Q6(a)

Discuss the major challenges related to women's reproductive health in India. What measures would you suggest to overcome these challenges?

UPSC Civil Services Mains 2024 · Sociology GS 2 · 20 marks · Population Dynamics

Population Dynamics: Population size, growth, composition and distribution; Components of population growth: birth, death, migration; Population policy and family planning; Emerging issues: ageing, sex ratios, child and infant mortality, reproductive health.

Core demand of the question

- Name major challenges to women's reproductive health in India
- Cover mortality, anaemia, unmet need, adolescent pregnancy, infertility stigma, violence, and unequal care
- **Then suggest measures:** public systems, ASHA, PCPNDT, education, nutrition, and male responsibility
- **Keep it sociological:** caste, class, patriarchy

Revision summary

Reproductive health covers survival, fertility control, nutrition and freedom from violence.

India improved institutional delivery while anaemia, unmet need and obstetric violence remain.

Caste, class and son preference structure who gets respectful care.

Female sterilisation still carries too much of the programme burden.

Measures must join public facilities to food, wages, schooling and male responsibility.

Introduction

Reproductive health is not only hospital births. It is the social chance to control fertility, survive pregnancy, eat enough, and live without sexual violence. In India those chances are still sorted by **class, caste, region and patriarchy**. NFHS rounds show progress in institutional delivery and stubborn gaps in anaemia, unmet need and respectful care. The challenge is a health system problem and a gender-structure problem together.

Body

Major challenges

Maternal mortality has fallen nationally but remains high in pockets of BIMARU and tribal districts. Anaemia among women of reproductive age is widespread, which is nutrition and unpaid work, not only iron tablets. Unmet need for contraception persists; female sterilisation still dominates the method mix, which places the body-burden on women. Adolescent marriage and pregnancy continue in several states. Unsafe abortion sits beside the MTP law because stigma and access fail. Infertility is medicalised for those who can pay and is a source of

abandonment for those who cannot. Son preference, despite **PCPNDT**, shapes sex-selective practices and the experience of repeated pregnancy.

Caste and Adivasi status structure who meets a specialist and who meets a rude labour room. **Dalit and Muslim women** report discrimination in some facilities. Violence-domestic and sexual-makes reproductive autonomy a fiction. Occupational exposure in agriculture and informal work, and the double shift of care, undermine health before a clinic is reached. Surrogacy and the ART market create a class split: some women's reproduction is a service.

Patriarchy is the hinge. Who decides the next child, who goes to the PHC, who pays for a C-section in a private nursing home-these are household power questions. **Uma Chakravarti**'s control of sexuality is visible in honour and in the silence around RTIs.

Measures

A public system of **free, high-quality antenatal, delivery, abortion and postnatal care**, including respectful midwifery, is the base. **ASHA** and ANM workers need pay, training and protection; they are the gendered frontline of the state. Expand reversible contraception and male methods so sterilisation is not the default. Enforce PCPNDT without turning every pregnancy into a police event. Tie **POSHAN**, PDS and women's wages (MNREGA, NRLM) to anaemia, because tablets fail on hungry bodies. Delay marriage through schooling (NEP-era access is relevant) and enforce child-marriage law with community work, not only raids.

- **Legal measures:** full implementation of MTP amendments, POSH and the Domestic Violence Act as reproductive-health infrastructure. Panchayat women members can audit facilities if they are not proxies. Community-based monitoring, as in some Jan Swasthya experiments, reduces humiliation. Address infertility as public care, not only as a private IVF market.
- **Measures must include** men and in-laws**:** counselling, paternity leave where the formal sector exists, and campaigns that treat spacing as a joint duty. For Adivasi areas, language-capable staff and FRA-linked livelihoods reduce the malnutrition that pregnancy then reveals.

Nutrition, violence and the last mile

ASHAs cannot fix a household that withholds food from a daughter-in-law or that demands a son. POSHAN and PDS matter only if women control rations. Transport to a FRU at night is a public-goods and safety question, which is why maternal death is also a village-road and police-attitude story. Private nursing homes convert obstetric emergency into debt, which is class. Measures that ignore this last mile will keep reproducing NFHS gaps even as institutional delivery percentages look good on a dashboard.

Without land, wages and an end to obstetric violence, clinic construction will not finish the job. Reproductive health is a **social development** target, which is why it belongs in Paper II beside education and labour.

Flow diagram

Patriarchy caste class -> MMR anaemia unmet need

Weak disrespectful care -> MMR anaemia unmet need

Public care nutrition contraception -> Improved reproductive health

MMR anaemia unmet need -> Public care nutrition contraception

Conclusion

Women's reproductive health in India is constrained by anaemia, uneven maternity care, a sterilisation-heavy programme, son preference, violence and caste-class barriers. Measures that work are a respectful public system, nutrition and wages, contraception that does not dump risk on women, and a direct attack on household patriarchy. Clinics without those social supports will keep reproducing the same NFHS gaps.

Facts & figures

NFHS

National Family Health Surveys tracking fertility, anaemia, delivery and contraception.

PCPNDT Act

Bans sex-selection diagnostics; son preference still shapes reproductive careers.

ASHA

Accredited Social Health Activist: community female worker at the centre of rural reproductive outreach.