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# Building a Brighter Future: Determinants of Sexual and Reproductive Health of Women in Rajasthan

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## ABSTRACT

*The objective of this research paper is to explore the factors which determine sexual and reproductive health (SRH) outcomes for women living in the state of Rajasthan with an emphasis on important variables including social and cultural norms, availability of health services, economic challenges, educational attainment, and gender issues. Utilizing secondary information, data from national health surveys (NHHS-6), and relevant academic studies, this paper points out some important lacunas in service provision, health seeking behavior, and other important factors affecting SRH outcomes in Rajasthan.*

***Keywords***: *Sexual Health, Reproductive Health, Rajasthan, Socio-Cultural Norms.*

## Introduction

Sexual and reproductive health (SRH) is the basis of women's wellbeing in terms of their physical, psychological, and social status and is recognized as a fundamental human right. (1) Providing comprehensive SRH services is a key concern in public health as well as an important element of gender equality and sustainable development. (2) However, progress in the field is rather irregular even in the country where SRH is guaranteed through constitutional laws and has been improving in recent years. This is particularly the case in India's second largest state, Rajasthan, which still has significant inequality between districts and communities in this respect. (3) The SRH situation in the state is conditioned by prevailing cultural norms, traditional families' structure, and economic inequalities which limit women's autonomy and access to SRH services. While there have been positive trends in the provision of maternal health services, institutional delivery, and outreach programs in the communities, there are still many alarming factors such as high mortality rates, low prevalence of contraception in certain areas, high number of teenage marriages and pregnancies, lack of knowledge about menstruation, and low degree of women's and girls' empowerment. The factors that determine the status of sexual and reproductive health outcomes in Rajasthan should thus be understood (4). Structural factors like poverty, weak health systems, and lack of education work in conjunction with interpersonal and intrahousehold determinants such as patriarchy, stigma, and reproductive choicelessness (5). A look at these intersections helps explain why some districts continue to have high burdens even when there have been improvements on the state level (6).

The objective of the research paper would be to investigate the various social, economic, and behavioral determinants impacting the SRH results in Rajasthan. The inclusion of the district-level analysis and thematic findings from the qualitative and secondary sources helps to identify the structural

impediments facing women and provides avenues for improving programs and policies (7). A proper comprehension of the issue is crucial to promote equity in the realm of SRH access for all women in Rajasthan to exercise their reproductive rights. Previous literature regarding SRH in Rajasthan has pointed out some structural and sociocultural impediments affecting the health results of women. There is considerable amount of literature available which has established a correlation between the high adolescent fertility in Rajasthan and cultural traditions of early and child marriages in the state (9). Early marriages prevent girls from going to schools and expose them to early and repetitive childbearing when they are not ready for such pregnancies.

Further research focuses on the importance of norms associated with gender roles and household settings, where patriarchal structures constrain mobility, decision-making capacity and access to health services (10). Constrained mobility restricts the use of services in antenatal, postnatal or family planning services, while limited autonomy, especially concerning contraceptive practices, makes women make decisions based mainly on their husbands' opinions. It has been found out that married women, especially adolescents and newlywed brides, find it hard to negotiate decisions concerning contraception because of the existence of power imbalances, fear of criticism from family members and myths associated with side effects (11). The areas of Rajasthan including rural and tribal areas, have been repeatedly considered as SRH poor zones. Literature reveals lack of skilled health personnel, unavailability of outreach services and weak connectivity as main barriers to accessing quality services (12). Lack of female health workers needed for cultural SRH counselling is another problem preventing the provision of services. In addition, social stigma in relation to the discussion of sexual matters is one of the most important barriers to discussing health-related issues (13). The stigma surrounding menstruation, contraception, and sex is another obstacle that not only leads to a lack of knowledge but promotes false beliefs as well (14). Poor infrastructure is yet another important element highlighted by empirical research. The unavailability of emergency obstetric services, inadequate transport means, and the absence of referral services are among those factors that lead to unnecessary problems associated with maternal and child health (15).

The national-level data sets, specifically the NFHS-6, have shown that there are considerable improvements in some of the SRH indicators, for instance, institutional delivery and antenatal care. On the other hand, there are high levels of prevalence of anaemia, unmet need for contraception, and increasing cases of intimate partner violence which are the factors that are undermining the reproductive health of women (16). Although there are policies like the JSY, JSSK and RKSK, the literature highlights the limitations in terms of implementation and effectiveness of such policies due to systemic and structural challenges (17). Overall, from the literature, it can be noted that there are various factors that influence SRH indicators in Rajasthan and it is important to understand the multiple-level determinants before designing any intervention in the region (18).

**Objectives of the Study**

- To understand the socio-cultural and economic determinants shaping SRH outcomes.
- To recommend policy and programmatic strategies to improve SRH for women.

**Methodology**

The current research employs a very strict qualitative and secondary data analysis methodological approach consistent with typical practices used in Scopus-indexed public health research studies. In particular, the methodological framework emphasizes the development of an evidence base founded on reliability, analytical rigor, and theoretical soundness.

**Research Design**

Descriptive analytical research design was utilized to examine in detail reproductive and sexual health (RSRH) indicators among women residing in the State of Rajasthan. The above research design enabled both the description of existing RSRH trends and analysis of the reasons behind them in order to provide a comprehensive picture of the reproductive health situation in the state. Different methodological techniques were applied to provide a multi-faceted analysis. First, systematic secondary data analysis was carried out relying on representative national surveys like NFHS, DLHS and others. Such a technique helped to reveal the trends, disparities, and gaps in different RSRH indicators, including early marriages, contraception use, utilization of maternal health services, and menstruation hygiene practices.

Secondly, a comparative analysis at the district level was conducted in order to analyse the variations that exist in SRH outcomes in the context of Rajasthan, which is rich in both socio-cultural and

geographic diversity. By conducting the comparative analysis at the district level, the research was able to bring to light districts that have higher levels of vulnerability, as well as those that have favourable outcomes relative to the state-level outcomes. Through such an analysis, it was possible to establish the context-specific factors that determine the access to and use of SRH services, which include caste, tribal status, and urban/rural status. Lastly, a multilevel analysis was undertaken using a known theoretical framework for analysing gender and reproductive health issues. Through this approach, the research was able to go beyond simple descriptive statistics to interpret the interaction between individual level factors such as education, age, and knowledge, household level factors such as decision making power and economic standing, and community level factors such as culture, services, and governance structures. On the whole, this descriptive analytical design enabled both wide and deep analyses to be carried out, as the research went beyond merely quantifying SRH indicators to understanding the socio-cultural and structural context within which such experiences took place.

**Data Sources**

The data used in this study have been sourced from trusted and nationally representative sources to ensure rigor and validity in terms of methodology. Some of the major sources of data are the National Family Health Survey (NFHS) Rounds, NFHS-6 (2023-24) and NFHS-5 (2019-21) district level fact sheets, provisional indicators, for comparison purposes, offering comprehensive data on reproductive, maternal, and child health status of Rajasthan. Demographic data from the Census of India and Reports of the Department of Health and Family Welfare, Rajasthan further provided data that offered important demographic context on health infrastructure and health programs. Moreover, peer-reviewed studies from Scopus indexed journals, and Reports from trusted development organizations such as UNFPA, UNICEF, and WHO have also been referenced in this report to validate the results as well as to analyze this issue within the larger body of literature on Sexual and Reproductive Health (SRH).

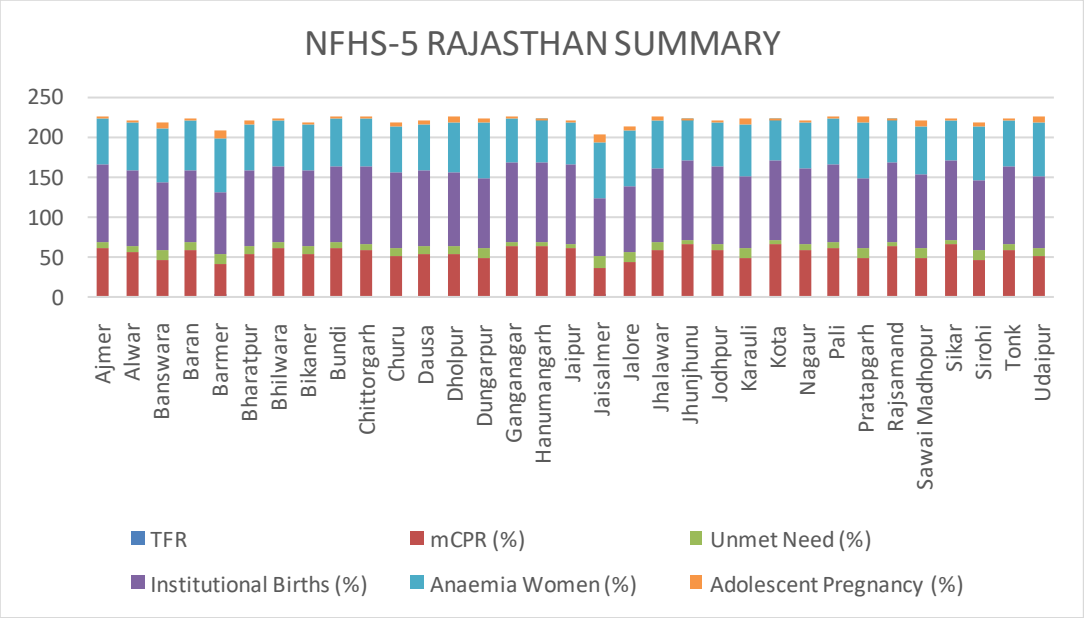


***Figure: NFHS-5 Rajasthan Data Summary***

Source: Nfhs 5 Data

- **Analytical Framework: Socio-Ecological Model (SEM)**

In order to ensure that the analysis was theoretically sound, the study incorporated the socio-ecological model (SEM), a framework that is commonly used in public health studies to investigate multi-level determinants of health outcomes. SEM helps in gaining insight into the way individual behaviors and health outcomes can be influenced not only through individual factors, but also interpersonal relations, community factors, and policy/structural environment (19). Through the incorporation of this framework, it

became possible to understand the different influences that affect the SRH of the women in the state of Rajasthan. On the individual level, the analysis considered the personal characteristics and capabilities of the individuals such as knowledge about reproductive health, education, age of marriage, knowledge and use of contraceptives, and nutrition. These factors are significant in making reproductive decisions of the women and accessing reproductive health services.

At the interpersonal level, the framework evaluated interactions within the households and intimate social networks. It entailed communication between partners, the decision-making process among couples and the level of support available in families that influence women's independence and ability to make informed decisions about their reproductive health. The community level looked at the social, cultural norms; social restrictions existing in the communities; mobility limitations and community health practices. Community's attitude towards menstruation, early marriages and family planning have an impact on individual's health behavior and access to health services, especially in rural and tribal regions (20). The structural and policy level analyzed the wider structural issues that include access and quality of health services, economic factors and implementation of policies that determine whether women can convert their knowledge and intentions into actions (21). Therefore, by incorporating these four levels, SEM offers a holistic view through which the interaction between individual, interpersonal, community and structural factors can be examined and understood in order to understand the effects on SRH outcomes (22).

**Data Analysis**

In order to ensure rigorous methodology, a two-part mixed-method approach was used. In terms of the quantitative evaluation, there was a comparison of district-level values in relation to NFHS key indicators, such as fertility rate, prevalence of contraceptive use, unmet need for family planning, antenatal and postnatal care utilization, adolescent fertility, prevalence of anaemia and institutional delivery. High burden districts were identified through ranking and pattern recognition (23). With respect to qualitative thematic analysis, the barriers and facilitators to SRH outcomes on the four SEM levels were coded with the help of secondary literature and program reports. Methodological triangulation was conducted to validate results. Thus, this combined and theory-based approach allowed to interpret the processes in which individual, family, community and structural aspects interact in shaping SRH outcomes. Altogether, this methodologically sound and multi-level approach ensured an empirical measurement and context-specific understanding, so that the research can capture complexity of reproductive health in Rajasthan in accordance with high academic standards.

**Findings**

**Socio -Cultural and Gender Dynamics**

- **Early Marriage and Adolescent Pregnancy (Early Pregnancies)**

In fact, Rajasthan remains among the states with the highest levels of child marriage in India, which is a traditional practice that influences the SRH of girls substantially. The practice of early marriage negatively affects education, as girls tend to drop out of school and thus lack the opportunity for further personal and professional growth (24). In particular, the prevalence of early marriage is much higher in rural Rajasthan. One in every four rural women aged between 20 and 24 (28.8 percent) was married off before 18 years, while the same rate in the urban areas was 10.8 percent (3.6). The fact of early marriage is reflected in the difference in the level of Total Fertility Rate, which is higher in rural areas and reaches 2.2 (the replacement level), while it is lower in urban areas and is equal to 1.7 (3.6). Early marriage leads to an increased risk of teenage pregnancy, which entails high risks for the mother and child (25). Moreover, young women lack awareness on the issue of family planning and contraception.

- **Contraceptive Use and Family Planning**

While awareness of contraceptive methods is relatively widespread throughout the state, usage rates vary widely across the districts, indicating gaps in accessibility and cultural practices as well as outreach efforts from the health system. Despite the relatively equal usage levels (76.4% urban vs. 73.8% rural), there is huge variance in methods used. While rural women make heavy use of female sterilisation (40.2% rural vs. 27.6% urban), urban women make considerably more use of traditional methods (19.8% urban vs. 16.5% rural). Total unmet need for contraception in the rural areas is higher (8.6%), due primarily to higher need for spacing methods (4.8%). The influence of male-dominated households in decision making, coupled with widespread fear of side-effects, has made it difficult to convince rural women to opt for modern methods of contraception (26). In reality,

sterilization remains the most popular method of contraception, overshadowing other spacing methods which would offer women more control over their reproductive choices (27). Women in rural areas of Rajasthan get married and start having children much earlier than women from urban areas and as such they will end up fulfilling their family size much sooner and choose sterilisation as their method of contraception much earlier in life.

- **Gender-Based Violence and Autonomy**

Violence against women, whether intimate partner violence, is an important threat for mental health and reproductive health. According to NFHS 6, spousal violence is much more common in rural settings (21.9%) compared to urban settings (17.3%). Women do not enjoy much independence in decision-making related to mobility, finances, and health care, which adversely impacts the access of women to critical SRH services (30). The connection among all these three factors keeps reinforcing the vulnerability, which shows that improvement in SRH cannot be achieved through healthcare interventions alone.

**Healthcare Infrastructure and Service Delivery**

- **Maternal Health and Healthcare Access**

As per the NFHS 6 data, there is better access to and utilization of maternity care amongst urban mothers. 70.2% of urban mothers had at least 4 visits during the ANC period as compared to 58.5% of rural mothers. C-section deliveries are largely found amongst urban populations making up 32.8% of all births, while in the rural population, only 11.4% are delivered through caesarean section deliveries. The C-section delivery percentage of urban Rajasthan (32.8%) is less than that of the national average (40.5%), but is still significantly more than the national average in general, which is 27.2%. What is interesting is that in the case of births occurring in institutions, rural mothers use public health institutions significantly more (72.3%) as compared to urban mothers (63.5%). There has been some progress in utilization of services due to the government schemes which promote institutional births. However, problems like the lack of skilled professionals, lack of proper functional health institutions, lack of adequate supply of essentials still persist in rural as well as tribal areas. Other structural barriers include the long distance between homes and health institutions, lack of transportation, poverty, and reluctance due to cultural reasons.

- **Menstrual Health and Hygiene**

Menstrual taboos still have an impact on limiting the mobility and participation of women in education and social activities (28). While the provision of menstruation products is better today than before, there are still inequalities, especially in marginalised groups. The use of hygienic menstrual products by adolescent females aged between 15 and 24 years is widespread in cities (96.1%) and lower in rural areas (86.3%) (36). Adolescents may lack information about menstruation because schools lack proper sexual and reproductive education and thus have many myths about hygiene (29).

**Discussion**

SRH conditions in Rajasthan have been found to be highly dependent on the interplay of social, economic, and cultural elements. Gender roles have been observed to have an impact on women's control over reproductive matters, thus limiting their access to necessary healthcare services as well as decision-making at the household level (31). Caste differences also contribute to the existing inequalities, since marginalized individuals have limited access to healthcare services as well as discrimination in their healthcare-seeking process (32). Economic inequalities have also become another reason for poor SRH outcomes in the state. Households that belong to lower socio-economic levels have limited access to nutritious food as well as reproductive services, which leads to greater morbidity among pregnant women (33).These structural conditions are exacerbated by individual level risk factors such as malnutrition, prevalence of anemia, lack of knowledge about SRH issues, and fear of being stigmatized, which dissuade women from visiting clinics. While there have been efforts by the government such as the Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK), and Rashtriya Kishor Swasthya Karyakram (RKSK) to promote the use of SRH services, these have not been very successful because of inequities in the system as well as sociocultural conditions prevailing in communities (34). Therefore, despite the initiatives taken by the government, women suffer from unfavorable SRH conditions.

**Recommendations for Improving Sexual and Reproductive Health in Rajasthan**

Improvements in SRH outcomes in Rajasthan demand an integrated approach that will tackle the determinants from various levels. Below are some recommendations that can be taken into consideration:

- **Strengthen SRH Education**

Comprehensive sex education should be incorporated into the school syllabus to ensure that adolescents and young adults receive scientific facts on sexual and reproductive health, consents, contraceptive measures, and menstruation hygiene. This can be done by having health workers in the community engage the people in rural and semi-urban areas, as well as using the digital media, including mobile apps and social media platforms, to reach adolescents who might not be in school. Consistent training of teachers and health workers is imperative to provide age and culture-sensitive education.

- **Delay Age of Marriage**

Early marriages continue to pose negative impacts on the reproductive health of young women. Campaigns should target the community's opinion leaders, parents, and young people to educate them on the impacts of child marriage on their health, education, and general welfare. At the same time, there is need for increased enforcement of laws, for example, the Prohibition of Child Marriage Act, which would discourage underage marriages. The programs can comprise mentoring, peer advocacy, and inducements to encourage retention of girls in schools.

- **Expand Choice and Counseling Regarding Contraception**

There is need for availability of various methods of contraception, including long-term methods of birth control. Health centers should offer counseling that is judgment-free and personalized in order to enable the individual or couples to make well-informed decisions regarding family planning. Combination of family planning services with existing maternal and adolescent health services could help to promote adoption of the services.

- **Improve Rural Healthcare Infrastructure**

Improvement of rural healthcare systems will be important for ensuring prompt and quality services for SRHRs. Healthcare centers need to be furnished with well-trained healthcare workers, obstetric and neonatal care services, and medicine. Mobile health care units and telemedicine will help in overcoming geographical barriers especially in faraway places. Regular monitoring and supervising of healthcare workers can be useful in improving service delivery.

- **Promote Gender-Equitable Social Norms**

Norms that hinder women's freedom should be tackled through community mobilization efforts. Programs in which men are involved in discussions on reproductive health, contraception use and gender equality will help in reducing resistance and enhancing women's freedom to make decisions. Community dialogue, work-shops, and drama can be some ways of overcoming social norms of inequality and discrimination against women.

- **Improvement of Menstrual Hygiene Programmes**

Management of menstrual hygiene needs to be taken as an essential part of SRHRs. The approach will include making available affordable menstrual products, raising awareness about menstrual health and provision of hygienic facilities for women in educational institutions, workplace and other public places. The program will include information on menstrual problems and removing menstrual taboos.

- **Integrate SRH with Nutrition Interventions**

The issues related to maternal and adolescent nutrition need to be addressed for ensuring better reproductive health results. The sexual and reproductive health programs must be associated with the interventions regarding nutrition in order to ensure that there is no issue of anaemia or undernutrition.

Overall, it means that there is a need to create an environment wherein women and adolescents receive adequate SRH services, and they have good social norms that can allow them to make reproductive choices.

## Conclusion

The SRH of women in Rajasthan is influenced by various cultural, education-related, socio-economic factors, and gaps within the healthcare delivery system itself. Recent surveys show that although there have been some improvements in terms of institutional deliveries, contraceptive knowledge, and use of maternal care services, the rate of progress has been quite slow and uneven due to several structural and social constraints (35). The existing gender norms restrict the freedom of movement and decision-making capacity of women, and lack of education makes it difficult for them to exercise informed choices with respect to SRH issues (36). Economic difficulties also play an important role in this matter, especially for women from poor and marginalized villages who do not have reliable reproductive health services available because frontline health workers are overworked (37). A gender-sensitive and comprehensive strategy which is one that enhances women's agency, upholds rights-based service provision, and involves family/community involvement has a lot of potential to revolutionize SRH performance in the state of Rajasthan (38). Provision of education, improvement in health infrastructure, availability of youth services, and inclusion of gender equality in policy/programmes will together contribute to an enabling environment in which women have the ability to make informed decisions regarding their body and health. Finally, any significant change in SRH will require sustained political commitment, multi-sectorial cooperation, and ongoing monitoring in order to ensure that every woman receives equitable and quality sexual and reproductive health care irrespective of her socio-economic condition and geographic area.

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