NFHS-5 have a voice in decision-making when it comes to healthcare matters, which is the stark reality of patriarchy and its influence on bodily autonomy. Thus, it can safely be said that there is an immediate need for qualitative changes in bodily autonomy despite the various efforts made by government policies.

INTRODUCTION

Reproductive Healthcare

Reproductive health encompasses the full range of interventions related to the health status, function, and wellbeing of individuals in all the phases of life cycle. Reproductive health, as stated by the International Conference on Population and Development (ICPD, 1994) is defined as the state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. (United Nations Population Fund [UNFPA], 1994). This new concept of shifting focus from population dynamics to the right to reproductive health plays an important role in understanding reproductive health care.

Reproductive healthcare is essential for two major reasons: first, as a health determinant, and second, as an indicator of social equity. Antenatal care, institutional deliveries, family planning and post abortion care are some of the major contributing factors in decreasing maternal mortality, safe pregnancy and neonatal status. In 2018-20 in India, MMR (Maternal Mortality Rate) stood at around 97 per 100,000 live births, according to the Sample Registration System (SRS). However, it has been reported that MMR for 2019-21 was 93 per 100,000 live births. (Registrar General of India, 2022).

Bodily Autonomy: Concept and Significance

Bodily autonomy pertains to people's rights to make voluntary, well-informed decisions regarding matters related to fertility, sexual and reproductive health, pregnancy, and healthcare access (UNFPA, 2021). It is a fundamental human right that is recognized through various international human rights instruments, such as the Universal Declaration of Human Rights (1948), CEDAW (1979), and Beijing Platform for Action (1995). The latest UNFPA report, titled State of World Population 2021, clearly defined the concept of bodily autonomy as follows: "the power and agency to make choices about one's body without fear, violence, or coercion" (UNFPA, 2021, p. 1).

In India, bodily autonomy is highly contingent upon several interlinking factors of gender, caste, class, religion, and geography. Decisions concerning timing of childbirth, number of children to be conceived and with whom, accessing medical facilities independently, and avoiding any unwarranted intervention remain severely compromised for women due to patriarchy within

[1] Kirori Mal College, University of Delhi, India
[*] Corresponding author's e-mail: smparihar@kmc.du.ac.in

households, financial dependence on male relatives, and societal belief in men being responsible for family planning decisions, not their wives. NFHS-5 survey findings show that around 71% of married women exercise complete control or share decision-making responsibility regarding their own health care services either independently or with their husbands (IIPS & ICF, 2021).

Global Perspective: ICPD, WHO, and the SDGs

The connection between reproductive rights and the results of the process of development has received worldwide acknowledgment, especially after the adoption of the ICPD Programme of Action, formulated by the International Conference on Population and Development (ICPD), which was held in Cairo in 1994. As argued by the World Health Organisation (WHO), universal access to reproductive health is essential in achieving the highest attainable level of health (WHO, 2017). Furthermore, the contemporary Sustainable Development Goal 3, which targets 'Ensure healthy lives and promote well-being for all at all ages' and SDG 5, aiming at 'Achieve gender equality and empower all women and girls' include the aspect of reproductive health within the framework of development agendas (United Nations, 2015). In other words, SDG 3.1 targets reducing the global maternal mortality ratio to less than 70 per 100,000 live births and SDG 3.7 envisions universal access to sexual and reproductive health care services and family planning. India, being one of the signatories of both agreements, has obligations concerning reducing maternal mortality and increasing reproductive rights.

Aim and Objectives

Research Aim

The main objective of the current study is to examine the correlation between the provision of reproductive health services and the issue of women's bodily autonomy in India, focusing specifically on the impact of policies adopted by the government as well as the disparities that exist in various regions, using NFHS-5 (2019-21) and NFHS-6 (2023-24).

Research Objectives

- To analyze the trends of important reproductive health care indicators like antenatal care, institutional deliveries, family planning services, and postnatal care between NFHS-4 (2015-16) and NFHS-6 (2023-24) at the country and state level.
- To conduct a critical analysis of how various government schemes and policies have worked regarding reproductive health care and body autonomy of women.
- To explore the factors behind regional differences in relation to reproductive healthcare and decision-making powers of women in Indian states.
- To analyze the extent of body autonomy exercised by women while taking decisions related to their reproductive health.
- To make recommendations based on the evidence available for improving reproductive health care and ensuring body autonomy of women in India.

LITERATURE REVIEW

This discussion is organized in a thematic format to present some of the seminal works that have been published on the topic within each of the five central themes: reproductive rights, reproductive health, empowerment of women, government initiatives, and regional disparities. This paper concludes with an important area of research that needs attention.

The core concepts of reproductive rights were elaborated on in the ICPD Programme of Action (UNFPA, 1994). According to the Programme, reproductive health is about having a satisfactory and safe sexual life, ability to procreate, and control over decisions regarding if, when and how frequently one wants to procreate. The authors of the groundbreaking study on reproductive rights and health and human rights, Cook and Dickens (2003), stated that denying individuals access to reproductive services was a form of discrimination and abuse of women's right to health protected internationally. Subsequently, the reproductive health strategy of the World Health Organization (2004) identified universal access to reproductive care as a necessary condition for health equity.

Building upon these premises, Cottingham, Germain, and Hunt (2012) emphasized the existence of a gap between international commitments and the implementation of such rights nationally, especially in developing countries. It was argued that reproductive rights were routinely violated due to institutional inefficiency, poor financing, and the existence of coercion in the context of population policies, an issue that is relevant to India in particular.

There are numerous examples of the link between women's empowerment and the reproductive health effects in the development literature. For instance, Jejeebhoy (1995) found that female literacy is significantly associated with positive health behaviors, delayed marriage, and reduced fertility in South Asia. Kishor (2000) used DHS data to demonstrate that women's empowerment in terms of decision-making, mobility, and resource control predicts better access to maternal healthcare in India.

Malhotra and Schuler (2005) proposed a complex, multidimensional definition of women's empowerment involving such aspects as economic, social, familial, legal, and psychological components while warning against simplistic definitions. Mosedale (2005) maintained that empowerment should be understood in relational terms: it is more than individual capabilities; it is a power shift on different levels, including households, communities, and institutions. This point is important since it explains why increased health capacity does not guarantee bodily autonomy.

Finally, UNFPA's latest study on the state of world population (2021) provides a comprehensive analysis of women's bodily autonomy today, concluding that only in 57 countries do women have the full authority over

their reproductive decisions, with bodily autonomy being highest in countries featuring strong gender equality, educational, and legal regimes.

The National Family Health Surveys (NFHS), which started in 1992-93 by IIPS and were being conducted in collaboration with ICF and the Ministry of Health and Family Welfare of India, have become the main source of evidence-based studies about reproductive health in India. Dyson & Moore (1983) discovered that there was a north-south divide in terms of women's autonomy within Indian society, with the southern states having more autonomous women due to differences in kinship and inheritance systems – a finding repeated in all subsequent NFHS surveys.

In their analysis of NFHS-4 data, Bhattacharyya, Rana & Bhattacharyya (2015) pointed to the existing differences in maternal health service provision in EAG and southern states, with the former lagging behind the latter owing to problems with the supply side of healthcare services (infrastructure, professionals) as well as issues on the demand side (literacy, mobility, autonomy). In a systematic review of literature about maternal health in India, Nair *et al.* (2012) noted that JSY was able to improve facility delivery rates in India.

The reproductive health policy after India gained its freedom saw changes from the coercive demographic control approach, which involved mass sterilization operations between 1975 and 1977 during the Emergency period, to a rights-based framework, partly influenced by ICPD commitments (Visaria, 2000). With the introduction of the NRHM (now NHM), India witnessed the largest structural change in public health since the country's independence in the form of over one million ASHAs used to address the community-health systems gap (MoHFW, 2005).

Lim *et al.*'s (2010) evaluation of the impact of the Janani Suraksha Yojana in The Lancet showed that the programme had succeeded in increasing deliveries in institutions; however, there were major problems with the quality of services provided, such as missing components of antenatal care and high caesarian delivery in private health institutions for no medical reason. Randive *et al.* (2013) concluded that although JSY had the biggest effect on poor states like those included in EAG, the move to institutional delivery did not go hand in hand with better obstetric emergencies services provision.

The extension of the MTP Act's gestation period from 20 to 24 weeks for certain groups of women, in 2021, has been hailed by many as a positive step in favor of reproductive rights; yet, several challenges have been pointed out that hindered women's access to such reproductive health care (Berer, 2019).

The geography of reproductive healthcare in India exhibits a structural divide. As per Dreze and Sen's (2013) famous study on development failures in India, the so-called BIMARU states (Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh) are symbolic of the development failure, characterised by economic progress without corresponding progress in human well-being. According to Pathak and Singh (2011), the women in BIMARU states are disadvantaged owing to their lower education levels, higher levels of early marriages, lower contraception usage rates, and weak decision-making powers in their households.

Subramanian, Nandy, Irving, and Davey Smith (2006) have undertaken multilevel analyses using DHS data and found that clustering of poor maternal health outcomes is not merely due to personal factors, but it has roots at the community and state level. Furthermore, Gillespie, Kadiyala, and Greener (2007) argued that health disparities in India were growing instead of shrinking due to economic growth favouring privileged communities only.

MATERIALS AND METHODS

Research Design

This study employs a descriptive-analytical research design based entirely on secondary data. The approach is documentary and comparative, systematically synthesizing nationally representative survey data, government policy documents, and peer-reviewed academic literature to analyze trends in reproductive healthcare and their relationship with women's bodily autonomy across Indian states. No primary data collection was undertaken.

Data Sources

The primary data sources are the National Family Health Surveys (NFHS) conducted by the International Institute for Population Sciences (IIPS) in collaboration with ICF International and the Ministry of Health and Family Welfare (MoHFW), Government of India, across three rounds:

- NFHS-4 (2015–16): Baseline for trend analysis.
- NFHS-5 (2019–21): Core dataset providing state-level disaggregated reproductive health and autonomy indicators.
- NFHS-6 (2023–24): Most recent national estimates for assessing recent progress.

Secondary sources include reports from WHO, UNFPA, NITI Aayog, the Registrar General of India (Sample Registration System), the World Bank, and MoHFW. Peer-reviewed literature was accessed via PubMed, Google Scholar, and JSTOR.

Variables and Indicators

The study examines indicators across four categories: (i) Maternal healthcare i.e. MMR, ANC visits (at least one; four or more), skilled birth attendance, institutional delivery rates, and caesarean section rates; (ii) Family planning i.e. contraceptive prevalence rate, unmet need, method mix, and TFR; (iii) Bodily autonomy i.e. women's participation in household and healthcare decision-making, attitudes toward domestic violence, and menstrual hygiene access; and (iv) Regional disparities i.e. state-level data disaggregated by EAG and non-EAG classification.

Analytical Framework

Data were analyzed descriptively using comparative statistics across NFHS rounds and across states to identify temporal trends and spatial disparities. The analytical framework is grounded in the rights-based approach to reproductive health as articulated in the ICPD Programme of Action (UNFPA, 1994) and WHO's reproductive health strategy. Policy evaluation assesses each government programme against the dual criteria of healthcare access improvement and promotion of women's agency and bodily autonomy. State-level data from NFHS-5 are presented in a comparative matrix (Table 1) covering 36 states and Union Territories, disaggregating EAG from non-EAG states. Spatial patterns are visualized through choropleth maps (Figures 1 and 2) generated from NFHS-5 state fact sheets using geographic information systems.

Scope and Limitations

The study covers the period from NFHS-4 through NFHS-6 (2015–2024) at national and state levels. Limitations include reliance on self-reported survey data (subject to recall bias), potential undercoverage in hard-to-reach populations, and the partial availability of NFHS-6 disaggregated microdata at the time of writing, with national-level estimates used for NFHS-6 where state-level data are unavailable.

RESULTS AND DISCUSSION

Reproductive Healthcare and Bodily Autonomy in India

Maternal Healthcare

India has achieved significant success, albeit with inconsistencies, in terms of maternal healthcare provision during the last three decades. While the Maternal Mortality Rate in India was calculated at 254 deaths per 100,000 live births between 2004 and 2006, it decreased to 97 deaths per 100,000 live births in 2018–2020, followed by a further reduction to 93 deaths per 100,000 live births in 2019-2021 (Registrar General of India, 2022). These trends have been facilitated through cumulative investments in healthcare infrastructures, staffing, financial security programs, and community outreach efforts. However, India contributes to around 8%-9% of all maternal deaths worldwide (WHO, 2023).

Antenatal Care

ANC is the main interface between the health sector and pregnant women and plays a critical role not only in shaping delivery service utilization but also in birth outcomes. There was an increase in the rate of utilizing at least one ANC visit from 84% in NFHS-4 to 94% in NFHS-5 and about 95% in NFHS-6 (IIPS & ICF, 2021; IIPS, 2026). On the other hand, the more stringent criterion of four or more ANC visits as per the WHO recommendation paints a less optimistic picture since it was met by only 59% of women in NFHS-5 compared to 51% in NFHS-4, while NFHS-6 shows that almost 65.2% reached this mark nationwide.

Content-wise, ANC visits are also important in improving the quality of care. Even though all surveyed women received ANC that involved measuring their weight (97%), blood pressure testing (96%), and blood and urine tests (94%), a mere 44% took iron and folic acid supplements for 100 days or more, and only 31% received treatment against intestinal parasites (IIPS & ICF, 2021). These shortcomings have serious implications for anaemia prevention and maternal nutrition, two areas where India underperforms.

However, disparities still persist between the urban and rural settings: In NFHS-5, 69% of urban women had four or more ANC visits, whereas only 55% of women from rural areas had done the same (IIPS & ICF, 2021). Also, of the lowest wealth quintile, only 72% got ANC from a skilled attendant.

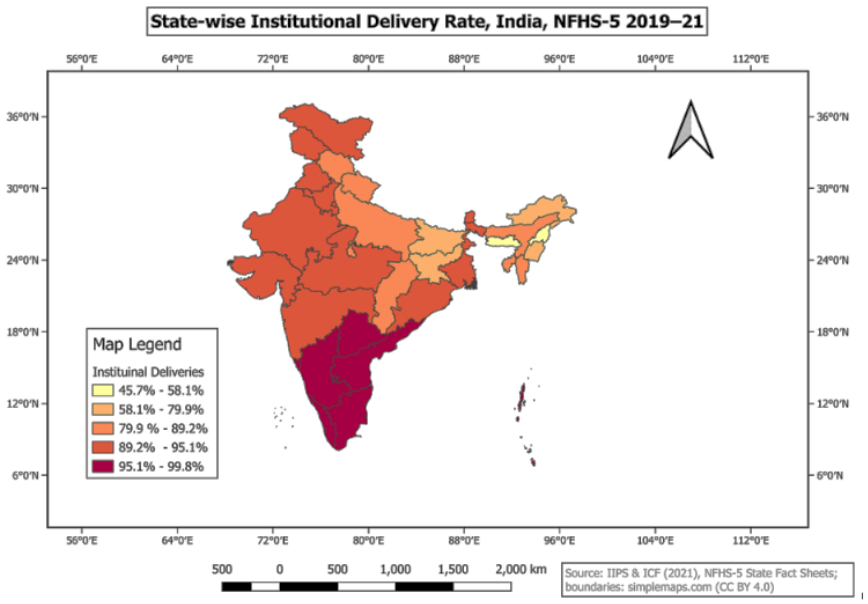

Figure 1: State-wise Institutional Delivery Rate, India, NFHS-5 (2019–21) Source: IIPS & ICF (2021), NFHS-5 State Fact Sheets; boundaries: simplemaps.com (CC BY 4.0)

Institutional Deliveries

The primary maternal health care indicator in Indian policy making, which is institutional delivery, witnessed tremendous progress from 39% in NFHS-3 (2005-06) to 79% in NFHS-4 (2015-16) and 89% in NFHS-5 (2019-21), with NFHS-6 showing an advancement to about 90.6% at the national level (IIPS & ICF, 2021; IIPS, 2026). First births are much more prone to institutional deliveries (94%) compared to sixth order or higher birth orders (64%). The likelihood of occurrence of urban births in health institutions is much higher (94%) than rural births (87%).

The education gap is particularly wide. The likelihood of an institutional delivery among mothers with 12 or more years of education stands at 97%, while among mothers without any education, the corresponding figure is 75% (IIPS & ICF, 2021). Likewise, the wealth gap is equally large, with the richest quintile registering 97% of institutional deliveries compared to the poorest quintile at 76%. While states such as Puducherry, Goa, Kerala, Lakshadweep, and Tamil Nadu register almost universal institutional delivery (almost 100%), Nagaland and Meghalaya stand at 46% and 58% respectively in NFHS-5.

In NFHS-5, the caesarean section rate has increased to 22%, as compared to 17% in NFHS-4, with a wide disparity in the public and private sectors, at 14% and 48%, respectively. The increase in caesarean births is a source of worry due to the possible non-medical reasons for caesareans and informed consent (IIPS & ICF, 2021; Johanson, Newburn, & Macfarlane, 2002).

Family Planning and Unmet Need

Family planning emerges as an essential component of reproductive health care and personal autonomy. Among currently married women, 66.7% were using any contraceptive method (any modern methods: 56.5%), and the unmet need for family planning was 9.4% in NFHS-5 (IIPS & ICF, 2021). As per the NFHS-6 estimates, this situation has improved with the total percentage of using any contraceptive method reaching almost 70%, while the unmet need has reduced to around 8.5%. Female sterilization continues to dominate (37.9% in NFHS-5) as the most preferred method, emphasizing the continuing gender disparity in bearing contraception-related risks and the question of voluntarism regarding sterilization.

Regarding the total fertility rate (TFR), it decreased from 2.2 to 2.0, which marks the first time in the history of Indian demographics that the rate falls below the replacement level; however, all EAG states have TFR greater than 2.5.

Women's Role in Healthcare Decision-Making

One of the clearest indicators of bodily autonomy as per NFHS is the proportion of women's participation in household decisions. According to NFHS-5, 71 percent of currently married women are involved in decisions regarding their health care, major purchases for the household and visiting family members, individually or in collaboration with their husbands; 11 percent are

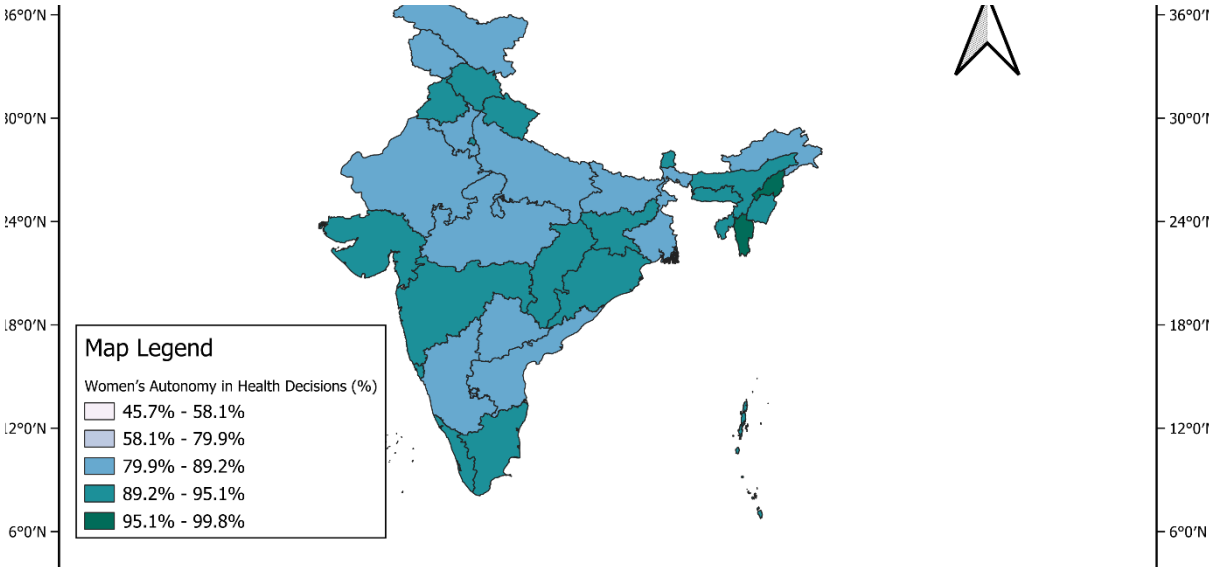

Figure 2: Women's Autonomy in Health Decision-Making, India, NFHS-5 (2019–21) Source: IIPS & ICF (2021), NFHS-5 State Fact Sheets; boundaries: simplemaps.com (CC BY 4.0)

involved in none of these decisions (IIPS & ICF, 2021). As far as individual involvement in healthcare decisions is concerned, 81 percent women are participating in such decisions, which is six percentage points more as compared to the 75 percent recorded during NFHS-4.

There are some critical limitations with regard to the way women participate in household decisions. Out of 81 percent women participating in decisions about their healthcare, 10 percent do it on their own, whereas 71 percent do it together with their husbands. In contrast to this, 33 percent men take decisions regarding their health on their own (IIPS & ICF, 2021). These figures indicate the presence of negotiation in the decisions instead of autonomy in women's actions. Furthermore, NFHS-5 shows that 45 percent of women and 44 percent of men believe in at least one reason justifying wife-beating.

Government Policies and Their Impact

India's reproductive health policy landscape has undergone significant evolution since the 1950s, transitioning from a coercive demographic control framework to a rights-based approach informed by ICPD commitments. This section critically evaluates the major policies and schemes

Table 1: Selected Reproductive Health Indicators Across Indian States — NFHS-5 (2019–21)

State/UT	Institutional Births (%)	Women's Participation in Healthcare (%)	EAG
Andaman & Nicobar Islands	99.0	94.5	No
Andhra Pradesh	96.5	84.1	No
Arunachal Pradesh	79.2	87.0	No
Assam	84.1	92.1	No
Bihar	76.2	86.5	Yes
Chandigarh	96.9	94.6	No
Chhattisgarh	85.7	92.7	Yes
Dadra & Nagar Haveli and Daman & Diu	96.5	91.9	No
Goa	99.7	93.1	No
Gujarat	94.3	92.2	No
Haryana	94.9	87.5	No
Himachal Pradesh	88.2	93.9	No
Jammu & Kashmir	92.4	81.6	No
Jharkhand	75.8	91.0	Yes
Karnataka	97.0	82.7	No
Kerala	99.8	94.1	No
Ladakh	95.1	80.4	No
Lakshadweep	99.6	92.2	No
Madhya Pradesh	90.7	86.0	Yes
Maharashtra	94.7	89.8	No
Manipur	79.9	94.8	No
Meghalaya	58.1	92.3	No
Mizoram	85.8	98.8	No
NCT Delhi	91.8	92.0	No
Nagaland	45.7	99.2	No
Odisha	92.2	90.2	Yes
Puducherry	99.6	97.9	No
Punjab	94.3	91.4	No
Rajasthan	94.9	87.7	Yes
Sikkim	94.7	89.7	No
Tamil Nadu	99.6	92.8	No
Telangana	97.0	87.2	No
Tripura	89.2	90.9	No
Uttar Pradesh	83.4	87.6	Yes
Uttarakhand	83.2	91.0	Yes
West Bengal	91.7	88.9	No

Source: IIPS & ICF (2021). National Family Health Survey (NFHS-5), 2019–21: India.

currently in operation.

National Health Mission (NHM)

The National Health Mission, introduced in 2005 under the name of the National Rural Health Mission and extended in 2013 to include the National Urban Health Mission, is the comprehensive programming strategy designed to improve the public health care system in India. One aspect of this mission that relates to reproductive and maternal health care is the reproductive and maternal health programme, known as RMNCH+A (Reproductive, Maternal, Newborn, Child and Adolescent Health) Programme.

According to the author's analysis, the greatest success story associated with the implementation of the NHM is the mobilization of almost 1.04 million Accredited Social Health Activists (ASHA) – female community-based health workers whose job is to act as intermediaries between local families and the health care system. These women are responsible for the proper registration for ANC, counselling for deliveries in institutions, payment of JSY benefits, transportation to and post-delivery follow-ups at healthcare facilities. The effectiveness of such intermediaries has been confirmed in several evaluations (Bhattacharyya *et al.*, 2019). Nevertheless, it should be noted that ASHAs are not officially employed by the government and earn through incentive payments only.

Janani Suraksha Yojana (JSY)

Introduced in 2005 by NHM, JSY is a Conditional Cash Transfer Programme, which gives incentives to women during pregnancy, especially those belonging to households below the poverty line, to give birth in institutions. The incentives provided vary from Rs. 700 to Rs. 1,400 for women giving birth in rural settings in Low Performing States. ASHAs get incentives for making JSY transactions.

The effects of JSY on the number of institutional deliveries have been documented in many studies and are generally positive: according to Lim *et al.* (2010), JSY contributed substantially to the rise in the number of births taking place in institutions between 2005 and 2009, and the biggest rises were observed among the poorest quintiles. NFHS reports show a substantial rise in the number of institutional deliveries. On the other hand, JSY has been severely criticized based on the issues of quality and autonomy. Firstly, the monetary reward system could encourage women to undergo facility births without considering quality since Randive, Diwan, and De Costa (2013) have reported incidents where women have undergone births at poorly-equipped facilities that lack proper healthcare personnel. Secondly, the financial motivation system might influence the women's reproductive choices in terms of whether the facility deliveries would be made based on proper assessment of risk or simply to receive the cash reward. Lastly, unnecessary caesarean sections performed in private hospitals, where JSY money is used, infringe on people's body autonomy (Johanson, Newburn, & Macfarlane, 2002).

Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)

PMSMA, which came into operation in 2016, ensures free, guaranteed and comprehensive ANC services to be delivered on the 9th day of each month by obstetrician/gynaecologists in government health clinics. PMSMA is intended for high-risk pregnant women, especially those who might not have benefitted from regular ANC due to poor coverage in rural regions.

This programme has been instrumental in improving the quality of ANC content provided to women in India, in particular identifying high-risk pregnancy cases (pregnancy-induced hypertension, gestational diabetes, severe anaemia), where specialised services are required. This programme aims at filling the gap detected by the NFHS in ANC content despite high ANC coverage. Importantly, unlike other programmes discussed above, PMSMA takes a voluntaristic approach guaranteeing women's rights to health services without linking incentives to them (MoHFW, 2016).

The programme suffers from uneven service delivery quality in different states, irregular accessibility of specialist obstetricians, especially in rural and remote areas, and lack of community awareness.

Mission Parivar Vikas

The Mission Parivar Vikas (MPV), initiated in 2016, focuses on the 146 high fertility districts spread across 7 states (UP, Bihar, Rajasthan, MP, Chhattisgarh, Jharkhand, and Assam), which have an above average TFR of more than 3.0. The main objective of the mission is to enhance the uptake of family planning services through 'basket of choice' approach, contraceptive social marketing, and demand generation programs (MoHFW, 2016).

While the shift to reversible methods, such as injectables, IUDs, and condoms in addition to female sterilization by the mission, marks an important move towards increasing options for women, there are apprehensions amongst scholars about the nature of the targeting in the mission which, in its implementation, can have coercive elements similar to previous population control programs (Banerjee, 2016). The fact remains that female sterilization continues to be predominant in the method mix at 37.9% (NFHS-5).

Medical Termination of Pregnancy (MTP) Act

One of the most liberal abortion acts was passed by India in 1971 and permitted abortion within 20 weeks if consented by either one or two doctors under certain conditions. In 2021, this act has been considerably modified allowing a termination of pregnancy of up to 24 weeks for those who belong to certain classes of individuals such as victims of sexual violence, rape, incest, disabled women, and adolescents; or at any

stage of pregnancy if a Medical Board confirms foetal abnormality incompatible with survival.

In spite of being a progressive step, the 2021 amendment brings certain difficulties for the population. In particular, rural women often have limited access to MTP facilities; the need for consent from two physicians to perform abortion for the period of 12 to 24 weeks complicates the process; social stigmatization discourages seeking abortion services; and private clinic prices prevent lower socio-economic strata from using MTP (Berer, 2019; Ganatra *et al.*, 2017). Unsafe abortions make a considerable part of maternal deaths.

Menstrual Hygiene Scheme

The Rashtriya Kishor Swasthya Karyakram (RKSK), or National Menstrual Hygiene Scheme, focuses on adolescent girls between 10-19 years in rural a

reas with subsidized sanitary napkins, MHM education, and counseling services by ASHAs. Menstrual hygiene is an aspect of reproductive health and bodily autonomy because it impacts the ability of girls to attend school, their confidence, and personal empowerment (Ministry of Health & Family Welfare, MoHFW, 2011).

Data from NFHS-5 for women aged 15-24 indicate considerable improvements in the use of sanitary protection among women in this age bracket: 77.3% of women of 15-24 years use sanitary protection during menstruation throughout the country as compared to 57.6% in NFHS-4. However, this statistic hides a serious disparity between urban and rural settings (73.6% rural versus 90.2% urban in NFHS-5), as well as marked differences at a state level. Furthermore, the availability of sanitary protection fails to address the underlying social taboo and stigmatization associated with menstruation.

Regional Disparities and Challenges

The North-South Divide

One of the most persistent spatial arrangements in India's reproductive health profile is that of north and south. The north-south split is a structure that was first noted systematically by Dyson and Moore (1983), and has since persisted in all iterations of NFHS data. The southern states, especially Kerala, Tamil Nadu, Andhra Pradesh, Telangana, and Karnataka, have persistently excelled over northern and central Indian states when it comes to maternal and reproductive health indicators. This spatial arrangement is characterized not only by different levels of investments in healthcare but also by distinct social and economic systems.

The best example of reproductive health success in the Indian context is that of Kerala. With near total literacy, a history of women's property rights, the matrilineal system of inheritance in some communities, and significant government investment in health and education from the Travancore princely times, the reproductive health achievements of Kerala have been on par with Southeast Asian middle-income countries. According to the NFHS-6 figures, institutional delivery is nearly universal in Kerala, with 99.7% of deliveries being carried out through institutions, and the percentage of unmet need for family planning being very low at only 3.2% (IIPS, 2026). Similarly, Tamil Nadu exemplifies the co-determinants of development and reproductive health success in terms of female education, efficient public health systems (with a good network of primary health centres), and relative gender equality in households (Bhattacharyya, Rana, & Bhattacharyya, 2015).

On the other hand, Bihar, which is India's most populous and underdeveloped major state based on multiple indicators, provides an example of the amplification of structural weaknesses. According to the results of NFHS-6, the percentage of institutional deliveries was around 83%, lower than the national average of about 90.6%, with just 34.6% of women undergoing four or more antenatal check-ups (national average of about 65.2%) (IIPS, 2026). Similar problems prevail in Uttar Pradesh, which is the most populous state in India.

Rural-Urban Disparities

Disparities in reproductive healthcare access between rural and urban populations form another axis of inequalities prevailing across all Indian states. According to NFHS-5, 94% of urban births took place at institutions, while only 87% of births among rural women occurred in institutions; in case of EAG States, this disparity widens even more. Women from urban areas are also considerably more likely to undergo four or more ANC checkups (69% as opposed to 55% among women in rural areas) and to utilize professional assistance during labor (94% in contrast to 88% among women from rural areas) (IIPS & ICF, 2021).

In this regard, it should be noted that the differences described above cannot be explained by the fact that urban populations live closer to health care facilities. Women residing in urbanized regions usually enjoy better education and greater economic autonomy, possess better access to health-related information, including internet usage rates, which grew from 36% according to NFHS-5 to higher figures among women in urban areas within NFHS-6, and make decisions independently within their households (MoHFW, 2021).

Educational Disparities

Education is undoubtedly one of the primary individual-level factors associated with utilization of reproductive health services and bodily autonomy in India. According to data obtained from NFHS-5, 97% of children born to mothers with 12 or more years of education were delivered in health facilities, whereas in comparison, only 75% of deliveries of women without any education took place in health facilities (IIPS & ICF, 2021). Educated women tend to utilize contraception, attend ANC during the first trimester, take part in health care decision-making processes, and reject coerced family planning policies. At

the same time, educated women have higher odds of making health care-related decisions independently or in concert with their spouses.

Conversely, poor female literacy, which prevails in Bihar (female literacy of 63.5% in NFHS-6), and Rajasthan (64.3%), is accompanied by the worst reproductive health indicators. Education is hence the key both as a resource and as rights. First of all, education gives women knowledge and empowerment that enable them to receive health care services. In addition, education enables them to exercise their right to autonomous bodily integrity as well.

Healthcare Infrastructure Gaps

Structural barriers include supply-side limitations in health infrastructure. There are many such constraints; for instance, the public health sector in India continues to be severely under-resourced, with expenditure on health accounting for about 1.84% of GDP in 2021-22 – much lower than the target of 2.5% recommended by the National Health Policy 2017 (NITI Aayog, 2022). The inadequacy of trained health professionals is particularly pronounced in the rural areas: according to the NFHS-5 surveys, the doctor-population ratio in rural government facilities in the Indian states of Bihar and Uttar Pradesh is well below WHO guidelines.

The states of Uttar Pradesh, Madhya Pradesh, and Bihar invariably rank low on the health systems performance index developed by the NITI Aayog (2020-21), which takes into account several dimensions of health outcomes, health sector governance, and other relevant process measures. On the other hand, Kerala, Tamil Nadu, and Andhra Pradesh lead the list of states.

Socio-Cultural Barriers and Patriarchal Norms

In addition to structural deficiencies in the health system, reproductive healthcare services in India are heavily influenced by socio-cultural norms that affect the movement, decision-making abilities, and access to information among women. The purdah system, common in many northern and central states of India, limits women's mobility outside the house as well as restricts their access to public spaces such as hospitals for healthcare. Despite son preference reducing in aggregate terms as per the NFHS, it has been observed that selective sex practices continue to thrive in some states, thereby impacting reproductive decision-making among women.

19% of women have stated that they did not receive permission from their husbands and families to go to a health facility for delivery—an instance of patriarchy's direct interference with the decision-making of women. In addition to this, another 28% of women believed it was unnecessary to attend the health facility for delivery—a view which might itself be influenced by socio-cultural norms regarding women's health care requirements (IIPS & ICF, 2021). 45% of women reported believing in at least one justification for beating up a wife according to the NFHS-5 findings.

CONCLUSION

The present paper has analyzed the interaction between the provision of reproductive healthcare services and the bodily autonomy of individuals in India, using secondary data and policy analysis as the analytical framework. The main observations from this study can be listed as below:

• The country has achieved remarkable success in terms of reproductive health care during the last three decades. This is evident from the high proportion of institutional deliveries (39% in 2005-2006 and around 90.6% in 2023-2024), reduction in the number of maternal deaths and improvement in ANC coverage due to government schemes such as JSY, PMSMA, and NHM.

• However, there exist structural inequalities at different levels – regional, rural/urban, educational attainment, and socioeconomic status-wise. While states like Bihar, Uttar Pradesh, and Rajasthan still struggle, other states like Kerala, Tamil Nadu, and Goa continue to outperform in all indicators of reproductive health care.

• Bodily autonomy in terms of reproductive health care for women is still underdeveloped. As per NFHS-5, only 71% of married women take part in the decision-making process concerning all the specified issues.

• Government policies aimed at enhancing healthcare access were not always formulated in a manner that promotes women's agency. Conditional cash transfers under JSY, the reliance on female sterilization as the main method of contraception, and increasing Caesarean deliveries in private hospitals are just some of the issues related to quality and voluntary reproductive services.

• The 2021 amendment to MTP Act can be seen as a milestone in reproductive rights, yet access is still challenging, especially for rural, poor, and marginalized women. Rights need to be coupled with accessibility, affordability, and nonjudgmental healthcare.

• Despite all health sector interventions, social norms such as patriarchal family, son preference, restriction on women's mobility, and intimate partner violence remain strong determinants of both healthcare access and bodily autonomy.

Policy Implications

These results have numerous policy implications. Firstly, India's current reproductive health policy needs to shift from its preoccupation with access indicators, including deliveries, ANC coverage, and contraceptive acceptors, towards quality-of-care indicators and indicators of women's reproductive autonomy. This entails incorporating indicators of informed choice, client satisfaction, and reproductive rights within routine monitoring systems such as NHM and other programs (WHO, 2017).

Secondly, the prevalence of female sterilization in the contraceptive mix needs to be tackled by encouraging men's participation in contraception, alongside promoting non-permanent forms of contraception, with adequate counseling and without any performance-based incentives. Thirdly, there is an urgent need to improve the

regulatory framework in the private sector, especially with regards to caesarean section rates and the quality of care during delivery in private healthcare institutions.

Recommendations

• Shift policy evaluation models to encompass autonomy-oriented indices: women's autonomy in the freedom to choose childbirth settings; satisfaction with provider information; autonomy in family planning without any pressure; and autonomous decision making in accessing health services.

• Increase funding for public health towards the target of 2.5% of national income envisaged by the National Health Policy 2017, with a larger share of funding going to EAG states and rural healthcare facilities, especially regarding emergencies during delivery and specialist availability.

• Implement regulatory policies in the private sector regarding obstetrics by introducing mandatory clinical audit of caesarean section rates, fee transparency, and informed consent practices.

• Change incentive schemes of ASHAs to include a guaranteed salary, given their important contributions and the potential negative effects of performance bonuses based on the number of procedures performed.

• Ensure that gender transformative education (focusing on issues such as patriarchy, son preference, and domestic abuse) is incorporated into NHM's outreach model in consultation with civil society organizations and self-help groups.

• Improve implementation of the MTP Act 2021 by staffing all district hospitals with MTP service providers and by making sure that second trimester abortion is not hampered by unnecessary bureaucracy.

• Conduct state-level reproductive health roadmaps for the EAG states, taking into account their unique sociocultural and demographic profile and with realistic timelines to address the disparity from national averages.

REFERENCES

Banerjee, A. (2016). Population policy in India: From control to choice. *Economic & Political Weekly, 51*(23), 12–15.

Berer, M. (2019). Abortion law and policy around the world: In search of decriminalization. *Health and Human Rights Journal, 19*(1), 13–27.

Bhattacharyya, S., Issac, A., Rajbangshi, P., Srivastava, A., & Avan, B. I. (2015). Neither we are satisfied nor they: Users and provider's perspective—A qualitative study of maternity care in low and middle income countries. *BMC Health Services Research, 15*, 1–13. https://doi.org/10.1186/s12913-015-1189-3

Bhattacharyya, S., Srivastava, A., Roy, R., & Avan, B. I. (2019). Factors influencing women's preference for health facility deliveries in Jharkhand state of India. *BMC Pregnancy and Childbirth, 19*, 1–8.

Cook, R. J., & Dickens, B. M. (2003). *Reproductive health and human rights: Integrating medicine, ethics, and law*. Oxford University Press.

Cottingham, J., Germain, A., & Hunt, P. (2012). Use of human rights to meet the unmet need for family planning. *The Lancet, 380(9837),* 172–180. https://doi.org/10.1016/S0140-6736(12)60732-6

Dreze, J., & Sen, A. (2013). *An uncertain glory: India and its contradictions*. Princeton University Press.

Dyson, T., & Moore, M. (1983). On kinship structure, female autonomy, and demographic behavior in India. *Population and Development Review, 9*(1), 35–60. https://doi.org/10.2307/1972894

Ganatra, B., Gerdts, C., Rossier, C., Johnson, B. R., Tunçalp, Ö., Assifi, A., & Bearak, J. (2017). Global, regional, and subregional classification of abortions by safety, 2010–14: Estimates from a Bayesian hierarchical model. *The Lancet, 390(10110),* 2372–2381.

Gillespie, S., Kadiyala, S., & Greener, R. (2007). Is poverty or wealth driving HIV transmission? *AIDS, 21(7 Suppl*), S5–S16.

International Institute for Population Sciences (IIPS) & ICF. (2021). *National Family Health Survey (NFHS-5),* 2019–21: India. IIPS.

International Institute for Population Sciences (IIPS). (2026). *National Family Health Survey (NFHS-6),* 2023–24: India and State/UT Fact Sheets.

Jejeebhoy, S. J. (1995). *Women's education, autonomy, and reproductive behaviour: Experience from developing countries*. Clarendon Press.

Johanson, R., Newburn, M., & Macfarlane, A. (2002). Has the medicalisation of childbirth gone too far? *British Medical Journal, 324*(7342), 892–895.

Kishor, S. (2000). Empowerment of women in Egypt and links to the survival and health of their infants. *In H. Presser & G. Sen* (Eds.), Women's empowerment and demographic processes (pp. 119–158). Oxford University Press.

Lim, S. S., Dandona, L., Hoisington, J. A., James, S. L., Hogan, M. C., & Gakidou, E. (2010). India's Janani Suraksha Yojana, a conditional cash transfer programme to increase births in health facilities: An impact evaluation. *The Lancet, 375(9730),* 2009–2023. https://doi.org/10.1016/S0140-6736(10)60744-1

Mahmuda, S., Mazumder, S., & Rahman, S. N. (2024). Factors affecting domestic violence against rural educated and uneducated women in Bangladesh: A sociological analysis. *American Journal of Youth and Women Empowerment, 3(*1), 25–33. https://doi.org/10.54536/ajywe.v3i1.3149

Malhotra, A., & Schuler, S. R. (2005). Women's empowerment as a variable in international development. *In D. Narayan* (Ed.), Measuring empowerment: Cross-disciplinary perspectives (pp. 71–88). World Bank.

Ministry of Health and Family Welfare (MoHFW), Government of India. (2005). *Framework for implementation: National Rural Health Mission* (2005–2012).

Ministry of Health and Family Welfare (MoHFW), Government of India. (2011). *Adolescent health and nutrition: A strategy.*

Ministry of Health and Family Welfare (MoHFW), Government of India. (2013). *National Health Mission: Mission document.*

Ministry of Health and Family Welfare (MoHFW), Government of India. (2016). *Pradhan Mantri Surakshit Matritva Abhiyan: Operational guidelines.*

Ministry of Health and Family Welfare (MoHFW), Government of India. (2021). *Family planning vision 2030.*

Mosedale, S. (2005). Assessing women's empowerment: Towards a conceptual framework. *Journal of International Development, 17*(2), 243–257.

Nair, H., Jain, P., Bhatta, R., Babu, B., Sachdeva, M., & Kant, R. (2012). Improving maternal health in India. *Bulletin of the World Health Organization, 90*(3), 221–228.

NITI Aayog. (2021). *Health index: Round IV*, 2019–20. Government of India.

NITI Aayog. (2022). *SDG India Index and dashboard* 2023–24. Government of India.

Pathak, P. K., & Singh, A. (2011). Trends in malnutrition among children in India: Growing inequalities across different economic groups. *Social Science & Medicine, 73*(4), 576–585.

Randive, B., Diwan, V., & De Costa, A. (2013). India's conditional cash transfer programme (the JSY) to promote institutional birth: Is there an association between institutional birth proportion and maternal mortality? *PLoS ONE, 8*(6), e67452.

Rashid, M. H., & Sultana, Y. (2025). Women's empowerment activities in rural areas of Bangladesh. *American Journal of Youth and Women Empowerment, 4*(1), 1–8. https://doi.org/10.54536/ajywe.v4i1.4254

Registrar General of India. (2022). *Special bulletin on maternal mortality in India 2018–20: Sample Registration System.* Government of India.

Singh, A., Pallikadavath, S., & Ogollah, R. (2012). Maternal health care providers and antenatal care in India. *Asian Population Studies, 8*(3), 309–325.

Subramanian, S. V., Nandy, S., Irving, M., & Davey Smith, G. (2006). Role of socioeconomic markers and state prohibition policy in predicting alcohol consumption among men and women in India. *Bulletin of the World Health Organization, 83*(11), 829–836.

United Nations. (2015). *Transforming our world: The 2030 Agenda for Sustainable Development* (A/RES/70/1). United Nations General Assembly.

United Nations Population Fund (UNFPA). (1994). *Programme of action of the International Conference on Population and Development.*

United Nations Population Fund (UNFPA). (2021). *State of world population 2021: My body is my own—Claiming the right to autonomy and self-determination.*

Visaria, L. (2000). From family planning to reproductive health: A review of the evidence from Gujarat. *Economic & Political Weekly, 35*(8 & 9), 579–588.

World Health Organization. (2004). *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets.*

World Health Organization. (2017). *WHO recommendations: Intrapartum care for a positive childbirth experience.*

World Health Organization. (2023). *Trends in maternal mortality 2000 to 2020: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division.*