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Whose Bodies Matter? Exploring Historical Flows and Fractures in Indian Reproductive Norms[1]

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ABSTRACT

Sexual and reproductive health (SRH), especially for women, continues to be stigmatised and silenced across cultures. The female body in Asia has long been a site of control, contestation, and power. As scholars suggest, it is embedded in a patriarchal arrangement of gender relations. Yet, this story is not a linear narrative. Religion, colonialism, caste, class, and capitalism, amongst other social forces, have continually reshaped gendered realities, producing distinct rights, struggles, and lived experiences across Asian nations. This paper examines India - the world's most populous country - at the intersection of women's SRH law(s), histories, and practice. India's legal framework regarding SRH is comparatively liberal, but translating it from theory to practice requires our focus. To challenge patriarchal structures, it is necessary to trace their roots. Ancient Indian medical texts elucidate health issues, contain detailed medical treatises; however, the question stays. Were women's needs ever conceptualised beyond fertility? By tracing continuities and ruptures in reproductive health discourse - from early expositions to contemporary debates and data figures on menstruation, reproduction, and abortion - we interrogate whether the female body has ever been truly centred on its own terms. The analysis bridges historical and sociological perspectives with field-based insights, mapping how rights-based narratives continue to challenge entrenched hierarchies. In doing so, we aim to offer a feminist vision for sustaining and democratising SRH rights and realities in India and beyond, in alignment with the SDG goals.

Keywords: Sexual and Reproductive Health (SRH), wellbeing, gender norms.

INTRODUCTION

According to the World Health Organisation (WHO, 2021), well-being is a positive state shaped by social, economic, and environmental factors. Among its key determinants is sexual and reproductive health (SRH), which covers fertility, maternal health, contraception, pregnancy, abortion, and infections. The relationship between SRH and gender roles remains complex and is often overlooked (Ouahid et al., 2025). Achieving Sustainable Development Goals 3 (Good Health and Well-being) and 5 (Gender Equality) requires positioning SRH at the core of policy and practice - particularly in Asia, home to 60% of the world's reproductive-age population (Mayall et al., 2025).

India, now the most populous nation, continues to leverage its demographic advantage. Yet, in collectivist and patriarchal contexts, family and kinship structures often dictate social norms and reinforce gender hierarchies (Harper et al., 2020, as cited in Jejeebhoy, 2024). The Gender Social Norms Index (GSNI) reveals that 99% of Indians hold at least one gender bias and 86% hold two (UNDP, 2023). Our findings show that SRH remains a deeply tabooed area across Asia, constrained by silence, stigma, and limited public discourse.

What is already known on this topic
Sexual and reproductive health (SRH) is often a sensitive and uncomfortable topic of discussion In 2015, SRH was formally prioritized under the United Nations' Sustainable Development Goals (SDGs)
What this study adds
Bringing together historical and sociological perspectives, this research traces the history of reproductive norms in India from ancient to contemporary times Using an intersectional framework, the study centres women in the discourse to understand past trends and inform future trajectories for Asia more broadly

OBJECTIVES

Through the integration of historical and sociological perspectives, this work aims to trace the evolution of reproductive norms in India, spanning from ancient to contemporary contexts, with a particular focus on the differences and intersections between norms, laws, and practices.

The objectives are:

1. To re-centre women's bodies within intellectual and policy debates on health
2. To examine past trajectories to understand better the current SRH landscape in India and, more broadly, across Asia
3. To propose recommendations that foster a deeper, gender-sensitive understanding of well- being within South Asian traditions, thereby contributing to greater societal awareness and dialogue on the theme

METHODOLOGY

This paper is primarily desk-based, drawing on secondary data from textual sources and qualitative and quantitative studies. Over 20 published works were reviewed to inform the analysis. The framework of intersectionality has been central to shaping this work. Historically, women's bodies have figured in health discourse largely through reproduction, as sites to control fertility and ensure lineage continuity. But it was not just a gender issue; it was an issue of an overlap of gender with caste and community.

Adopting an intersectional lens, based on Kimberle Crenshaw's work, this paper examines how caste, class, gender, and community intersect to situate individuals within layered systems of privilege and disadvantage (see Figure 1) (Crenshaw, 1991). It traces how women's bodies and experiences were represented in South Asian historical records. Early patriarchal ideologies framed women as both *abala* (weak) and *pramada* (temptress) (Shah, 2019, p. 32), valuing them primarily for their reproductive role. This raises the question of whether attention to women's health historically extended beyond their reproductive function.

Using this lens, the paper explores how historical, legal, and sociocultural forces - including religion, colonialism, caste, class, and patriarchy - have shaped reproductive autonomy and recognition. By situating contemporary SRH challenges within these trajectories, the analysis seeks to foster a nuanced understanding of women's well-being - one that recognizes both structural barriers and individual agency, without reducing experiences to binaries of victimhood or heroism. However, we must start with the past.

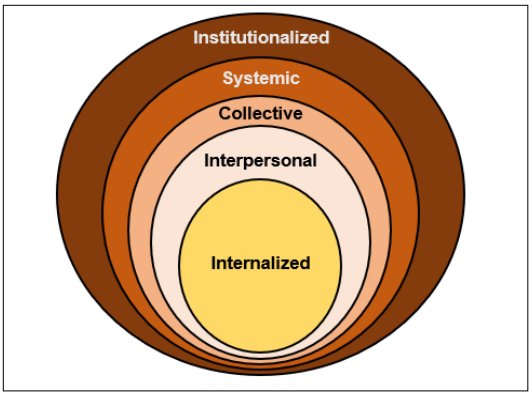

Figure 1: Intersecting Layers of Structural Positionality

REVIEW OF RELATED LITERATURE

The Female Body in the Past

Shah (2019), argues that early Sanskrit texts conceptualized the female body not merely as biological but as a cultural construct reflecting hierarchies of gender, caste, and belief. This was particularly evident in the emphasis on producing male heirs. Employing agricultural metaphors, the male "seed" was seen as superior to the female "field" (Menski, 1991, p. 49). Consequently, women's health was viewed primarily through the lens of reproduction, vital for sustaining lineage.

Paliwal (2025), explores Mughal women's reproductive experiences and their emotional dimensions - grief, resilience, and loss - against the backdrop of high maternal and infant mortality. Ray (2015), highlights the efforts of female medical missionaries and colonial administrators' wives to improve healthcare for secluded upper- and middle-class women affected by *purdah*. Gupta (2024) examines writings of Ayurvedic practitioner Yashoda Devi from early twentieth-century Allahabad, showing how indigenous understandings of women's health, sexuality, and illness intersected with emerging biomedical discourses. These works together illuminate how gender, caste, and community shaped the historical construction of women's bodies and health in South Asia. Our study of the contemporary situation requires a theoretical understanding of the concept of 'Well-being'.

Well-Being Through the Gendered Lens

The notion of "well-being" has evolved across theoretical traditions. Esposito et al. (2024) trace this progression from hedonic and eudaimonic to ecological approaches. In the hedonic view, subjective well-being reflects an individual's emotional balance and life satisfaction (Diener et al., 1985, as cited in Esposito et al., 2024). Ryff's eudaimonic model (1989, as cited in Esposito et al., 2024) emphasises psychological functioning - autonomy, purpose, growth, and positive relationships.

Critiques of both perspectives note that they often focus on individual responsibility, neglecting structural factors. To address this, Keyes (1998, as cited in Esposito et al., 2024) proposed *a* definition of social well-being, which encompasses social integration, contribution, acceptance, actualisation, and coherence. Building on this, community psychology foregrounds social context and collective agency. Prilleltensky's ecological framework (2005, as cited in Esposito et al., 2024) integrates personal, interpersonal, and societal dimensions, underscoring how systemic conditions influence individual well-being.

An ecological understanding recognises that inequality mediates access to well-being. For example, men may derive well-being from formal networks, whereas women often rely on community ties, making them more susceptible to social norms (Esposito et al., 2024). Matud et al. (2019) similarly demonstrate that gender roles influence psychological well-being, with individuals who embody both instrumental and expressive traits reporting higher levels. In collectivist Asian societies, interdependence and social harmony often take precedence over individual autonomy, suggesting that gender and well-being are dynamic, intertwined constructs rather than separate entities.

Is Well-Being the Norm?

Social norms, defined as "unwritten rules that determine what is appropriate and acceptable behaviour in any society" (UNFPA, 2024, p. 2), play a decisive role in shaping gendered experiences of health. Gender norms, in particular, influence ideologies, behaviours, and the allocation of opportunities and resources. An intersectional approach is therefore essential to understanding how these norms operate across class, caste, and community.

Reed (2021) observes that women's well-being in India is closely tied to their household status, which correlates with fertility, contraceptive use, and childbearing. Motherhood may enhance mobility and access to certain resources, yet the burden of reproduction remains primarily on women. Reed (2021, p. 5) reports that female sterilisation is far more common than male vasectomy; in her fieldwork, villagers described sterilisation as a "sacrifice" women made to spare their husbands from contraception. Although bearing a son can elevate a woman's social standing, it rarely translates into sustained control over resources or decision-making. These dynamics reveal that well-being in South Asia has historically been gendered - women are often valued as mothers rather than as individuals with health and autonomy of their own, and this raises the question of 'Reproductive Justice'.

Reproductive Justice

The framework of Reproductive Justice emerged from dialogues among women of colour following the 1994 International Conference on Population and Development in Cairo. Ross (as cited in Chrisler, 2012) emphasised that bodily autonomy is constrained by intersecting structures such as poverty, racism, and systemic injustice, linking reproductive rights to broader struggles for social equity.

Leyser-Whalen (2024) notes that abortion has long been treated as distinct from other reproductive health issues in academic, medical, and activist domains. Schurr et al. (2025) argue that while the reproductive justice framework has evolved, it must now move beyond gender to adopt a fully intersectional perspective, accounting for layered and compounding inequities. Advancing reproductive justice, therefore, requires understanding how

reproduction, bodily control, and population politics converge to shape lived realities. Is Reproductive Justice a reality in South Asia?

And the Stigma…Continues

The female body remains a site of taboo in India. Many unmarried girls lack awareness of the link between menstruation and pregnancy, delaying care-seeking (UNFPA, 2024). Health providers often hesitate to discuss contraception with unmarried adolescents, while parents fear that such conversations encourage premarital sex (Shukla et al., 2022; Jejeebhoy & Santhya, 2015, as cited in UNFPA, 2024).

How can reproductive justice become a reality when gendered exclusion persists across everyday life? women and girls are often barred from domestic or social activities during menstruation (Jejeebhoy et al., 2019; McGammon et al., 2020; Chandra-Mouli & Patel, 2017). Boys' exclusion from menstrual education further entrenches inequitable attitudes. Practices such as early and arranged marriages continue to shape women's social identities (UNFPA, 2024).

Across the Asia-Pacific, one in seven girls becomes a mother before age 18, often due to child marriage and unmet contraceptive needs; one in eight adolescent pregnancies is unintended, contributing to an estimated 3.6 million unsafe abortions annually (Riabroi et al., 2024). Persistent stigma around SRH education and conversations about sexuality deepens these vulnerabilities. Their well-being is last on the list of social priorities.

Socioeconomic disparities exacerbate barriers to SRH access, particularly for unmarried and marginalised women. Services remain focused on married women, reinforcing the view that reproductive health, and by extension, well-being, belongs within the bounds of marriage.

DISCUSSION

From Ancient to Contemporary Times

While Ayurvedic literature in Early South Asia sought to promote overall longevity, the main emphasis was on reproductive health, especially for women. There are detailed descriptions of uterine (*garbhavyapta*) and genital (*yonivyapata*) tract diseases that underscored women's essential role in continuing lineages. Vagabhata informs us in the *Ashtangasangraha* (*Sarirasthana*, II.40) that since a woman is the chief cause of progeny, protecting her is tantamount to the protection of the progeny (the son). The uneven focus on male and female issues also becomes evident from the fact that female reproductive fluids were overshadowed by greater attention to male fluids (*virya, sukra, retas*) and organs, revealing an apparent disparity in treatment. Menstruation was seen as polluting, while male emissions were not taboo. *Artava Kshaya* is a reference to a menstrual disorder, which indicates scanty flow and is associated with pain of variable duration. The ancient text recognises the issue but there appears a reluctance on the part of the writers to be forthcoming on its resolution. We sight a similar diffidence in dealing with the issues of ageing, as women reach their menopausal state, and that as their reproductive capacity dwindles, the interest of medical writers also wanes. Men's ageing issue, however, receives a fairly good postulation and we encounter therapies for older men to regain their sexual energy.

One occasion when women come centre-stage is when they become pregnant. *Charaka Samhita*, a medical treatise from the early centuries of the Common Era, advices them on their food and rest routines. But what happens when a woman is unable to reproduce? She is denigrated with titles *vandhya* (barren, infertile), and if she were to produce only girls (*striprasuti*) she is equated to a barren woman. With such biases prevailing can abortion ever be justified? By and large, abortion or *bhrunahatya* was considered a sin; however, there are references in the medical treatise to permitting abortion if the mother's health is in danger. This becomes more relevant if the foetus dies risking mother's health. Medical issue then becomes the rationale for acknowledging an occasional case of abortion. Clearly a woman's choice to terminate the pregnancy was of no consequence.

Throughout the medieval period, issues related to reproductive health continued to pervade the writings of scholars and travellers. Prof Shireen Moosvi (2014, pp. 101–109) notes high infant mortality rate in the Mughal harem which must have caused trauma. Induced abortion was also practiced by some as a matter of harem politics when some royal women used it against their rivals. (Paliwal, 2025, pp. 11–24). According to Paliwal natural or forced abortion could lead to issues like insomnia, eating disorders, stress, anxiety, anger, loneliness, and these could puncture self-esteem of some women in medieval times too.

In the colonial period, we come across references to Clara Swain and others, who were associated with missionary activities and established professional medical practices in the late nineteenth and early twentieth centuries. Lady Dufferin, Lady Minto, and Lady Chelmsford arranged funds for both medical and nursing training. Reproductive health care improved as more hospitals were established and training initiatives undertaken. As pointed out by Sharmita Ray, from the late nineteenth century, some of the earliest Indian women doctors, among them Kadambini Ganguly and Haimabati Sen - served in various hospitals established and supported by the Countess of Dufferin Fund (Association) across India (Ray, 2015, p. 542). Although these efforts by female missionaries and Vicereines helped many Indian women, they also became a mechanism for the colonial state to strengthen its power.

Along with Western medical practices, women at large also received help from women who practiced traditional Ayurvedic medicine. One such woman was Yashoda Devi, who established a *Striaushadhalaya* (Female Dispensary) in the 1920s to address essentially the issues of procreation, but in the process also drew attention to the problems of male sexuality. We remember Yashoda Devi not only for the gynae care she provided but for the fact that she sharply condemned some men's for excessive sexual urges, that she held responsible for the spread of venereal diseases and women's poor health (Gupta, 2024, p. 170). It is in writings like these that we begin deciphering a woman's growing consciousness of autonomy over her anatomy, at least from the perspective of sexual and reproductive health.

In contemporary times, much has changed, yet many things remain the same. Since the International Conference on Population and Development (ICPD) in 1994, sexual and reproductive health has been prioritised globally, with over 60 countries decriminalizing abortion in the past three decades (Mayall et al., 2025). Still, the enduring power of cultural norms requires ongoing effort for transformation, shaping lives even before birth. Let us turn to this more closely.

Laws, Norms and the Shaping of Practice

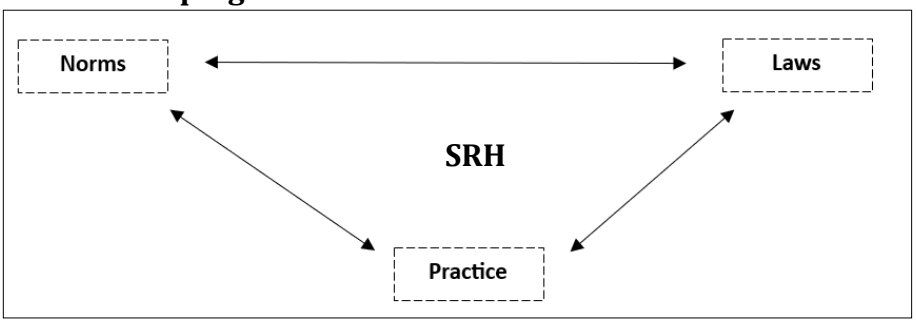

Figure 2: Interdependence of Norms, Laws and Practice

Legal systems and cultural norms continually mould one another, shaping practices around SRH (see Figure 2). Neither holds primacy over the other. The Asian context offers several examples. In Kerala's Sabarimala temple, women aged 10-50 were traditionally barred based on beliefs of menstrual "impurity." Despite the Supreme Court's ruling permitting entry for all, right-wing activists violently resisted, underscoring how legal reform can be undermined by entrenched social opposition (Contractor et al., 2022). Similarly, in Sri Lanka, abortion is legal only to save a woman's life. Public health advocates sought to expand legal grounds, but religious leaders opposed the move, and without "religious consensus," the government abandoned reform (Contractor et al., 2022).

Across Asia, the impact of law on gendered power imbalances remains limited by the persistence of social norms. In India, laws exist against dowry, sex-selective practices, and unsafe abortions, yet these continue in covert forms. From a Bordieuan lens, this is unsurprising: individuals' *habitus* - their worldview - is shaped by both their field (environment) and their access to *capital* (resources). Thus, caste, community and religion, amongst other factors, shapes norms and practice.

Contemporary Reproductive Norms and Practices

Recent data reveal deep-rooted contradictions.

- In a national survey by Ipas Development Foundation (IDF, 2023), 72% of Indians supported abortion, yet only 29% believed women should be the primary decision-makers. Age, gender, and education significantly shaped these views
- Fertility remains valued, but pregnancy is often seen as routine, not requiring special care. Between 2019-21, 11% of women delivered outside a health facility, 41% had fewer than four antenatal visits, and 16% received no postpartum care (UNFPA, 2024). Gendered power dynamics continue to restrict women's decision-making, mobility, and financial control
- Cultural beliefs limit girls' mobility and autonomy. In Nepal, menstruating girls avoid contact or movement for fear of harm, while premarital sexual activity is labelled *kharab bani* (bad behaviour). Providers often discourage contraceptive use before marriage: "Health care professionals would say contraceptives are of no use to unmarried adolescents…" (Riabroi, 2025, p.6)
- Resource distribution also reflects gender bias: men, viewed as needing strength, often eat first and most, while women eat last and least. In India, 57% of women, compared to 25% of men - are anaemic (IIPS & ICF, 2022, as cited in UNFPA, 2024)

Those interventions that acknowledge social norms and their power, have demonstrated success. The Janani Suraksha Yojana in India (JSY) - one of the world's largest conditional cash transfer programmes has improved maternal and neonatal outcomes by incentivising institutional deliveries. In low-performing states, JSY beneficiaries reported higher contraceptive use, early breastfeeding initiation, and postpartum check-ups. Similarly, the PRACHAR programme in Bihar, India reduced early fertility by promoting contraception and reproductive health education among married adolescents and young women (Daniel et al., 2008).

CONCLUSION

This paper has interrogated the continuities and ruptures in India's reproductive norms, centring women's embodied experiences as an analytical site. The concept of well-being has historically excluded women's realities, even as their reproductive value has been recorded. Self-decision on reproductive issues has not been taken well socially. Evidence from a diary-based inquiry on self-managed abortion (SMA) in India demonstrates this duality. Some participants articulated a sense of agency, stating, "The decision was of my own." In contrast, others described experiences of shame and social abandonment, such as "I felt ashamed" and "Nobody supports me" (IDF, 2023). These accounts highlight the intricate interplay between autonomy, affect, and structural constraints in women's reproductive lives.

Across India and much of Asia, reproductive health interventions at the level of the state and community remain oriented towards demographic regulation and familial stability rather than the advancement of women's autonomy or well-being. When reproductive health is instrumentalised for population or development objectives, it reinforces rather than dismantles gender hierarchies. Realising the transformative intent of the Sustainable Development Goals - particularly SDGs 3 and 5 on health and gender equality - requires a paradigmatic shift: from framing women's wellbeing as a means to collective progress to recognising it as integral to justice, dignity, and human flourishing.

Recommendations

- **Historical Context Matters:** Clearly articulating that restrictive gender norms are rooted in historical and socio-cultural contexts can make it easier to address and transform them
- **Measuring Norm Change:** The UNFPA (2024) report underscores that gender norms significantly constrain development, highlighting the need not only for interventions that drive norm change but also for robust measurement tools. While India's National Family Health Survey (NFHS) provides nationwide data on gender-related attitudes, norms themselves - distinct from attitudes - are rarely captured. Greater attention is needed to incorporate norms into data collection frameworks
- **Challenging Heteronormativity:** Current healthcare, SRH research, and discourse often assume heteronormative frameworks. Recognising and addressing this assumption is critical to creating inclusive sexual and reproductive health policies and programs
- **Blended Approaches in Religious and Collectivistic Contexts:** In deeply religious and collectivistic Asian societies, strategies that combine the public health benefits of SRH policies with engagement in progressive theological debates can help shift public opinion and foster greater acceptance.

Limitations and Strengths

This work is primarily desk-oriented, does not incorporate primary data, and focuses predominantly on a single Asian nation and women, which may limit the generalizability of findings. However, its strengths lie in offering a longitudinal perspective that can inform future strategies, integrating historical and sociological analyses, and centring women within the reproductive health discourse, an approach that foregrounds their experiences, agency, and structural contexts.

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