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RESEARCH ARTICLE

BRIDGING DIVIDES, BUILDING SOLUTIONS: STAKEHOLDER CONSULTATIONS ON SRH DISPARITIES IN JAIPUR DISTRICT, INDIA

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ABSTRACT

Women's Sexual and Reproductive Health (SRH) remains a critical area of concern, particularly in contexts were gendered power relations limit women's autonomy and decision-making capacity. This study investigates the multifaceted aspects of SRH including family planning, maternal healthcare, awareness of sexually transmitted infections (STIs), and women's autonomy through a comparative analysis of rural and urban women in Jaipur district, Rajasthan. Using an exploratory research design, the study draws insights from a diverse group of stakeholders including policymakers, healthcare professionals, academicians, NGO (Non- government Organization) representatives, community leaders, and frontline workers. Purposive sampling was employed to recruit panel members with relevant expertise and engagement in the field of SRH. Data was collected through stakeholder consultation meetings, utilizing the Delphi method to facilitate structured discussions and consensus-building around complex SRH challenges. Findings highlight significant disparities in SRH awareness, access to healthcare services, and decision-making power between rural and urban women. The study underscores the urgent need for context-specific policy interventions, community engagement, and multi-sectorial collaboration to enhance SRH outcomes and uphold women's reproductive rights in Rajasthan.

KEYWORDS

sexual and reproductive health, urban and rural disparities, family planning, challenges and opportunities, Delphi method, stakeholder's consultation, rajasthan.

INTRODUCTION

The World Health Organization defines Sexual and Reproductive Heath as a comprehensive state of physical, emotional, mental and social well-being concerning sexuality and the functioning of the reproductive system [1]. With in the Indian context- particularly in the Northern zone regions- deeply entrenched patriarchal structure and ideologies continue to pose significant challenges to women's overall wellbeing. These socio-cultural frameworks not only shape gender roles rather systematically constrain women's autonomy and agency. Consequently, women's SRH and their decision-making capacities must be examined with in the broader context of patriarchy and traditional organization, where in power relations are inherently gendered and often skewed in favour of men.

Rural areas in India are frequently characterized by structural limitations, including inadequate healthcare infrastructure, limited awareness, restrictive cultural norms, and persistent socioeconomic constraints, all of which adversely influence SRH outcomes among women [2].
In contrast, urban settings tend to offer relatively better access to healthcare services, higher levels of education, and increased employment opportunities, there by contributing to comparatively SRH indicators. A critical examination of the disparities between rural and urban contexts is therefore essential for the development of nuanced, evidence-based policies and interventions aimed at addressing the diverse and context specific SRH needs of women [3].

Scholarly discourse on women's decision-making power, particularly in the domain of SRH, has increasingly emphasized the role of gendered power relations. Women often remain marginalized in decision-making processes, with their reproductive rights insufficiently acknowledged or prioritized. Health outcomes and rights are profoundly shaped by an array of social and cultural determinants. From an early age, individuals are socialized into distinct gender roles through culturally embedded practices, symbols, norms, and value systems that construct and reinforce notions of masculinity and femininity [4].

Therefore, the present study is theoretically anchored in the theory of Gender and Power proposed by R.W. Connell. which offers a robust analytical framework for examining gender-based disparities in SRH. The theory delineates three different but interrelated structures; namely, the sexual division of labour, the sexual division of power, and the structure of cathexis, each of which critically influences women's access to resources, autonomy in decision making and health related behaviours. With in SRH domain, these structural dimensions shape women's ability to access maternal healthcare services, utilize family planning methods, and acquire knowledge regarding sexually transmitted infections (STI).

In regions such as the Jaipur district of Rajasthan, where socio-cultural norms and economic conditions exhibit considerable variations across rural and urban settings, these gendered power dynamics assume a decisive role in shaping health outcomes. By employing the theoretical lens, the study moves beyond an individualistic understanding of health behaviour and instead foregrounds the structural and systemic determinants of SRH. Accordingly, the study seeks to critically examine how entrenched social norms and structural inequalities influence women's autonomy and access to SRH services, while incorporating insights from a diverse range of stakeholders, including policymakers, healthcare professionals, academicians, and community leaders.

RESEARCH METHODOLOGY

STUDY AREA:

The comparison of SRH between Rajasthan's rural and urban women illuminates the complex issues that are present in this particular geographic setting. Over the years, Rajasthan, a state with a largely rural terrain, has seen a dramatic urbanization process that has changed the population's health characteristics. Examining SRH discrepancies is made more interesting by the state's distinctive features, which include differences in healthcare infrastructure, cultural variety, and economic development levels, offer an engaging context for analysing SRH discrepancies. This study seeks to explore the multifaceted aspects of SRH, encompassing family planning, maternal healthcare, awareness of sexually transmitted infections (STIs), and women's autonomy in decision-making. By conducting a comparative analysis, we aim to uncover disparities in SRH outcomes and access to healthcare services among rural and urban women in Rajasthan.

The study is conducted in Jaipur also referred as 'Pink City'. Rajasthan, encompassing both rural and urban settings to capture variations in sexual and reproductive health (SRH) indicators. Since this paper is derived from an on-going major research project sponsored by ICSSR, New-Delhi where we proposed study area as Jaipur District, the most populous district of Rajasthan State. It comprises of 13 Tehsils, each encompassing both urban towns and rural villages. From these Tehsils, 'Jaipur Tehsil' is meticulously chosen due to its substantial population size and its inclusion of both urban and rural areas. In the rural segment, five of the most populous villages were purposively selected from a total of 72 villages to ensure adequate population representation: *Niwaroo* (11,745), *Boytawala* (8,667), *Kalwar* (8,393), *Vijaypura (*8,000), *and*

Hathod (6,199). In the urban segment, the study area comprised *Jaipur* Town, administered by the Municipal Corporation of Jaipur, which has a total population of 763,574 across 77 wards. Five wards were randomly selected to represent the urban population, ensuring geographic and demographic diversity. The inclusion of both rural villages and urban wards enabled a comparative assessment of SRH indicators, including family planning practices, maternal healthcare utilisation, awareness of sexually transmitted infections, and reproductive healthcare access, across different socio-cultural and infrastructural contexts in Jaipur district.

ETHICAL CLEARANCE STATEMENT:

The research work titled "*Bridging Divides, Building Solutions: Stakeholder Consultations on SRH Disparities in Jaipur District*" is conducted under the **ICSSR sponsored project** at the **University of Rajasthan, Jaipur**. The study received ethical clearance from the Institutional Ethics Committee, University of Rajasthan. All procedures performed in this study involving human participants were in accordance with the ethical standards of the Departmental research committee and the guidelines of the Indian Council of Social Science Research (ICSSR). Informed consent was obtained from all participants, and confidentiality, anonymity, and voluntary participation were strictly maintained throughout the research process.

STUDY DESIGN AND RESPONDENTS:

An exploratory qualitative research design was employed for the study to get insights on opportunities and challenges for enhancing knowledge and practice on women's SRH in the urban and rural areas of Jaipur district from experts, policymakers, academicians, healthcare professionals, community representatives, NGO's and frontline workers to facilitate structured dialogue and consensus among key stakeholders.

STAKEHOLDER IDENTIFICATION AND ENGAGEMENT IN THIS QUALITATIVE LEG OF DATA COLLECTION:

The study adopted purposive sampling to recruit participants. Panel members were purposefully selected based on their experience, expertise and engagement in the field of SRH of women. To ensure comprehensive understanding of SRH landscape in the region, experts from multidisciplinary background including policymakers, academicians, implementers and healthcare providers were included in the sample. Altogether, 55 experts agreed to participate in the meeting, representing a broad spectrum of disciplines. The diversity was intended to enhance the validity and generalizability of the consensus outcomes and conclusions.

The stakeholder mapping and analysis framework was employed to identify the roles and level of involvement of various stakeholders. A total of 55 members, comprising of both state- level informants and community-level informants, participated in the process. The expert panel (N=55) was purposively balanced to include both macro-level perspectives (State Directors and Development Partners) and micro-level insights. To ensure rural-urban parity, the consultation included equal representation from grassroots functionaries (ASHA, ANM) across the five purposively selected rural villages and five randomly selected urban wards.

Participants for the stakeholder's meet were policymakers, state Development partners included representatives from UNICEF and *Jhpiego*, while state-level participants comprised Director RCH, Additional State Programme Officer, Representative from State Institute of Health and Family Welfare Rajasthan, *Saksham Mahila Samiti*, and Foundation for Reproductive Health Services (FRHS). The meeting also included representatives from UPHC, *Gandhi Nagar* and UPHC *Shanti Nagar*, senior medical officers, and community workers such as *Sarpanch*, ASHA, and ANM, reflecting a broad spectrum of disciplines and perspectives.

DATA COLLECTION:

Duration and Format of the Stakeholders' Consultation

The study incorporated a one-day stakeholders' consultation as part of its qualitative research design. The consultation was conducted over a duration of approximately six hours (09:30 AM–03:45 PM) and was organised as a face-to-face structured consultative workshop. The format combined expert presentations, guided discussions, and experience-sharing sessions to elicit policy, programmatic, and community-level perspectives on sexual and reproductive health (SRH) in Rajasthan.

The consultation was systematically structured into three components: an inaugural and contextualisation phase, thematic expert presentations, and facilitated discussion rounds. This format enabled both evidence-based framing of SRH issues and participatory engagement of diverse stakeholders, including policymakers, academicians, healthcare providers, grassroots workers, development organisations, and community representatives.

DISCUSSION ROUNDS

Two thematically guided discussion rounds were conducted to ensure depth and triangulation of perspectives.

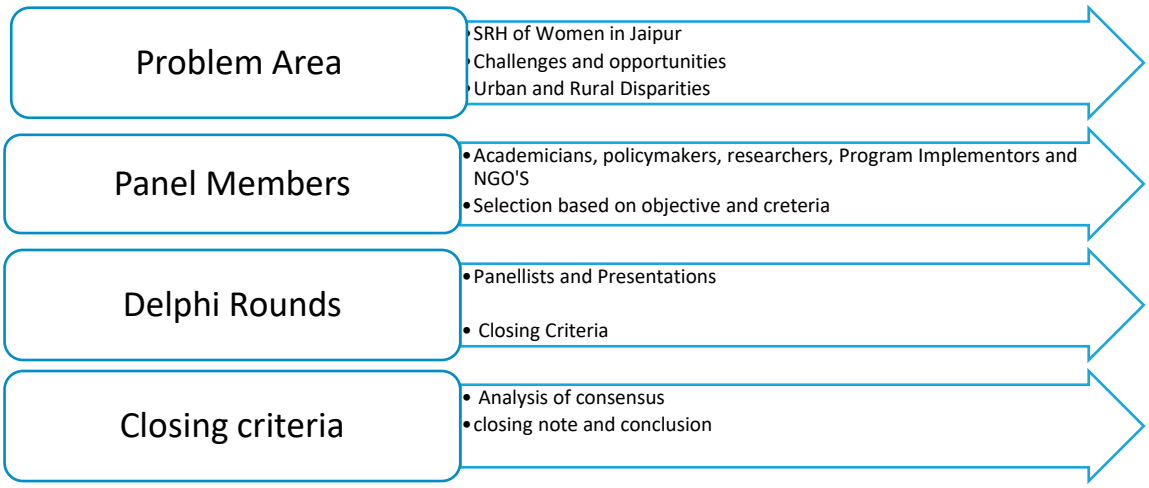
Discussion Round I Challenges and Opportunities in SRH (11:30 AM–01:00 PM) focused on structural, policy, and health system–related dimensions of SRH. Participants deliberated on barriers faced by marginalised women in accessing SRH services, the role of the public healthcare system, the influence of gender norms and power relations on women's reproductive decision-making, and gaps in existing policies and programmes requiring reform.

Discussion Round II Government Schemes and Innovation on SRH Rajasthan (01:45 PM–03:45 PM) was designed as an experience-sharing and participatory dialogue session. Grassroots health functionaries (ASHA, ANM, AWW), elected local representatives, development organisations, non-governmental organisations, and community members shared field-level experiences related to service delivery, utilisation challenges, sociocultural constraints, and implementation gaps. This round strengthened the qualitative component of the study by incorporating lived experiences and contextual realities.

The data was collected through panel discussion and presentations given during the Stakeholders consultations meet. Prior to data collection, all participants were briefed about the objectives of the study and informed consent was obtained for recording their responses. The panel discussion was facilitated by a moderator, assisted by a note-taker and a local translator. With prior consent from the panel members, the discussions were audio-recorded in addition; the presentations delivered during the session were also audio recorded with the permission of the key informants and participants. Panel discussion and presentation on SRH was held in English and the local language.

The Delphi technique was originally designed as a tool for business forecasting, utilizing structured discussions among panel of experts, based on the premise that collective judgement tends to be more reliable than individual assessments [5]. This approach is particularly useful in areas where statistical evidence is lacking, knowledge remains uncertain or incomplete and where the consensus of experts is considered more dependable than isolated opinions [6].

FIGURE 1: STEPWISE ASSESSMENT OF DELPHI METHODOLOGY



DATA ANALYSIS:

The audio files were transcribed verbatim, and translations into English were carried out where required. To ensure confidentiality, all transcripts were anonymized through systematic coding, with no identifying information retained. Prior informed consent was obtained from participants for the use of verbatim quotations during the stakeholder consultation meeting. The coded data were stored securely on a password protected laptop, accessible only to the researcher. The transcripts were processed and edited using Microsoft Word. The field notes were anonymized using special codes and added to the edited transcripts. The major themes and subthemes pertaining to SRH were identified using a thematic framework technique. We used *Murray-Webster & Simon's (2006)* stakeholder mapping analysis approach, which first characterizes stakeholders in terms of their potentials - power, attitude, and interest [7].

POTENTIALS OF STAKEHOLDERS

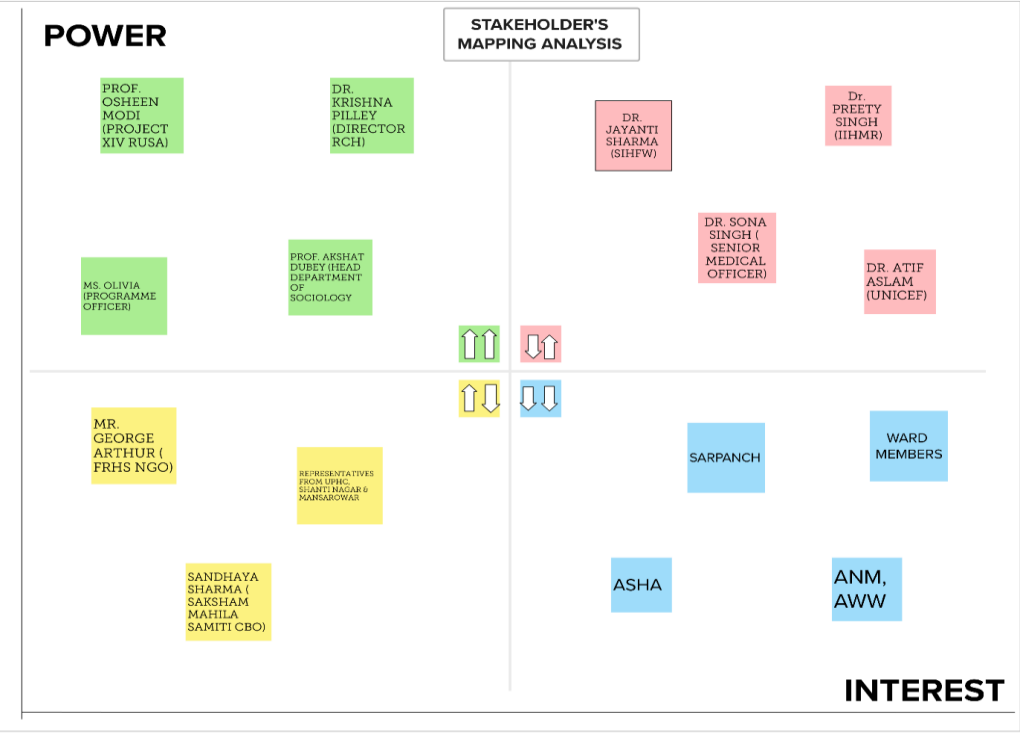
The framework divides stakeholder potentials into three categories, starting with

Power: This relates to how stakeholders view their ability to influence the State's execution of the SRH program. Their influencing ability was classified as "strong" or "weak" in this study.

Attitude: This relates to how stakeholders view their support for the State's implementation of the SRH program. Their support was classified in this study as "non-supportive" for negative views and "supportive" for positive attitudes.

Interest: This is how stakeholders view the implementation of the SRH program. Interest was divided into two categories: "passive" for those who are unwilling or reluctant to participate in the adolescent SRH program and "active for those who are highly interested and willing to do so.

FIGURE 2: STAKEHOLDER'S MAPPING FRAMEWORK ANALYSIS



(NOTE: All names used in this matrix are pseudonyms and have been anonymized to protect the identity and confidentiality of stakeholders involved in the consultation.)

FIGURE 3: RESULT MATRIX OF STAKEHOLDER'S CONSULTATION MEET TABLE

Stakeholder	Power	Interest	Quadrant
Prof. Osheen (Project XIV, RUSA)	High	High	Manage Closely
Prof. Akshat Dubey (Head, Sociology)	High	High	Manage Closely

Dr. Krishna Pilley (Director RCH)	High	High	Manage Closely
Ms. Olivia (Programme Officer)	High	Low	Keep Satisfied
Dr. Preety Singh (IIHMR)	High	High	Manage Closely
Dr. Atif Aslam (UNICEF)	High	High	Manage Closely
Dr. Sona Singh (Senior Medical Officer)	High	High	Manage Closely
Dr. Jayanti Sharma (SIHFW)	High	High	Manage Closely
Mr. George Arthur (FRHS NGO)	Low	High	Keep Informed
Sandhaya Sharma (Saksham Mahila Samiti, CBO)	Low	High	Keep Informed
Representatives from UPHC, Shanti Nagar, Mansarovar	Low	High	Keep Informed
Sarpanch	Low	Low	Monitor
Ward Members	Low	Low	Monitor
ASHA ANM AWW	Low	Low	Monitor

RESULT: CHALLENGES AND OPPORTUNITIES IN THE AREA OF SRH OF WOMEN

The shareholders consultation meeting was attended by key stakeholders including healthcare professionals, policymakers, and researchers. Participants emphasized the critical role of SRH in public sector and in promoting gender equality. They also highlighted the importance of interdisciplinary collaboration in addressing systemic barriers. Special attention was given to the disparities in SRH services between urban and rural populations. The findings from the consultation are as follows:

SRH PROGRAM AND POLICIES IN RAJASTHAN

Government Schemes and Their Accessibility

India's Family Welfare Programme, instituted in 1952, represents a pioneering effort in public health policy, positioning the country as the first globally to implement a comprehensive, state-sponsored family planning initiative. The programme's principal objective is to achieve population stabilization through the provision of accessible and equitable family planning services to eligible couples [8]. Concurrently, it seeks to mitigate maternal and infant mortality by advocating for pregnancies at biologically appropriate ages and promoting optimal birth spacing through informed contraceptive practices.

Even the study done by Sharma, S.P, *et al*. underscores that, despite the rapid urbanization of Jaipur, reproductive health perceptions and practices remain deeply embedded within entrenched socio-cultural frameworks. Traditional gender norms, patriarchal structures, and intra-household power hierarchies particularly the influence exerted by husbands and mothers-in-law—continue to shape decisions concerning family size and a persistent preference for male offspring. While Jaipur's near-universal institutional birth rate of 99.8% constitutes a significant public health achievement, contrary to this finding also revealed enduring constraints on women's autonomy, especially in rural settings. In these areas, the prevalence of early marriage—nearly twice that observed in urban counterparts results in a substantial proportion of women entering motherhood before the age of eighteen, often with limited educational attainment. This perpetuates a cyclical pattern of disadvantage, wherein the mere availability of healthcare infrastructure and medical professionals does not necessarily translate into autonomous healthcare-seeking behavior. Instead, such decisions remain largely

mediated by prevailing familial and cultural dynamics, thereby undermining women's agency in matters of reproductive health [9].

The different government schemes that have been started in Rajasthan are;

Janani Suraksha Yojana *(JSY)* Maternal Mortality Rate (MMR) in Rajasthan has significantly reduced from 141 to 87 in recent years. One of the key interventions contributing to this decline is the *Janani Suraksha Yojana* (JSY), implemented under the National Heath Mission, is a safe motherhood initiative designed to decrease maternal and neonatal mortality [10]. The program encourages institutional deliveries, particularly among economically disadvantaged pregnant women. This scheme provides conditional cash transfers to encourage institutional deliveries and improve access to medical care. It is a centrally sponsored scheme that integrates financial assistance with delivery and post-natal care services. A critical component of JSY is the involvement of Accredited Social Health Activist (ASHA) who serves as a vital link between the health system and pregnant women, ensuring timely access to services and promoting health awareness.

Pradhan Mantri Matru Vandana Yojana *(PMMVY)* is a maternity benefit scheme administered by the ministry of Women and Child Development, Government of India [11]. Initially introduced in 2010 as the *Indira Gandhi Matritva Sahyog Yojana*, it was restructured and renamed as PMMVY in 2017 [12][13]. The program is a conditional cash transfer initiative targeted at women aged 19 years and above, applicable for their first living child during pregnancy and lactation [14]. It seeks to provide partial wage compensation for women to compensate for wage-loss during childbirth and childcare. Along with income support, the scheme also seeks to encourage safe delivery practices, proper nutrition and healthy feeding habits for both mother and child.

Mission Parivar Vikas is a focused initiative launched by Government of India to address high fertility in selected districts. The campaign promotes responsible reproductive choices- by improving access to family planning services, particularly in high-fertility districts. The key objective of MPV include increasing the availability and use of modern contraceptives, raising awareness about family planning, and strengthening the supply chain to ensure uninterrupted availability of contraceptive commodities.

Innovations in creating awareness on SRH in Rajasthan

Nayi Pahal Kits – These kits distributed to newly married women, include bridal ornaments and contraceptives, to promote awareness about reproductive health and family planning. The kit contains condoms, birth control pills, a mirror, two towels, handkerchiefs for the husband and wife, a bindi, comb, nail cutter, and an informative booklet that highlights the importance of planned parenthood. This initiative reflects the government's thoughtful and sensitive approach to engaging newlywed couples in discussion around reproductive health and family planning.

FEMALE ASHA "ASHA *worker actively participates in this scheme by distributing the kits. Open conversations around this delicate subject are possible when frontline worker build rapport and establish trust, which lays the foundation for the healthy communication and strong relationship in the future. To raise awareness about safe sex and family planning among newlywed couples, this initiative has been started.*"

Purush Sahbhagita Sammelan – In the context of rising population growth, male involvement in family planning has become crucial. While family planning is important for both men and women, the uptake of male contraceptive method remains low. Even in a study done by Diamond-Smith et al. (2024) in *Udaipur* and *Rajsamand* districts found that family planning remains heavily 'feminized'. Men often view contraception as 'women's business', and significant cultural barriers prevent husbands from engaging in SRH dialogues, fearing a loss of 'masculinity' [15]. Therefore, to encourage greater male participation, a vasectomy acceptor is invited to serves as a role model. He is honoured and encouraged to share his personal experience to promote awareness and acceptance of male sterilization and vasectomy.

Prof. Osheen "*Include Men in this crusade, this is human right not women's issue and men and women are equally part of it and living in 2025 this mind-set must be challenged and changed.*"

Key initiatives in Rajasthan

Saas Bahu Sammelan - A "*Saas Bahu Sammelan*," or Mother-in-Law and Daughter-in-Law Meeting," is a community event, typically organized by government or community organizations, to foster better relationships and promote healthy practices within households. These events focus on key issues such as maternal and child health, family planning, and addressing misconceptions related to childbirth and nutrition. More than 30,000 *'Saas Bahu Sammelans*' are organized annually in Rajasthan's rural areas.

Dr. Usha prof. IIHMR "In many households Mother-in-law often plays a key role in decision-maker particularly regarding reproductive choices, such as when the newlyweds will have children and expectation around the gender of the child."

Meena Rural Woman "My baby was seven months in my womb when I lost the pregnancy, Doctor said it was because of iron deficiency, but my family refused to believe it. After the miscarriage, my periods stopped, and instead of taking me to a doctor, they whispered that an evil spirit had caught me… that something had 'bound' my body. My mother-in-law kept me inside the house, made me sit alone in dark corners, and warned me not to step out at dusk. Even today, the fear of that time still sits inside me."

Tele counselling and Family welfare counselling centre-The government of Rajasthan has launched an initiative, offering 24X7 counselling services to married couples through a toll-free number. In rural areas where healthcare providers are often limited or unavailable, tele-counselling can play a crucial role in supporting informed decision-making and improving access to reproductive health information.

Tele-counselling allows individuals and couples to receive guidance on family planning, spacing practices, maternal care, and adolescent health through remote platforms, which is particularly useful for those living in geographically or socially constrained settings [16]. Family Welfare Counselling Centres operate at selected public health facilities and provide personalised, in-person counselling on contraceptive options, postpartum family planning, fertility-related concerns, and appropriate referrals [17]. Both services emphasise informed choice, confidentiality, and voluntary participation, and are aligned with broader family welfare initiatives such as Mission Parivar Vikas. Collectively, these mechanisms contribute to strengthening awareness, counselling quality, and continuity of family welfare services across rural and urban areas of Rajasthan.

EXISTING CHALLENGES AND OPPORTUNITIES

Gender norms and Decision-making

Despite over five decades of commemorating International Women's Day and sustained global and national commitments toward gender equality, the imperative to accelerate progress remains pressing. Although numerous initiatives have been implemented, their impact is often constrained by fragmented and siloed approaches. Achieving meaningful societal transformation and advancing national development necessitate the systematic translation of empirical evidence and community perspectives into coherent, actionable policy frameworks.

Access to sexual and reproductive health (SRH) services continues to represent a critical public health challenge, particularly for women. This access is shaped by a constellation of interrelated factors, with gender inequality serving as the foundational determinant that exacerbates other structural and socio-cultural barriers. While notable progress has been made, significant gaps persist, and considerable efforts are still required to ensure that all women and girls can fully exercise their reproductive rights.

Empirical evidence from the longitudinal UDAYA (Understanding the Lives of Adolescents and Young Adults) study conducted in Uttar Pradesh and Bihar highlights substantial deficiencies in SRH knowledge among adolescent girls in India. This knowledge gap exposes them to a range of preventable health risks, including early and unintended pregnancies, as well as gynecological morbidities such as irregular menstrual cycles and abnormal urethral discharge, among others. Deeply entrenched social stigma, coupled with limited autonomy, further restricts adolescents—particularly those from marginalized communities—from accessing accurate, comprehensive, and timely SRH information through familial or local healthcare channels.

These barriers significantly undermine health-seeking behaviors and contribute to avoidable adverse reproductive health outcomes. In urban contexts such as Jaipur, where SRH remains a socially sensitive and often stigmatized subject, innovative approaches are essential. In this regard, social media and digital platforms offer considerable potential as transformative tools for disseminating information, fostering awareness, and addressing misconceptions surrounding SRH in a culturally sensitive manner [18].

Men are expected to be assertive and powerful while women are often perceived as weak or passive. In rural areas women juggle multiple responsibilities day and night, leaving no time for self-care moreover no say in deciding when to have child, number & spacing of children since the decision-making power is in the hand of mother-in-law or husband.

Prof. Olivia "A woman or girl's fundamental rights to equality, privacy, and bodily integrity are based on her ability to make independent decisions regarding her own body and reproductive functions. Women's empowerment is the first step toward their freedom to express themselves and make decisions."

Inclusion of Men & Breaking Taboos

There are a multiple contraceptive options available for women but very few for men. Women can choose from wide range of methods such as, *MALA-N, E pills, Chhaya,* Contraception injection *Antara, IUCD*, Sub dermal contraceptive implant and female sterilization. In contrast, the options for men are limited primarily to vasectomy, condoms and withdrawal methods. To address this imbalance and promote male participation in family planning, district and regional level consultation and training should be mandatory. These platforms are essential for dispelling myths and misconceptions surrounding male vasectomy and encouraging informed, positive attitudes towards male contraceptive responsibility.

Anita (ASHA WORKER): "more incentives are provided to ASHA/ front line workers to mobilize male members for sterilization but they refuse saying their masculinity will be lost in the whole process but when the research was carried out the results were shocking as it's the female members of the family who act as the major barrier in decision making."

Sunita (Rual Woman) "I have been pregnant nine times, and five of those babies were girls… so I was forced to abort them. The guilt and pain kept building inside me. I couldn't bear it anymore, so I secretly got the sterilization done without telling my family. Since then, I feel extremely weak, emotionally and physically."

*Dr Suman (PHC DOCTOR**): "**When a 16-year-old boy approached the PHC to ask about the benefits of condoms and pregnancy prevention, it highlighted the discomfort adolescents often face in seeking such information. To mitigate this, sanitary pads and condoms were placed at an external counter accessible round the clock, ensuring privacy and ease of access."*

The above narrations depicts that reproductive health is not just a women's issue it is a human rights issue. Male participation is the key in decision-making which is still challenging in many rural areas in Rajasthan.

Community & Mind-set Shift

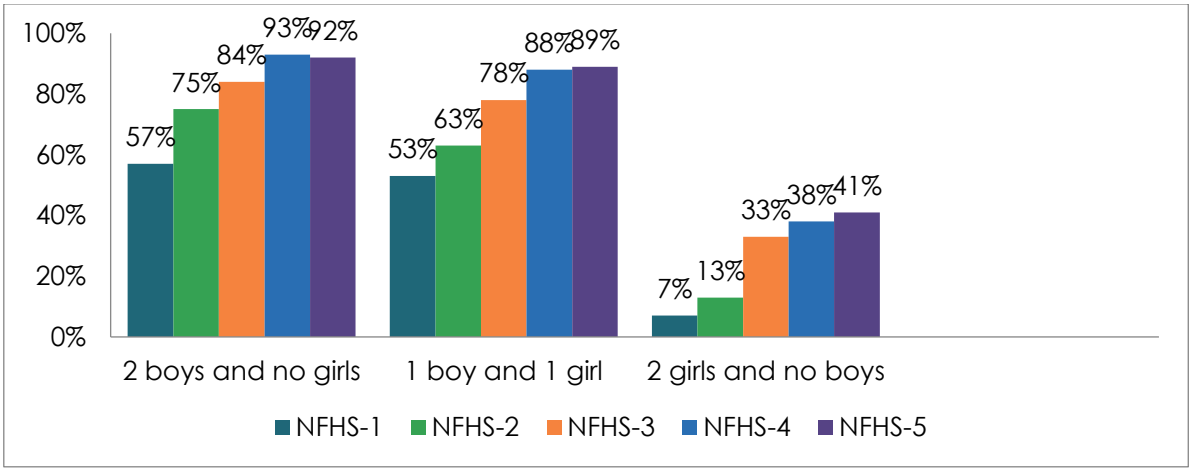
At the grassroots level, many ASHA/ANM themselves are not fully convinced about promoting contraceptive methods, particularly male vasectomy. Therefore, addressing misconception around male sterilization and family planning at this level is crucial. Changing perception among frontline worker can create a ripple effect, ultimately transform community attitudes and expand acceptance in the long run. For instance, *Antara* injections require women to take two doses within a specific time frame. However, many women either discontinue the injection or delay the second dose, leading the contraceptive failure. This is often due to misinformation, such as being told that the injection is unhealthy or that reduces fertility. This highlights the urgent need for training at grass root level to shift mind-set and challenge prevailing societal norms. While a woman has access to a basket of contraceptive options, it is the grassroots health workers who guide them in making informed choices through personal counselling and support. Since there grassroots workers are also a part of the same community, it is necessary to address their attitude and behaviour first before addressing the community's drift.

Deepika Rural woman "The ASHA worker comes to our house just long enough to take my signature and then leaves. She never explains anything, never brings medicines or sanitary pads, and never checks on our health. At the grassroots, many of them treat their work like a routine tick-mark activity, so women like us remain unaware and unsupported. It feels as though the system reaches our village on paper, but not in practice."

Social and Cultural Stigma

Despite its rich cultural legacy, Rajasthan continues to grapple with several social and cultural taboos, particularly those related to marriage, menstruation, and gender roles. The dominance of a patriarchal system often restricts women's ability to fully exercise their autonomy over their sexuality and reproductive choices. Prevailing social norms tend to reinforce female submissiveness, restrict sexual agency and maintains male control over decisions in the sexual and reproductive sphere [19]. While certain customs gradually fading due to urbanization and industrialization. Son preference continues to persist in some communities, influencing family size and in some cases, contributing to harmful practices such as female feticide. In Rajasthan, most married individuals prefer smaller families, with around 70% of women and 67% of men wanting no more children or being sterilized. Among those who do want more children, many prefer to wait at least two years before the next birth. Despite widespread acceptance of a two-child norm, a strong preference for sons remains. About 16% of both women and men want more sons than daughters, while only 2% prefer more daughters. This gender bias influences reproductive choices especially among women with two daughters, many of whom continue childbearing in hopes of having a son [20].

FIGURE 4: CURRENT SEX COMPOSITION OF FAMILIES WITH TWO LIVING CHILDREN



Source: International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), India, 2019-21: Rajasthan. Mumbai: IIPS

Certain communities observe restrictions on food preparation and consumption during specific times or for certain individuals, such as during menstruation, pregnancy or religious rituals.

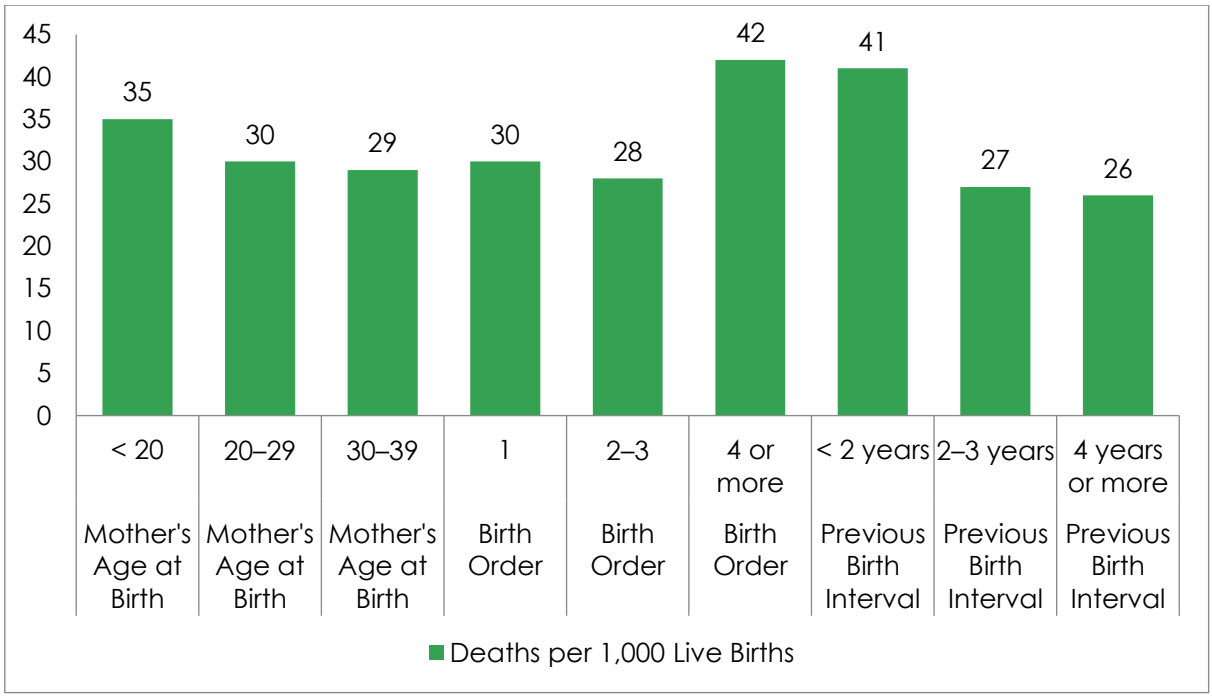
Dr. Krishna Pilley (Director RCH) : During a filed visit to an Anganwadi centre in Udaipur, one of the panel members, accompanied by teammates and state-level officers was shocked to find that a 4-month-old child weighed only 1.5 kg. Upon further inquiry, it was revealed that the mother avoided consuming all white foods, including milk due to prevailing cultural belief or personal misconception. This case highlights the urgent need for nutrition education and behaviour change communication and the grassroots level.

They organized "*Saas-Bahu Sameelan*" to dispel the myth that white food items should be avoided. The key message shared was if you don't eat healthily, how can your child be healthy? As a result of these efforts, the child's weight has improved from 1.5 Kg to 2.6 kg, and the team continues to monitor the situation to ensure the child's survival and development.

Another significant barrier is early marriage in many rural areas; girls are married off before the age of 18 long before they gain understanding of family planning, safe sex, or reproductive autonomy. Adolescents' mothers face increased risk of

complications such as preterm birth and low birth weight babies. Additionally, son preference continues to prevail in some communities, influencing family size decision and contributing to sex-selective practices. Infants born to mothers younger than 20 years old face a greater risk of dying in their first year compared to those born to women aged 20 to 29 [21], who are in the typical childbearing range. Among teenage mothers, the infant mortality rate is 35 per 1,000 live births. In comparison, it's 30 per 1,000 for mothers aged 20 to 29, and slightly lower at 9 per 1,000 for those aged 30 to 39. Infant deaths are more common in rural areas than in cities, while the mortality rate for older children (under age 5) tends to be higher in urban settings. Additionally, a mother's level of education plays a significant role in infant survival. Children of mothers with no formal education face higher mortality rates than those whose mothers completed some schooling. The lowest rates are found among children whose mothers have more than 10 years of education.

FIGURE 5: HIGH-RISK BIRTHS HAVE HIGHER MORTALITY RATES (DEATHS IN THE FIRST YEAR OF LIFE PER 1,000 LIVE BIRTHS)



Source: (Source: International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), India, 2019-21: Rajasthan. Mumbai: IIPS

Despite decades of independence, the presence of an education system, and numerous awareness campaigns, gender-based violence and discrimination remain deeply rooted across both rural and urban communities. Among these, menstrual health continues to be a taboo subject, especially in conservative rural communities. Menstruation marks the beginning of a women's reproductive life and plays a vital role in overall health. This is why the desert state of Rajasthan is making an extra effort to raise awareness of the tabooed subjects of menstruation health, sanitation, and hygiene on women's health. However, breaking the taboo will still take many years**.** The menstruation situation is linked to secrecy in these conservative societies. Menstruation myths are harmful social beliefs that create unnecessary shame and fear around a natural, healthy process. Common myths include the idea that menstruation blood is dirty and harmful. Social taboo around menstruation leads to shame, isolation and school absenteeism among adolescent girls and school dropout among young girls.

Prof. Amelia (IIHMR) "I went to Chandalai School where girls from school's dropout when their periods start as mostly answered that they are told to isolate in such a situation and are offered different food and kept in a room."
Himani (Rural Woman) "After attending several health camps and seeing awareness campaigns on social media, I have come to understand the importance of changing sanitary pads and maintaining hygiene. I make sure my daughter has access to sanitary pads and explain to her how important it is to stay clean during her periods."

Education & Empowerment

In order to enlighten us as human beings about our fundamental rights, education can be a helpful tool that is included into the system. Information and choice go hand in hand; without the former, you are left without an option. Empowering women to participate in decision-making should be the first step, and this can only be accomplished via education.
One panel member shared an observation from a field visit, where she met a girl who was officially 14 years old but was being presented as 18 years old. The girl had no knowledge of safe sex practices, consent, or contraception. Early marriage, coupled with lack of awareness significantly contributes to high rated of anaemia, maternal mortality, adolescent pregnancies, and inadequate prenatal care in rural areas. These factors put both the mother and her unborn child at serious risk. Another case involved a 21years old woman who was married at the age of 18 and has undergone five abortions to date. This raises concerns about the risk of infections, uterine damage, and future pregnancy complications. The lack of open discussion around safe sex, consent, and reproductive rights, largely due to social taboos, combined with high rates of early marriages, contributes to the prevalence of teenage pregnancies and unsafe reproductive practices. Even Goyal and Ambedkar investigated gender mainstreaming in Rajasthan and found that even women in leadership roles (for example councillors) also face 'intersectional oppression' and a lack of institutional support for gender specific health issues which reinforce the 'silence'. This underscores the urgent need for the comprehensive sex education, particularly for rural women to raise awareness, empower them with knowledge and promote informed decision making about reproductive health [22].

Access to Contraceptive & Healthcare

Over 62% of couples use some form of contraception, yet the responsibility disproportionately falls on women [20]. In many low- and middle-income countries, poor access and low prevalence of contraception are common. Contraceptive uptake varies by region, leading to high unmet needs because of various socio-economic and cultural factors. Women's fear of side effects or other health concerns related to contraceptive methods, as well as opposition from husband- often rooted in concern about trust or perceived infidelity [23]

Dr. Krishna Pilley (Director RCH) "one of the male patients underwent a vasectomy and after few days his wife became pregnant and the husband started questioning about the child's paternity, leading to marital dispute."

In this case the doctor and the ASHA/ANM workers should have properly counselled the patient about the need to use condom or abstain from sexual contact for at least three months after vasectomy, as the procedure does not provide immediate sterility. In a patriarchal society the emotional burden women bear often get unacknowledged. Many women, despite being malnourished or physically vulnerable, end up prioritizing their partners comfort and pain over their own wellbeing.

To maintain SRH, people need accessibility to safe, effective, affordable and acceptable contraception methods. They must be informed and empowered to protect themselves from sexually transmitted diseases. And when they plan to have children, women must have awareness and access to proper health services that can help to have a safe pregnancy, safe delivery and healthy child. Every individual has a fundamental right to make their choices about their SRH matters. According to Green (2018) relevant information, awareness and accessibility of family planning products and services are limited to women in India, and their decision-making power is also considerably very low [24].

CONCLUSION

Investing in women's health is essential for overall development, and reproductive health is a fundamental human right. While significant progress has been made, more efforts are needed to ensure that all women in Rajasthan have equitable access to reproductive health services. While Rajasthan has seen rapid clinical improvements, the deep-seated cultural norms surrounding menstrual taboos and reproductive autonomy change at a much slower pace. Based on current trends in the World Economic Forum's Global Gender Gap Report, achieving full gender parity in health and economic

participation could take over five generations (approximately 131 years) globally if interventions do not accelerate beyond their current trajectory [25]

To effectively address SRH issues, the use of technology should be promoted at the local level. Debunking myths and misinformation are essential to creating lasting change and shifting societal attitudes towards women. In rural areas, the abortion rate remains high often due to lack of accurate information and limited access to contraception
In general, social change is difficult, and it becomes even more complex when it touches on deeply rooted gender roles within the home and society. There is a growing recognition that the norms governing the roles, status and resource access of men and women can significantly influence the prospects for equitable and sustainable development. In the era of rapid urbanization and globalization, improving the lives of both men and women requires local solutions one that reflects regional realities and cultural customs and are grounded in a shared understanding of justice, including gender equality. Not just women, but all members of society are affected by reproductive health and access to reproductive health care. The ultimate goal of reproductive rights is to ensure the well-being of the individual and the family. In addition to protecting citizens' right to choose their reproductive outcomes while also taking into consideration local and cultural norms and preferences, governments have a duty to offer their citizens high-quality reproductive health services. Additionally, there is a rising need to educate the legal system on the importance of informed consent in the context of abortion, ensuring that reproductive rights are upheld within right based and ethical framework.

Recently, HPV vaccinations have been made available in field settings given the high prevalence of anaemia, adolescent pregnancies, and limited access to the HPV vaccine, [26] it is imperative to incorporate comprehensive reproductive health education into the school curricula. Introducing sex education at an early stage can significantly improve women's health outcomes and shift societal perspectives towards reproductive health.

By concentrating on four key areas of concern, we can move forward and accomplish our goals of enhancing women's SRH*:*

Universal access- It is crucial to guarantee that everyone has access to complete reproductive healthcare services. Introduction of *Chiranjeevi yojana, bhramasatra yojana* has led to greater accomplishment in health service providing field and making Rajasthan the biggest state with great number of insurance coverage. *Nishulk dawai yojana, Jannani Suraksha yojana* are the schemes that have promoted universal access to each and every segment of the society especially targeting rural women.

Research and Innovation- Putting money into research and innovation will advance reproductive health solutions and technologies. When it comes to women's health and decision-making power the rural and urban setting varied significantly. Hence providing the right information and the right time is crucial. The action needs to be taken to translate the research work into policies to enable the change now.

Infrastructure- For better service delivery, hospital infrastructure and human resources must be strengthened. But the major drawback comes when there is no staff available/ employed or we can address the term as hidden employment leading to staff deficit impacting the common people and overall.

Social hurdles- In order to achieve reproductive health equity, it is still imperative to address social and cultural barriers. As from NFHS1 to NFHS 5 i.e. 1952 to 2025 no such major changes have taken place when we talk about rural development and women's SRH [27]. The discussions reinforced that reproductive health is not just about contraception, it's about ensuring women have the right information, resources, and autonomy to make decisions for themselves. Small steps today can lead to big changes in the future.

RECOMMENDATIONS

To significantly improve health and wellness outcomes across Rajasthan's urban and rural populations, the Ministry of Health and Family Welfare must urgently expand and deepen its digital health mission. While the state has made remarkable progress by registering over 6.22 million *Ayushman Bharat Health Accounts* (ABHA) [28], rural awareness of this initiative remains limited, necessitating targeted outreach through local languages and community networks. Simultaneously, the inclusion of women over 45 years who hold influential roles as primary decision-makers within families and communities in SRH programs is critical to advancing gender equality and empowering communities. These women serve as vital community influencers whose engagement can accelerate positive behavior change and family planning acceptance.

In the clinical domain, it is imperative to safeguard women's health by ensuring that IUCD insertions, particularly first-time or medically complex cases, are conducted by qualified doctors rather than Auxiliary Nurse Midwives (ANMs) alone. Establishing clear referral protocols will reduce the risk of complications, reinforce clinical quality, and strengthen trust in public health services. Furthermore, reproductive health education should be normalized within co-educational settings to dismantle long-standing stigmas promoting open dialogue and shared learning between boys and girls. This approach fosters psychological comfort and encourages young people to become informed, supportive adults who can serve as future community role models.

The study reveals that high institutional birth rates (99.8% in Jaipur) do not equate to reproductive autonomy. The above data on the paternity dispute and male sterilization fears suggests that policy must move beyond female-centric clinics. Therefore, we recommend mandating *Men-only Sammelans* that utilize vasectomy acceptors as role models to decouple sterilization from loss of masculinity. Even in another study done by Prusty & Begum (2023), suggested that the greater participation of men in family planning has been shown to enhance women's reproductive health and promote more equitable gender outcomes. However, in the Indian context, contraceptive practices continue to be predominantly centered on women. [29]

Men's engagement is equally vital in shifting family planning paradigms from women-centered responsibility to shared duty. Organizing men only *Sammelans* and group discussions in both rural and urban areas will create safe spaces for open conversations, addressing fears and misconceptions about male contraceptive methods such as vasectomy. Introducing modest financial incentives and public recognition can motivate greater male participation, while respectful, myth-busting counseling ensures informed decision-making. Drawing on stakeholders' emphasis on the need to "include men in this crusade" and the identified gap in male-focused counselling to mitigate marital tensions, the study advocates for the institutionalization of "*men-only sammelans*" as a culturally sensitive forum to challenge and dispel prevailing myths surrounding contraception.

Frontline health workers including ASHAs, ANMs, and MPWs should be empowered as active referral agents for family planning services trained to promote the 24x7 toll-free helpline and equipped with culturally appropriate, dialect-specific IEC materials. This localized communication strategy is essential for building trust and overcoming barriers related to language and tradition.

Addressing persistent menstrual health taboos requires a comprehensive community-based strategy that integrates menstrual hygiene education in schools, capacity building for teachers and health workers, and active involvement of men and boys in awareness efforts. Improved access to affordable and eco-friendly menstrual hygiene products, alongside enhanced sanitation infrastructure, will directly impact women's health and dignity. Engaging religious and community leaders in respectful dialogue can help reinterpret cultural norms, fostering an environment that supports women's empowerment and generational change.

Together, these interlinked measures can create a robust ecosystem that improves reproductive health outcomes, advances gender equality, and promotes holistic wellbeing for Rajasthan's diverse populations.

CONFLICT OF INTEREST:

The authors declare no conflict of interest.

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