

Women's Reproductive Health: A Gendered Analysis of Social Determinants and Inequalities

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Abstract :

Women's reproductive health is influenced by a complex interaction of biological, social, economic, cultural and gender-related factors. Contemporary approaches to reproductive health increasingly emphasize social determinants, health equity, reproductive autonomy and women's rights rather than focusing exclusively on medical care. The present study examines women's reproductive health in relation to selected socio-economic and demographic characteristics, with particular emphasis on socio-economic status, place of residence and age. The study is based on an original sample of 480 married women from Gulbarga district of Karnataka. Respondents were classified according to socio-economic status, rural-urban residence and age. A socio-economic status scale, reproductive-health questionnaire and personal data schedule were used for data collection. The original study employed descriptive statistics and independent-samples t-tests to compare reproductive-health scores across groups. The reported descriptive findings indicate that women belonging to the higher socio-economic group had a higher mean reproductive-health score than women belonging to the lower socio-economic group. Urban women recorded a higher mean score than rural women, while women aged 20-35 years recorded a higher mean score than women aged 36-51 years. These findings are examined in relation to contemporary evidence on social determinants of health, gender inequality and reproductive-health rights. Recent WHO and UNFPA frameworks emphasize that inequalities in income, education, geographical access, social position, power and resources contribute to avoidable health inequities (WHO, 2024, 2025; UNFPA, 2024). The study argues that improving women's reproductive health requires more than expanding health facilities. Gender-responsive interventions must address socio-economic disadvantage, rural-urban disparities, health literacy, women's autonomy and unequal gender relations. The article concludes that reproductive-health equity should be pursued as both a public-health priority and a gender-justice concern.

Keywords: women's reproductive health; social determinants; gender inequality; reproductive-health equity; socio-economic status; rural-urban disparities; women's autonomy; Karnataka.

1. Introduction

Women's reproductive health is an essential component of individual well-being, human rights and social development. Reproductive health extends beyond the prevention and treatment of reproductive diseases and includes the physical, psychological and social well-being of individuals in matters related to the reproductive system. Contemporary sexual and reproductive health approaches include access to contraception, fertility and infertility care, maternal and perinatal health, prevention and treatment of sexually transmitted infections, protection from sexual and gender-based violence, and access to appropriate information and education (World Health Organization [WHO], 2024).

The understanding of reproductive health has progressively shifted from a predominantly biomedical approach towards a broader framework based on rights, equity, autonomy and social justice. WHO emphasizes that sexual and reproductive health and rights are fundamental to the right to health and are closely linked to universal health coverage and sustainable development (WHO, 2024). However, significant inequalities continue to determine who can access appropriate reproductive-health information and services and who remains excluded.

The social determinants of health framework is particularly useful for understanding these inequalities. Social determinants include the conditions in which people are born, grow, live, work and age, as well as their access to power, money and resources. These conditions have a substantial influence on health outcomes and on the distribution of health inequities (WHO, 2024, 2025). The WHO's 2025 *World Report on Social Determinants of Health Equity* further emphasizes that inequalities associated with income, education, geographical location, gender and access to resources produce avoidable and unjust differences in health (WHO, 2025).

Women's reproductive health is especially affected by gender relations. Gender norms and unequal power relations can influence women's mobility, access to financial resources, decision-making and ability to seek health care. WHO notes that gender inequality can restrict women's access to health information and essential services through limitations on mobility, decision-making autonomy, financial resources and social status (WHO, 2021).

The reproductive-health agenda therefore cannot be separated from gender equality. Women may have access to a health facility but may still be unable to use the service if they lack money, transportation, permission, information or decision-making authority. Consequently, reproductive-health inequalities are produced through the interaction of individual circumstances and wider structural conditions.

UNFPA's *State of World Population 2024* places inequality at the centre of the global sexual and reproductive health and rights agenda. It argues that although considerable progress has occurred during the last three decades, the benefits have not been equally distributed and the most marginalized women and girls continue to face substantial barriers to reproductive-health services and rights (UNFPA, 2024).

The Indian context is particularly significant because of considerable social, economic, geographical and cultural diversity. The National Family Health Survey-5 (NFHS-5), conducted during 2019–21, provides extensive evidence concerning fertility, family planning, maternal health, women's empowerment, nutrition and related health indicators in India (Ministry of Health and Family Welfare [MoHFW] & International Institute for Population Sciences [IIPS], 2021).

The present article revisits an empirical study of 480 married women from Gulbarga district of Karnataka. The original study examined differences in reproductive-health status according to socio-economic status, place of residence and age. The present article reframes these findings through the contemporary perspectives of **social determinants, gender inequality and reproductive-health equity**.

2. Review of Literature

2.1 Social Determinants and Women's Health

The social-determinants perspective recognizes that health is produced not only through health services but also through social and economic conditions. Income, education, occupation, housing, social support, physical environment and access to resources influence people's health opportunities (WHO, 2024). The WHO's operational framework for monitoring social determinants emphasizes the importance of identifying structural factors that produce health inequities and of developing multisectoral policies to address them (WHO, 2024).

For women, these determinants operate within gendered social structures. Women's access to education, paid employment, financial resources and decision-making can affect their ability to obtain health services and exercise reproductive choices. Gender inequality may therefore magnify the effects of socio-economic disadvantage.

2.2 Socio-Economic Inequality and Reproductive Health

Socio-economic position is an important determinant of reproductive-health outcomes. Women from disadvantaged households may face financial barriers, lower health literacy and greater difficulties in reaching appropriate health facilities. Socio-economic inequalities can also influence the timing and quality of antenatal care, institutional delivery and postnatal services.

Indian evidence indicates that maternal and newborn health-care coverage varies significantly according to socio-economic position and geographical location. Kumar et al. (2020) found substantial inequalities in coverage of maternal and newborn care in India, demonstrating the importance of examining health services through an equity lens.

Patel et al. (2021) similarly demonstrated that socio-economic inequality is associated with women's experience of home delivery in India. Such evidence indicates that reproductive-health behaviour is influenced by structural circumstances rather than solely by individual preference.

2.3 Rural–Urban Inequalities

Place of residence is another important social determinant. Rural women may encounter barriers related to distance, transportation, availability of health professionals, quality of services and access to information. Rural disadvantage may be particularly significant when combined with restrictions on women's mobility and decision-making.

Research from Karnataka has demonstrated important rural–urban differences in women's nutritional, socio-economic and environmental conditions. Rural women were found to experience greater disadvantages in areas such as education, living conditions, nutritional status and anaemia (Dwarkanath et al., 2018). These broader inequalities can indirectly influence reproductive health.

2.4 Women's Autonomy and Gender Relations

Women's reproductive autonomy is central to reproductive-health equity. Autonomy includes the ability to make informed decisions concerning contraception, pregnancy, childbirth and health-care utilization.

UNFPA (2024) emphasizes that reproductive-health inequalities are closely associated with unequal power and persistent discrimination. Reproductive-health programmes that focus exclusively on women without addressing household and community power structures may therefore have limited impact.

Research on gender-synchronized family-planning interventions in rural India demonstrates the importance of involving both women and men in reproductive-health interventions. The CHARM2 trial showed the potential relevance of interventions addressing marital communication, contraception and gender relations rather than placing reproductive responsibility exclusively on women (Sarnquist et al., 2022).

2.5 Age and the Life-Course Perspective

Women's reproductive-health needs change throughout the life course. Younger women may require information and services related to contraception, pregnancy and childbirth, while women in later reproductive life may require attention to infertility, reproductive disorders, cancer screening and the transition to menopause.

A life-course approach therefore challenges the tendency to define women's reproductive health only in relation to pregnancy and motherhood. Contemporary women's-health frameworks emphasize health across the entire life course, from adolescence to older age (WHO, 2024).

3. Research Gap

Although substantial research has examined maternal health, contraception and reproductive-health service utilization in India, fewer studies integrate **socio-economic position, rural–urban residence and age within a gendered social-determinants framework**.

Much of the reproductive-health literature focuses on service utilization or specific outcomes such as institutional delivery and contraception. The present article contributes by revisiting reproductive-health differences among women through a broader gender and social-inequality perspective.

The study is particularly relevant because socio-economic status, residence and age do not operate independently. Their effects may intersect with women's autonomy, access to information, mobility and decision-making power. A gendered analysis can therefore provide a more comprehensive interpretation of differences in reproductive health.

4. Objectives of the Study

The study was undertaken with the following objectives:

1. To examine the reproductive-health status of women belonging to different socio-economic groups.
2. To analyse differences in reproductive-health status between rural and urban women.
3. To examine differences in reproductive-health status between selected age groups.
4. To interpret reproductive-health differences through the framework of social determinants and gender inequality.
5. To suggest policy and programme measures for promoting reproductive-health equity among women.

5. Hypotheses

The original study examined the following comparative assumptions:

01: There is no significant difference in reproductive-health status between women belonging to higher and lower socio-economic groups.

02: There is no significant difference in reproductive-health status between rural and urban women.

03: There is no significant difference in reproductive-health status between women belonging to the two selected age groups.

6. Methodology

6.1 Research Design

The study followed a descriptive and comparative research design. The approach was used to examine variations in reproductive-health scores across selected socio-economic and demographic groups.

6.2 Study Area

The original study was conducted in Gulbarga district of Karnataka. The district is now officially known as **Kalaburagi**.

6.3 Sample

The study included 480 married women.

	Category	
Socio-economic status	Higher	201
	Lower	279
Place of residence	Rural	222
	Urban	258
Age	20–35 years	291
	36–51 years	189
Total		480

The original investigation employed three major tools:

1. **Socio-Economic Status Scale**
2. **Reproductive Health Status Questionnaire**
3. **Personal Data Schedule**

6.4 Statistical Analysis

The original study used mean, standard deviation and independent-samples *t*-tests for group comparisons.

7. Results

7.1 Socio-Economic Status and Reproductive Health

The original study reported the following descriptive results:

Socio-economic group	N	Mean	SD
Higher	201	56.50	32.58
Lower	279	49.56	10.98

Women belonging to the higher socio-economic group recorded a higher mean reproductive-health score than women belonging to the lower socio-economic group.

The finding suggests that socio-economic position may be associated with women's reproductive-health opportunities. Women with greater economic resources may have better access to health information, transportation, professional health services and preventive care.

This interpretation is consistent with the social-determinants framework, which identifies income and social status as important determinants of health inequalities (WHO, 2024, 2025). Indian research also demonstrates socio-economic inequalities in access to maternal and reproductive-health services (Kumar et al., 2020; Patel et al., 2021).

7.2 Rural–Urban Differences

The original study reported:

Residence	N	Mean	SD
Rural	222	48.405	12.39
Urban	258	55.969	33.247

Urban women recorded a higher mean reproductive-health score than rural women.

The difference may be associated with unequal availability and accessibility of health facilities, transportation, health information and educational opportunities. Rural women may have to travel longer distances to access specialized reproductive-health services.

However, rural–urban differences should not be interpreted simply as differences in individual health behaviour. They may reflect structural differences in infrastructure, income, education and social opportunities.

Research in Karnataka has documented broader rural–urban differences in women's socio-economic and nutritional conditions (Dwarkanath et al., 2018). Such differences provide a useful context for interpreting the reproductive-health findings.

7.3 Age and Reproductive Health

The original study reported:

Age group	N	Mean	SD
20–35 years	291	53.28	32.03
36–51 years	189	51.21	11.92

Women aged 20–35 years recorded a higher mean reproductive-health score than women aged 36–51 years.

The difference highlights the importance of a life-course approach. Younger women may have greater exposure to reproductive-health programmes and contemporary health information. Women in the older age category may require different reproductive-health services and greater attention to screening, reproductive disorders and changing health needs.

Contemporary WHO approaches to women's health emphasize that reproductive and general health needs change throughout the life course and should not be limited to pregnancy and childbirth (WHO, 2024).

8.RESULT AND FINDINGS:

The findings demonstrate that women's reproductive health is associated with broader social and demographic circumstances. The higher reproductive-health score among women from the higher socio-economic group indicates the potential role of material and social resources in shaping health opportunities.

WHO (2025) emphasizes that social determinants such as income, education, gender and access to power and resources produce avoidable health inequities. The findings of the present study can therefore be interpreted as evidence of the relationship between social position and reproductive-health opportunities.

The rural–urban difference also supports the importance of geographical equity. Health services cannot be considered genuinely accessible when women face substantial transportation, financial or social barriers to

reaching them. The availability of reproductive-health services must therefore be accompanied by measures that address the conditions affecting their utilization.

The findings are also consistent with contemporary evidence that reproductive-health inequalities are disproportionately experienced by marginalized women. UNFPA (2024) argues that global progress in sexual and reproductive health and rights has not benefited all groups equally. Women experiencing poverty and other forms of marginalization continue to face greater barriers.

A gender perspective adds another layer to this interpretation. Women's reproductive-health decisions may be shaped by family expectations, economic dependence, restrictions on mobility and unequal decision-making. WHO (2021) identifies gender inequality as a barrier to access to health information and critical health services.

Thus, the differences observed in the present study should not be understood merely as individual-level characteristics. They may reflect the interaction between **socio-economic inequality, geographical disadvantage and gender relations**.

9. Limitations of the Study

The study has several limitations. The sample was restricted to women covered by the original investigation in Gulbarga district and therefore cannot automatically be generalized to all women in Karnataka or India.

The study also focused on selected variables and did not comprehensively examine education, occupation, household income, parity, health literacy, reproductive autonomy, marital communication or health-service utilization.

10. Conclusion

Women's reproductive health is shaped by the interaction of biological, socio-economic, geographical and gender-related factors. The present study demonstrates differences in reproductive-health scores according to socio-economic status, place of residence and age.

Women belonging to the higher socio-economic group recorded a higher mean reproductive-health score than women belonging to the lower socio-economic group. Similarly, urban women recorded a higher mean score than rural women, while women aged 20–35 years recorded a higher mean score than women aged 36–51 years.

These findings acquire greater significance when viewed through the contemporary social-determinants framework. WHO (2024, 2025) emphasizes that social and economic conditions, access to resources and structural inequalities contribute substantially to health inequities. UNFPA (2024) similarly highlights the persistence of inequalities in sexual and reproductive health and rights, particularly among marginalized populations.

A gendered interpretation further demonstrates that reproductive-health inequalities are connected with women's autonomy, access to resources, mobility and decision-making power. Improving reproductive health therefore requires interventions that go beyond medical services.

The study concludes that **reproductive-health equity must be approached as both a public-health priority and a gender-justice issue**. Policies should strengthen rural health infrastructure, improve health literacy, reduce socio-economic barriers, promote reproductive autonomy and challenge unequal gender norms. Such an integrated approach can contribute to healthier women, stronger families and a more gender-equitable society.

References

- Dwarkanath, P., Vasudevan, A., Thomas, T., Anand, S. S., Desai, D., Gupta, M., Menezes, G., Kurpad, A. V., & Srinivasan, K. (2018). Socio-economic, environmental and nutritional characteristics of urban and rural South Indian women in early pregnancy: Findings from the South Asian Birth Cohort (START). *Public Health Nutrition*, 21(8), 1554–1564.
- Ministry of Health and Family Welfare (MoHFW), Government of India, & International Institute for Population Sciences (IIPS). (2021). *National Family Health Survey (NFHS-5), 2019–21: India report*. IIPS.
- Patel, R., Marbaniang, S. P., Srivastava, S., Kumar, P., & Chauhan, S. (2021). Why women choose to deliver at home in India: A study of prevalence, factors, and socio-economic inequality. *BMC Public Health*, 21, 1785.
- Sarnquist, C. C., et al. (2022). Evaluation of a gender synchronized family planning intervention for married couples in rural India: The CHARM2 cluster randomized control trial. *eClinicalMedicine*.
- United Nations Population Fund. (2024). *State of world population 2024: Interwoven lives, threads of hope—Ending inequalities in sexual and reproductive health and rights*. UNFPA.
- UN Women & United Nations Department of Economic and Social Affairs. (2024). *Progress on the Sustainable Development Goals: The gender snapshot 2024*. UN Women.
- World Health Organization. (2021). *Gender and health*. WHO.
- World Health Organization. (2024a). *Determinants of health*. WHO.
- World Health Organization. (2024b). *Extending sexual and reproductive health and rights to future generations through science and evidence*. WHO.
- World Health Organization. (2024c). *Operational framework for monitoring social determinants of health equity*. WHO.
- World Health Organization. (2024d). *Women's health*. WHO.
- World Health Organization. (2025). *World report on social determinants of health equity*. WHO.

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