ORIGINAL ARTICLE

Women's Reproductive Health in India: Connecting Government Policies and Programmes with NFHS 5 Data

Bijayalaxmi Nanda[1], Nupur Ray[2], Shambhavi Mani[3]

1Department of Political Science, Miranda House, University of Delhi
[2]Department of Political Science, Kamla Nehru College, University of Delhi
[3]Department of Political Science, Vivekananda College, University of Delhi

CORRESPONDING AUTHOR
Prof. Bijayalaxmi Nanda, Principal and Professor at Department of Political Science, Miranda House, GC Narang Road, University of Delhi, New Delhi- 110007
Email: bijayalaxmi.nanda@mirandahouse.ac.in

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ABSTRACT

Background: Women's reproductive health is an integral part of their overall well-being, and India has made considerable progress in improving reproductive health services. Despite these efforts, persistent issues such as spatially heterogeneous policy outcomes, especially in remote and marginalized areas, remain. **Objectives:** This research intends to study assess the current state of women's reproductive health in India, with a focus on contemporary policies and socio-economic differentials. **Methods:** The study employs a policy review and secondary data analysis method. The data analysed is from NFHS-5 (National Family Health Survey), which provides a comprehensive national representation. Key indicators analysed include maternal health, fertility rate, anaemia, family planning, and gender-based violence to analyse women's reproductive health. **Findings:** It is suggested that while government policies have improved education, awareness, and gender equality, certain challenges persist. Notably, anaemia among women aged 15 to 49 increased from 53% in 2015–16 to 57% in 2019–21. **Conclusion:** It has been noted that initiatives of the government have led to improvement on ground level on fertility behaviour and continuum of care of mother and infants. However, nutritional security for women requires specific attention of the state and society. A community health approach which is sensitive and participatory is recommended for the same.

KEYWORDS

Gender, Policy, Reproductive Health, Maternal Health, Anaemia, NFHS-4, NFHS-5, PCPNDT Act, RCH Programme, NRHM, Janani Suraksha Yojana.

INTRODUCTION

Reproductive health is a basic aspect of holistic wellbeing and plays an important role in shaping the policy environment of any state in India. Even with significant strides in healthcare infrastructure and awareness initiatives, reproductive health in India continues to face challenges. The challenges are due to the socio-economic diversities and inequalities that exist in the society. These issues impact community health outcomes, especially for women, adolescents, and marginalized groups.(1) India's National Health Policy, along with initiatives like the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) strategy, has made advancements towards improving maternal and child health. Programs such as Janani Suraksha Yojana (JSY) and Mission Indradhanush have effectively boosted institutional deliveries and vaccination rates, leading to a reduction in maternal and infant mortality. However, the policy outcome shows regional variation between urban and rural areas, as well as among different socio-economic groups. States like Uttar Pradesh, Madhya Pradesh, Bihar, etc. have surely come a long way, but are still struggling to keep up and provide a comprehensive reproductive health coverage.

Community health in India is intricately linked to reproductive health, as aspects like family planning, safe motherhood, adolescent health, and the prevention of sexually transmitted infections (STIs) contribute to both individual and collective well-being. Family planning, in particular, is a vital area where reproductive health intersects with community development. Cultural practices, gender inequality, and a lack of awareness amongst the general populace continue to hinder the widespread adoption of reproductive health services.(2) Against this backdrop, this article attempts to provide a comprehensive overview of the existing policies concerning women's reproductive health and its efficacy in addressing the concerns and issues regarding the matter, It uses the recent National Family Health Survey-5 data to analyze the current status of Indian women's reproductive health focusing on the indicators of fertility rate, maternal health, nutrition and gender-based violence. A comparison between NFHS 4 and 5 provides an understanding of the effectiveness of the policies and programmes that exist in the country.

MATERIAL & METHODS

The methodology followed in this article is a review of the policies and programmes related to reproductive health of women in India by examining their advancement through the years. It uses review of secondary data of NFHS 4 and 5, especially the indicators related to maternal health, anaemia, family planning, fertility and domestic violence to assess the reproductive health status of women as well as measures the success of the existing policies and programmes.

The Policies and Programmes of India regarding Reproductive Health – A Chronological Overview

India has launched several policy initiatives and programs aiming to improve women's reproductive health. recognizing it as a pertinent part of overall health and development. These initiatives have evolved over the years, adapting to shifting public and community health needs, demographic changes, and global health commitments. India is a signatory to several international treaties and commitments with regard to reproductive health which includes the Sustainable Development Goals (SDGs). Furthermore, India is a signatory to various international conventions like the International

Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Rights of the Child (CRC), and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), all of which acknowledge reproductive health.

One of the earliest and most impactful interventions was the **National Family Planning Programme**, which kicked off in 1952. India was the first country in the world to launch such a programme on a national scale. Initially aimed at controlling population growth, the program has gradually transitioned to a rights-based and health-focused approach. In recent times, it highlights informed choice, spacing methods, and a more comprehensive reproductive health framework instead of just concentrating on reducing fertility.

The **Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act**, 1994, (amended in 2003.) tackles an important issue in reproductive health: the abuse of prenatal diagnostic technologies for gender-biased abortion and sex selection. This legislation makes sex determination and sex selection illegal and seeks to address the troubling decline in the child sex ratio in India.

The **Reproductive and Child Health (RCH) Program**, introduced in 1997, represented a significant shift in policy by merging family planning with maternal and child health services. This initiative aimed to deliver holistic reproductive healthcare, which includes antenatal care, safe delivery services, postnatal care, management of reproductive tract infections (RTIs), and access to contraception. It also stressed the importance of decentralization and community involvement. Building on the RCH framework, the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) strategy was launched in 2013. This approach unified various healthcare components under one umbrella, taking a life-cycle perspective. It acknowledged the connections between different life stages and sought to tackle reproductive health as part of a continuum rather than in isolation. With RMNCH+A, there is a stronger emphasis on adolescent health, safe abortion services, and enhancing the quality of care in health facilities.

The **National Rural Health Mission (NRHM**), which began in 2005, plays a pivotal role in this ongoing effort and in shaping reproductive health policies (it was later clubbed with National Urban Health Mission and was called National health Mission since 2012). The policy encompasses a variety of programs that focus on different facets of women's reproductive health. For example, the Janani Suraksha Yojana (JSY) promotes institutional deliveries by providing cash incentives to expectant mothers. Meanwhile, the Janani Shishu Suraksha Karyakram (JSSK) guarantees free delivery services, covering everything from cesarean sections to medications and diagnostic tests. It also focuses on increasing awareness through the frontline workers and increasing accessibility by bridging infrastructural gaps.

Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) is a significant government initiative that was kicked off in 2016 by India's Ministry of Health and Family Welfare. Its main goal is to ensure that pregnant women receive reliable, comprehensive, and high-quality antenatal care on the nineth of every month. This program specifically targets women in their second and third trimesters, making sure they have at least one check-up with a healthcare professional. The services offered include health assessments, diagnostic tests, and counselling. PMSMA

places a strong emphasis on the early identification of high-risk pregnancies to help lower maternal and infant mortality rates. It also encourages private sector doctors to voluntarily participate, aiming to enhance maternal health outcomes throughout India**.**

Additionally, initiatives like the **Integrated Child Development Services (ICDS)** and **POSHAN Abhiyaan** play a supportive role by enhancing maternal nutrition and child development, both of which are essential factors in reproductive health.

What do the numbers say? A Comparative Analysis of NFHS 4 and 5 on Critical Indicators

This section of the article deals with the statistical analysis of women's reproductive health by analyzing the indicators of fertility rate, maternal health, domestic violence and nutritional wellbeing. These indicators also serve as important parameters to measure the success of policies mentioned and discussed earlier.

The National Family Health Survey (NFHS-5), which took place from 2019 to 2021, shows a notable drop in India's total fertility rate (TFR), falling from 2.2 to 2.0 children per woman. This decline means that the country's TFR has dipped below the crucial replacement level of 2.1, a key point for stabilizing the population. However, it's important to note that there are still significant regional differences. States like Bihar (3), Uttar Pradesh (2.4), Jharkhand (2.3), still have TFRs above the replacement level, indicating that progress isn't uniform across the nation. The survey also highlights how education and economic status play a role in fertility rates. India's overall fertility rate has dropped below replacement levels, these regional differences and socio-economic factors still shape reproductive trends, pointing to the need for focused policies to tackle these inequalities.

Table 1 Total Fertility Rate (Children per women) across states and UTs of India

States/UTs	NFHS-1 (1992-93)	NFHS-2 (1998-99)	NFHS-3 (2005-06)	NFHS-4 (2015-16)	NFHS-5 (2019-21)
Andhra Pradesh	2.6	2.3	1.8	1.8	1.7
Arunachal Pradesh	4.3	2.5	3.0	2.1	1.8
Assam	3.5	2.3	2.4	2.2	1.9
Bihar	4.0	3.5	4.0	3.4	3.0
Delhi	3.0	2.4	2.1	1.8	1.6
Goa	1.9	1.8	1.8	1.7	1.3
Gujarat	3.0	2.7	2.4	2.0	1.9
Haryana	4.0	2.9	2.7	2.1	1.9
Himachal Pradesh	3.0	2.1	1.9	1.9	1.7
Jammu and Kashmir	3.1	2.7	2.4	2.0	1.4
Karnataka	2.9	2.1	2.1	1.8	1.7
Kerala	2.0	2.0	1.9	1.6	1.8
Madhya Pradesh	3.9	3.3	3.1	2.3	2.0
Maharashtra	2.9	2.5	2.1	1.9	1.7
Manipur	2.8	3.0	2.8	2.6	2.2
Meghalaya	3.7	4.6	3.8	3.0	2.9
Mizoram	2.3	2.9	2.9	2.3	1.9
Nagaland	3.3	3.8	3.7	2.7	1.7
Odisha	2.9	2.5	2.4	2.1	1.8

States/UTs	NFHS-1 (1992-93)	NFHS-2 (1998-99)	NFHS-3 (2005-06)	NFHS-4 (2015-16)	NFHS-5 (2019-21)
Punjab	2.9	2.2	2.0	1.6	1.6
Rajasthan	3.6	3.8	3.2	2.4	2.0
Sikkim		2.8	2.0	1.2	1.1
Tamil Nadu	2.5	2.2	1.8	1.7	1.8
Tripura	2.7		2.2	1.7	1.7
Uttar Pradesh	4.8	4.0	3.8	2.7	2.4
West Bengal	2.9	2.3	2.3	1.8	1.6
Chhattisgarh			2.6	2.2	1.8
Jharkhand			3.3	2.6	2.3
Uttarakhand				2.1	1.9
Telangana				1.8	1.8
Andaman and Nicobar (UT)				1.4	1.3
Chandigarh (UT)				1.6	1.4
Dadra and Nagar Haveli & Daman Diu (UT)				2.1	1.8
Lakshadweep (UT)				1.8	1.4
Puducherry (UT)				1.7	1.5
Ladakh (UT)					1.3

Source: Economic Survey 2023-24 (https://www.indiabudget.gov.in/budget2024-25/economicsurvey/doc/stat/tab818.pdf); Note: In NFHS-5, Jammu & Kashmir is Union Territory excluding Ladakh (UT)

Another point to highlight is the relationship between education, awareness and fertility behaviour. According to the data released by Press Bureau of India in 2025, it has been revealed that fertility peaks between 20-29 years across all groups, but it is much higher among illiterate and below primary level of education women compared to graduates.

Maternal Mortality Rate, another significant indicator of women's health, has seen a significant decline in the last two decades, with India lowering it to 97, closer to the goal of Universal Health Coverage. However, some states like Madhya Pradesh, Uttar Pradesh, Assam, etc. have a higher rate of maternal deaths, making it an uneven achievement.

A key factor influencing maternal survival is where and how a woman gives birth. According to the NFHS-5 data, a remarkable 88.6% of births in India now take place in institutional facilities, a significant jump from 78.9% recorded in NFHS-4 (2015–16). This improvement and awareness about the importance of institutional birth can be attributed to government initiatives like the Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK), and also to the ASHA/ frontline workers who make women aware about such initiatives, thereby encouraging them to deliver in institutions. Interestingly, urban areas boast a higher rate of institutional deliveries at 93.8%, while rural areas lag behind at 86.7%, underscoring the ongoing rural-urban divide.

According to the NFHS-5 survey, a remarkable 89.4% of deliveries were supported by skilled health personnel, which is a significant jump from 81.4% in NFHS-4. This group includes doctors, nurses, and auxiliary nurse-midwives. The rise in the number of skilled birth

attendants is strongly linked to a lower risk of complications and mortality during childbirth.

Getting proper antenatal care early on is really important for highlighting and handling any risks that might come up during pregnancy. According to the NFHS-5, 58.1% of women had at least four ANC visits, which is an improvement from 51.2% in NFHS-4. However, regional differences still continue, for example, Kerala boasts over 90% coverage for four ANC visits, while places like Nagaland and Bihar are struggling to increase it.

Table 2 Fertility and Family Planning (NFHS-4 and NFHS-5)

	Indicator	NFHS-5 (2019-21)	NFHS-4 (2015-16)
	Fertility and Family Planning		
1	Total Fertility Rate (TFR)	2	2.2
2	Women age 15-19 years who were already mothers or pregnant at the time of the survey (%)	6.8	7.9
3	Current Use of Family Planning Methods-Any method (%)	66.7	53.5
4	Current Use of Family Planning Methods-Any modern method (%)	56.4	47.8
5	Total unmet need for Family Planning (%)	9.4	12.9
	Maternity and Delivery Care		
6	Mothers who had an antenatal check-up in the first trimester (%)	70	58.6
7	Mothers who had at least 4 antenatal care visits (%)	58.5	51.2
8	Mothers who received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery (%)	78	62.4
9	Institutional births (%)	88.6	78.9
	Child Vaccination and Child Feeding Practices		
10	Children age 12-23 months fully vaccinated based on information from either vaccination card or mother's recall (%)	76.6	62
11	Children under age 6 months exclusively breastfed (%)	63.7	54.9
	Infant and Child Mortality Rates (per 1000 live births)		
12	Neonatal Mortality Rate (NNMR)	24.9	29.5
13	Infant Mortality Rate (IMR)	35.2	40.7
14	Under-five Mortality Rate (U5MR)	41.9	49.7

Source: Ministry of Health and Family Welfare, GoI. (https://www.pib.gov.in/PressReleasePage.aspx?PRID=1847431#:~:text=Government%20of%20India.-,As%20per%20the%20fifth%20round%20of%20National%20Family%20Health%20Survey,is%202.1%20children%20per%20woman. , accessed on 8.7.2025).

Although emphasis is laid on antenatal care, one should not ignore the importance of the continuum of care for birthing mothers. Postnatal care within the first two days after delivery is crucial for preventing maternal deaths from

postpartum complications, and currently, 78% of women across the country are receiving this care. This marks a significant improvement from the NFHS-4 data, which showed it at only 62.4%, highlighting the progress we've made in providing maternal care beyond just childbirth.

Another major factor which impacts adequate maternal care is Out of Pocket Expenditure (OOPE). Even though there have been some positive changes in maternal health indicators in India, there is this major hurdle that prevents fair access to care. The NFHS-5 (2019–21) shows that financial strain continues to be a big obstacle, especially for families who are economically disadvantaged. The data indicates that the average OOPE for giving birth in public health facilities was ₹2,916. The expenditure in private facilities is significantly higher, making its accessibility difficult. While public facilities aim to provide free maternal care through programs like JSY, JSSK, and PMMAY, there are still hidden costs that increase the financial burden. Expenses for transportation, diagnostics, and informal payments can put a significant strain on family budgets. For families with limited resources, even the relatively low out-of-pocket expenses in public institutions can be a major hurdle, causing delays in getting the care they need or forcing them to turn to unskilled providers.

India has the highest anaemic population in the world. The NFHS-5 unveils a troubling increase in anaemia rates among women in India, especially those between the ages of 15 and 49. On a national level, the prevalence jumped from 53% in 2015-16 to 57% in 2019-21. However, there are some states with progress like Kerela and Arunachal Pradesh who have improved anaemia. Though states which have more alarming figures; for example, West Bengal tops the list with a staggering 71.4% and other states like Assam and Jharkhand have the rate more than 65%. These regional differences highlight a complicated mix of dietary habits, access to healthcare, cultural traditions, and socio-economic factors. Additionally, socio-demographic elements like education, wealth, and caste have a strong connection to anaemia levels.(3) It's also important to note that nutritional status is tied to body weight; for instance, underweight women are 20% more likely to experience anaemia compared to those with a normal Body Mass Index.(4) These insights emphasize the critical need for comprehensive strategies that bring together food security, health education, and better access to iron-rich foods and supplements. If we don't tackle the root causes of anaemia, India's broader objectives concerning women's health, productivity, and maternal outcomes could remain out of reach.

Gender based violence continues to be a serious problem in India, deeply affecting women's physical, emotional, and reproductive well-being. According to the National Family Health Survey-5, 29.3% (Urban) of ever-married women aged 18–49 have reported facing spousal violence, which shows a decrease from 31.2% in the previous NFHS-4 survey. The decrease in the numbers or the improvement, though appreciable, still raises concerns. There needs to be stronger state and community support systems for women. In order to make policies and programmes more effective, there is a need for sensitization and awareness generation programmes and stronger implementation of all laws in the country for the protection of women and girls.

Table 3 Anaemia Prevalence (NFHS-4 and NFHS-5)

	State/UT	NFHS	Children age 6-59 months who are anaemic (<11.0 g/dl)	Non-pregnant women age 15-49 years who are anaemic (<12.0 g/dl) (%)	Pregnant women age 15-49 years who are anaemic (<11.0 g/dl) (%)	All women age 15-49 years who are anaemic (%)	Adolescent girls age 15-19 years who are anaemic (%)	Adolescent boysage 15-19 years who are anaemic (<13.0 g/dl) (%)
	India	**NFHS-5**	**67.1**	**57.2**	**52.2**	**57**	**59.1**	**31.1**
		NFHS-4	**58.6**	**53.2**	**50.4**	**53.1**	**54.1**	**29.2**
1	Andaman & Nicobar Islands	**NFHS-5**	40	57.6	53.7	57.5	44.9	27.1
		NFHS-4	49	65.8	61.4	65.7	68.1	43
2	Andhra Pradesh	**NFHS-5**	63.2	59	53.7	58.8	60.1	18.7
		NFHS-4	58.6	60.2	52.9	60	61.1	29.3
3	Assam	**NFHS-5**	68.4	66.4	54.2	65.9	67	39.6
		NFHS-4	35.7	46.1	44.8	46	42.7	23.5
4	Bihar	**NFHS-5**	69.4	63.6	63.1	63.5	65.7	34.8
		NFHS-4	63.5	60.4	58.3	60.3	61	37.8
5	DNH& DD	**NFHS-5**	75.8	62.6	60.7	62.5	63.9	37
		NFHS-4	82	73.4	-62.3	72.9	75.9	36.1
6	Goa	**NFHS-5**	53.2	38.9	41	39	44.5	15.8
		NFHS-4	48.3	31.4	26.7	31.3	30.5	6.6
7	Gujarat	**NFHS-5**	79.7	65.1	62.6	65	69	36
		NFHS-4	62.6	55.1	51.3	54.9	56.5	31.9
8	Himachal Pradesh	**NFHS-5**	55.4	53.4	42.2	53	53.2	22.1
		NFHS-4	53.7	53.6	50.4	53.5	52.7	25
9	Jammu & Kashmir	**NFHS-5**	72.7	67.3	44.1	65.9	76.2	53.5
		NFHS-4	53.8	49	46.9	48.9	49.9	29.5
10	Karnataka	**NFHS-5**	65.5	47.8	45.7	47.8	49.4	26.5
		NFHS-4	60.9	44.8	45.4	44.8	45.3	24.5
11	Kerala	**NFHS-5**	39.4	36.5	31.4	36.3	32.5	27.4
		NFHS-4	35.7	34.7	22.6	34.3	37.8	14.3

	Lakshadweep	**NFHS-5**	43.1	26	20.9	25.8	31.4	*
12		**NFHS-4**	53.6	46.3	39	46	59	*
14	Ladakh	**NFHS-5**	92.5	93.7	78.1	92.8	96.9	93.1
		NFHS-4	91.4	78.4	79.3	78.4	81.6	57.6
15	Maharashtra	**NFHS-5**	68.9	54.5	45.7	54.2	57.2	27.9
		NFHS-4	53.8	47.9	49.3	48	49.7	27.5
16	Meghalaya	**NFHS-5**	45.1	54.4	45	53.8	52.5	30.1
		NFHS-4	48	56.4	53.3	56.2	52.1	25.2
17	Manipur	**NFHS-5**	42.8	29.3	32.4	29.4	27.9	7.8
		NFHS-4	23.9	26.4	26	26.4	21.1	9.2
18	Mizoram	**NFHS-5**	46.4	34.8	34	34.8	34.9	21.5
		NFHS-4	19.3	24.7	27	24.8	21.3	14.4
19	Nagaland	**NFHS-5**	42.7	29.3	22.2	28.9	33.9	19.6
		NFHS-4	26.4	27.7	32.7	27.9	26.3	12.2
20	Sikkim	**NFHS-5**	56.4	42.1	40.7	42.1	46.7	17.6
		NFHS-4	55.1	35.2	23.6	34.9	48.7	16.7
21	Telangana	**NFHS-5**	70	57.8	53.2	57.6	64.7	25.1
		NFHS-4	60.7	56.9	48.2	56.6	59.7	19.2
22	Tripura	**NFHS-5**	64.3	67.4	61.5	67.2	67.9	27.2
		NFHS-4	48.3	54.5	54.4	54.5	52.2	22
23	West Bengal	**NFHS-5**	69	71.7	62.3	71.4	70.8	38.7
		NFHS-4	54.2	62.8	53.6	62.5	62.2	31.7
24	Arunachal	**NFHS-5**	56.6	40.8	27.9	40.3	48.5	24.9
	Pradesh	**NFHS-4**	54.2	43.5	37.8	43.2	48.2	22.9
25	Chandigarh	**NFHS-5**	54.6	60.1	*	60.3	57.7	*
		NFHS-4	73.1	75.9	*	75.9	74.7	22.4
26	Chhattisgarh	**NFHS-5**	67.2	61.2	51.8	60.8	61.4	31.5
		NFHS-4	41.6	47.3	41.5	47	45.5	27.4
27	Nct Of Delhi	**NFHS-5**	69.2	50.2	42.2	49.9	51.6	18.9
		NFHS-4	59.7	54.7	46.1	54.3	55.1	25.9

28	Haryana	**NFHS-5**	70.4	60.6	56.5	60.4	62.3	29.9
		NFHS-4	71.7	63.1	55	62.7	62.7	29.7
29	Jharkhand	**NFHS-5**	67.5	65.7	56.8	65.3	65.8	39.7
		NFHS-4	69.9	65.3	62.6	65.2	65	35.3
30	Madhya	**NFHS-5**	72.7	54.7	52.9	54.7	58.1	30.5
	Pradesh	**NFHS-4**	68.9	52.4	54.6	52.5	53.2	36.5
31	Odisha	**NFHS-5**	64.2	64.4	61.8	64.3	65.5	30
		NFHS-4	44.6	51.2	47.6	51	51	30.3
32	Punjab	**NFHS-5**	71.1	58.8	51.7	58.7	60.3	32.7
		NFHS-4	56.6	54	42	53.5	58	30.8
33	Puducherry	**NFHS-5**	64	55.5	42.5	55.1	58.4	30.7
		NFHS-4	44.9	53.4	26	52.4	55	40.6
34	Rajasthan	**NFHS-5**	71.5	54.7	46.3	54.4	59.4	34
		NFHS-4	60.3	46.8	46.6	46.8	49.1	22.1
35	Tamil Nadu	**NFHS-5**	57.4	53.6	48.3	53.4	52.9	24.6
		NFHS-4	50.7	55.4	44.4	55	54.2	26
36	Uttar Pradesh	**NFHS-5**	66.4	50.6	45.9	50.4	52.9	28.2
		NFHS-4	63.2	52.5	51	52.4	53.7	31.5
37	Uttarakhand	**NFHS-5**	58.8	42.4	46.4	42.6	40.9	27.6
		NFHS-4	59.8	45.1	46.5	45.2	46.4	22.2

Source: Ministry of Health and Family Welfare, GoI. (https://www.pib.gov.in/PressReleasePage.aspx?PRID=1795421, accessed on 8.7.2025).

RESULTS

The findings which emerge from this analysis of policies and programmes and NFHS data point to the fact that education, awareness and gender equality have improved due to the proactive nature of the policies and programmes of Government of India specially related to institutional delivery.

Secondly, the institutional delivery and continuum of care of the mother has provided enhanced access to healthcare and improved the Maternal Mortality Rate (MMR) and Infant Mortality Ratio (IMR).

A major finding is that nutritional security is still not available evenly to women across the country. Anaemia continues to remain a significant concern. On a national level, the prevalence jumped from 53% in 2015-16 to 57% in 2019-21 for women in the age group of 15 to 49 which incidentally happens to be prime age of labor productivity and reproduction.

While there is a huge improvement in fertility behaviour leading to a decline in fertility rates, there are barriers exist due to a lack of education and awareness. In states like Bihar and Uttar Pradesh poverty, lack of education and awareness lead to high fertility. The choices and needs of the community and the voices of women are not heard within the policy discourse. Less emphasis is given on spacing methods and more on female sterilization. Domestic Violence has decreased; however, this decrease is minimal and require greater intervention by the state and adequate Implementation of laws.

CONCLUSION

An understanding of reproductive health of women in India by analyzing the policies and programmes of the Government of India and the secondary data of the NFHS 4 and NFHS 5 provides us a comprehensive picture of the status of women in India. The findings reveal a positive connection between proactive policies and the ground level realities. Certain issues especially women's health related to nutritional security require specific attention.

A community health approach which is sensitive and participatory is recommended for the same. Educational institutions should also play a significant role in promoting health for all, with a special emphasis on women.

RECOMMENDATION

The policy implications via these indicators have shown significant strides in reproductive health with a spatial heterogeneity across the nation. It is also important to note that the approach to gender in these reproductive policies focuses on the technical assimilation of 'gender' without addressing the utilitarian dynamics that contribute to women's subordination.(5) These policies tend to overlook women who did not fall into the reproductive age category, for instance, unmarried women and women who choose not to have children or have infertility issues. Scholars also argue that this approach often neglects women's specific needs and rights, reducing them to mere instruments for development efficiency. Women should not only be reduced to need-based beneficiaries. Efforts should be made to include their voices through community participation from the grassroots levels such as the gram panchayats, gram sabha, self-help groups, etc.

There is an emphasis on male involvement in the reproductive health program as a means to achieve "sameness with women," aiming for equitable representation in family planning and reproductive decision-making. It seeks to address women's historical discrimination by positioning men as partners in reproductive health. However, it fails to address the deeper structural inequalities between women and men which exist in access to resources, opportunities for education and employment and decision-making. (6)

Thus, our main recommendation is that structural inequalities have to be addressed, thereby increasing and enhancing women's participation in all fields of decision-making. Education across all genders should involve sensitizing them to their health needs and improving accessibility, affordability and availability of all essential services related to health. Women's health should not be limited to supporting only their reproductive health but also examine the support provided for them through the life cycle approach, beginning from conception to death. Promoting good nutrition, supporting autonomy and choice, ensuring safety and security in the adolescent period, and a

continuum of care is necessary. The needs of menopausal women should also be included within the women's health discourse.

LIMITATION OF THE STUDY

The study doesn't involve any field/primary related data.

RELEVANCE OF THE STUDY

The study gives a comprehensive view of the status of women's reproductive health through the relevant statistics and data. This reflection will assist the policymakers, demographers to link policy with practice.

AUTHORS CONTRIBUTION

All authors have contributed equally.

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