REPRODUCTIVE HEALTH, CASTE- BASED MARGINALITY AND THE LIMITS OF WELFARE JURISPRUDENCE IN INDIA

Ms. Loraine Lukose, B.A.LL.B. (Hons), School of Law, Christ University, Bangalore

ABSTRACT

Caste- based marginality continues to significantly shape access to reproductive healthcare in India despite constitutional guarantees of equality, dignity and social justice under Articles 14, 15, 21 and 46 of the Indian Constitution. Although Indian courts have recognized reproductive health as an integral component of the right to life, welfare jurisprudence has largely remained formalist in orientation, emphasizing access and service delivery without adequately addressing the structural and lived inequalities produced by caste hierarchies. Employing a doctrinal and socio- legal methodology, this paper critically examines Constitutional provisions, statutory frameworks, and judicial pronouncements governing reproductive health, with particular reference to judicial pronouncements in this regard. The analysis reveals that while judicial discourse has expanded reproductive autonomy and articulated state obligations, it has insufficiently engaged with caste as a systemic determinant of reproductive health outcomes. This paper argues that the persistence of caste-based exclusion exposes the limits of welfare oriented legal frameworks and underscores the need for an intersectional, substantive equality-based approach to reproductive healthcare governance, aligned with the transformative Constitutional vision of social justice in India.

Keywords: Reproductive Health, Caste, Welfare jurisprudence, Intersectionality, Constitution

INTRODUCTION

The Constitutional promise of the "Right to Life" under Article 21[1] and the subsequent evolution of welfare jurisprudence in India have theoretically expanded the horizon of reproductive rights. Judicial expansion of this right along with introduction of welfare-oriented schemes such as the National Health Mission and Janani Suraksha Yojana[2], reflects the States formal commitment to improving maternal and reproductive healthcare outcomes. Yet, the bar of reproductive rights remains profoundly unequal in essence. For women from the marginalized communities, Constitutional guarantees and welfare entitlements often fail to translate into effective access, revealing a persistent gap between legal recognition and lived experience.

Caste operates as a structural determinant of reproductive health in India mediating access to care through entrenched hierarchies of purity pollution and social exclusion. Discriminatory practices within public healthcare institutions, which ranges from delayed treatment and segregated facilities to coercive population control measures, continue to disproportionately affect Dalit and Adivasi women[3]. Empirical evidence demonstrates that marginalized caste groups experience lower utilization of antenatal and postnatal services and significantly higher maternal mortality rates compared to national averages, despite the formal availability of free maternal healthcare schemes[4]. The disparities highlight that caste-based exclusion is not merely economic but institutional and systemic in nature.

While Indian jurisprudence has advanced reproductive autonomy and state accountability, particularly through judicial decisions such as Suchita Srivastava vs Chandigarh Administration[5] and Devika Biswas vs UOI[6], its focus has largely remained access- oriented and formalist. Courts and policies often assume a homogenous beneficiary, insufficiently engaging with caste as a structural barrier that shapes healthcare delivery and outcomes. This paper argues that such an approach exposes the limits of welfare jurisprudence in addressing reproductive injustice and underscores the need for an intersectional, substantive equality

[1] INDIA CONST. art. 21.
[2] Government of India Ministry of Health & Family Welfare, Janani Suraksha Yojana, National Health Mission, https://nhm.gov.in/index1.php?lang=1&level=3&lid=309&sublinkid=841
[3] National Human Rights Commission, Report on Maternal Health and Human Rights in India, https://nhrc.nic.in
[4] International Institute for Population Sciences & Ministry of Health & Family Welfare, *National Family Health Survey (NFHS-5), 2019–21* (Gov't of India).
[5] Suchita Srivastava and Ors. Vs. Chandigarh Administration: MANU/SC/1580/2009
[6] Devika Biswas vs. Union of India (UOI) and Ors. (14.09.2016 - SC) : MANU/SC/0999/2016

framework that meaningfully accounts for caste-based marginality. Aligning reproductive healthcare governance with the transformative vision of the Constitution requires moving beyond formal access towards dismantling the social conditions that impede the exercise of reproductive rights.

HISTORY OF OPPRESSION, RESERVATION AND FREE HEALTHCARE

The history of reproductive health in India cannot be disentangled from the history of the caste-based oppression, which has long regulated access to bodily autonomy, institutional care and social dignity. The caste system functioned as a rigid hierarchy of graded inequality, historically constructing Dalit bodies as 'polluted' and therefore unworthy of physical proximity, care or healing. Ancient legal social texts like the *Manusmriti* entrenched occupational segregation and social exclusion, confining Dalits to stigmatized labour while denying them access to public spaces, including sites of medical and ritual care[7]. This exclusion translated into disproportionate morbidity, maternal mortality and systemic neglect of reproductive health among marginalized communities, a legacy that continues to shape contemporary healthcare experiences[8].

Recognizing the entrenched nature of caste disadvantage, the framers of the Indian Constitution envisaged reservation and welfare not as temporary concessions but as structural correctives essential to achieving substantive equality. Articles 15(4) & (5), 16(4), and 46 impose a positive obligation on the state to promote the educational, economic, and health interests of Scheduled Castes and Scheduled Tribes. As B.R. Ambedkar repeatedly emphasized, formal equality is insufficient where social relations are marked by deep asymmetries of power and dignity[9]. The reservation policies first institutionalized through the colonial-era reforms through various legislations and was later constitutionally entrenched in the year 1950, which were designed to dismantle structural barriers by redistributing access to public resources and decision-making spaces. Judicial affirmation of this redistributive logic was upheld in the case of Indira Sawhney vs. Union of India (UOI) and Ors.[10], where the Supreme Court upheld reservations as a Constitutional tool to remedy historical exclusion rather than violative of the principle of

[7] therrationalist, *The Unvarnished Truth About Manusmriti: A Deep Dive into Its Controversial Stances*, Medium (date unknown), https://medium.com/@therrationalist/the-unvarnished-truth-about-manusmriti-a-deep-dive-into-its-controversial-stances-b15b348eb463.
[8] B.R. Ambedkar, *Annihilation of Caste* (1936).
[9] *Id*
[10] Indira Sawhney vs. Union of India (UOI) and Ors. MANU/SC/0771/1999

equality.

Post independence initiatives such as the National Rural Health Mission (NRHM)[11], the National Health Mission (NHM)[12], Janani Suraksha Yojana (JSY)[13] and more sought to provide free or subsidized maternal and reproductive healthcare services to vulnerable communities. These schemes were premised on the assumption that removing financial barriers would automatically translate into equitable healthcare access, however, the assumption overlooks the persistence of caste as a social determinant of healthcare.[14]

Data and human rights documentation reveal that caste-based discrimination continues to operate within public healthcare institutions producing what scholars describe as *clinical exclusion*[15]. Dalit and Adivasi women frequently report denial of adequate pain relief, lack of privacy during childbirth, verbal abuse, segregation in hospital wards, and coercive reproductive procedures[16]. The physical intimacy required in reproductive healthcare, such as pelvic examinations or assisted deliveries often triggers latent caste and societal biases among healthcare providers, resulting in apprehension toward seeking medical care.

While reservation rules and free healthcare programs constitute substantial Constitutional gains, their influence is restricted when applied within societal institutions that continue to devalue marginalized people. Welfare jurisprudence, when separated from an intersectional understanding of caste discrimination, risks perpetuating the disparities it aims to address. As a result, the history of oppression not only contextualizes but also explains current shortcomings in reproductive healthcare, emphasizing the importance of a caste-sensitive, dignity-centered approach to health governance based on transformational Constitutionalism.

THE CONTEMPORARY REACH OF CASTE SYSTEM IN INDIA WITH RESPECT TO REPRODUCTIVE HEALTH

Despite Constitutional guarantees of equality and decades of affirmative action, caste continues

[11] Ministry of Health & Family Welfare, *National Health Mission – Vision and Objectives*, National Health Mission (NHM), Government of India, https://nhm.gov.in/index1.php?lang=1&level=1&lid=49&sublinkid=969
[12] Government of India Ministry of Health & Family Welfare, **National Health Mission**, https://nhm.gov.in/,
[13] Government of India Ministry of Health & Family Welfare, *Janani Suraksha Yojana*, National Health Mission, https://nhm.gov.in/index1.php?lang=1&level=3&lid=309&sublinkid=841
[14] Rachana Thapa, Edwin van Teijlingen, Pramod R. Regmi & Vanessa Heaslip, *Caste Exclusion and Health Discrimination in South Asia: A Systematic Review*, 33 ASIA PAC. J. PUB. HEALTH 828 (2021).
[15] *Id*
[16] Human Rights Watch, *Human Rights Watch Submission to CEDAW Committee* (June 13, 2014), https://www.hrw.org/news/2014/06/13/human-rights-watch-submission-cedaw-committee

to operate as a pervasive structural determinant in contemporary India. Its influence extends beyond social identity into material access to land, housing, education, and critically healthcare. In the sphere of reproductive health, caste shapes not only health outcomes but the very condition under which reproductive autonomy may be exercised. For women from marginalized communities reproductive health becomes a site where historical exclusion intersects with modern governance.

Empirical evidence confirms persistent caste- based disparities in maternal and child health outcomes. Data from the National Family Health Survey (NFHS-5) 2019-2021, shows that Schedules Castes (SC) and Scheduled Tribe (ST) women experience lower access to full antenatal care, higher levels of anemia, earlier childbearing, and higher neonatal and infant mortality rates compared to upper-caste groups.[17] Studies demonstrate that maternal mortality ratios among SCs and STs remain significantly higher than among socially advantaged groups, suggesting that disparities cannot be explained by economic factors alone, indicating that caste operates independently as a social determinant of health.[18] These patterns reveal that economic explanations alone are insufficient to account for disparities in reproductive health.

Caste- based marginality is further reproduced within healthcare institutions themselves. Human rights documentation and public health research record instances of segregated wards, delayed treatment, verbal humiliation, denial of adequate pain relief, and coercive sterilization practices disproportionately affecting women of rural areas.[19] As Gopal Guru and Sundar Sarukkai argue, caste is not merely an external social structure but an embodied experience, reproduced through everyday interactions.[20] Within public settings this manifests as what scholars describe as the 'clinical exclusion' where institutional behavior reflects graded hierarchies of social worth.

The contemporary reach of caste is also spatial. Many Dalit communities continue to reside in segregated hamlets within inadequate infrastructure and limited emergency transport, restricting timely access to obstetric care. Even though welfare schemes are in place which

[17] Int'l Inst. for Population Scis. (IIPS) & ICF, National Family Health Survey (NFHS-5), 2019-21: India (2021), http://rchiips.org/nfhs/NFHS-5_FCTS/India.pdf.
[18] Lina Sanneving, Nawi Trygg, Deepak Saxena, Dileep Mavalankar & Stig Thomsen, *Inequity in India: The Case of Maternal and Reproductive Health*, 6 GLOBAL HEALTH ACTION 19145 (2013).
[19] Oxfam India, *India Inequality Report 2021* (2021), https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2021-07/India%20Inequality%20Report%202021_single%20lo.pdf
[20] Gopal Guru, *Rejection of Humiliation*, *in* Humiliation: Claims and Context 42 (Gopal Guru ed., 2009).

formally guarantee free maternal healthcare services, the realization of these entitlements is mediated by caste location and provider bias.

In Suchita Srivastava vs. Chandigarh Administration (2009), the judiciary expanded reproductive autonomy, finding that human liberty and dignity include reproductive choice under Article 21[21]. However, the jurisprudential paradigm primarily views autonomy in individualistic terms, failing to confront caste as a structural limitation on meaningful choice. Welfare jurisprudence often assesses compliance through service availability and scheme execution rather than investigating institutional power dynamics. As a result, there is a continuing divide between nominal equality (admission to a facility) and substantive equality (freedom from humiliation, coercion, and discrimination within that institution).

Thus, the modern reach of caste demonstrates the structural limitations of welfare-oriented reproductive government. Unless reproductive health policy and Constitutional adjudication embrace an intersectional and caste-sensitive perspective based on the equality principle under Articles 14, 15, and 21, the promise of reproductive autonomy will be realized unevenly. In India, reproductive health is more than just a service delivery issue; it is also a Constitutional location where graded inequality is being negotiated and perpetuated.

MARGINALITY AND INTERSECTIONALITY

Marginality in India's reproductive health landscape cannot be understood through a single axis framework of gender disadvantage, rather it is constituted at the intersection of caste, class, geography and institutional power. The framework of intersectionality, which was first developed by Kimberlé Crenshaw, provides an analytical lens to understand how overlapping systems of subordination create distinct forms of vulnerability that are not reducible to isolated categories of identity.[22] In the Indian context, this framework reveals that women of the marginalized communities experience reproductive injustice not merely because they are women, but as caste- located subjects whose bodies have historically been sites of graded inequality. As Dr. B.R Ambedkar argued in his book *Annihilation of Caste*, caste hierarchy is sustained through control over social reproduction and endogamy, placing women's bodies at the center of caste preservation.[23] Reproductive health therefore becomes a Constitutional site

[21] Suchita Srivastava and Ors. Vs. Chandigarh Administration: MANU/SC/1580/2009
[22] Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex*, 1989 U. CHI. LEGAL F. 139.
[23] B.R. Ambedkar, *Annihilation of Caste* 45–52 (1936).

where caste power and gender subordination converge.

The National Family Health Survey (NFHS-5, 2019-21) records persistent disparities between SCs and STs and other socially backward groups in maternal mortality, anemia prevalence, early marriage and access to full antenatal care.[24] Importantly these disparities persist even beyond income and educational variables, indicating that caste functions as an independent determinant of health. Scholars argue that caste is reproduced through embodied, everyday practices that normalize humiliation and exclusion within public institutions[25]. In reproductive healthcare settings, this manifests as delayed treatment, coercive sterilization, denial of informed consent, verbal abuse and inadequate pain management, patterns documented in the case of *Devika Biswas.*

The intersection of caste and gender also produces what many termed differentiated 'biological citizenship'.[26] While upper- caste reproductive autonomy is framed within discourse of choice and wellness; women of the marginalized groups are frequently positioned within a population control paradigm. The history of target- driven sterilization policies condemned but not fully dismantled in the Devika Biswas case, demonstrates how reproductive governance has disproportionately burdened the Dalit and the Adivasi women. Welfare schemes instituted by the government aim to reduce financial barriers, yet they often remain blinded to the caste barriers in the society in its design and implementation. Financial incentives for institutional delivery cannot be a remedy for structural discrimination embedded within service delivery itself.

Judicial expansion of reproductive rights in The Constitution particularly, Article 21, in the case of Suchita Srivastava vs. Chandigarh Administration marked significant doctrinal advancement, affirming reproductive choice as intrinsic to personal liberty and dignity.[27] However, this jurisprudence largely conceptualizes, liberal-individualistic notions of autonomy posits a rights-bearing individual empowered for genuine choice, yet for caste-marginalized women, such agency is curtailed by economic vulnerability, geographic isolation, healthcare provider prejudice, and deficient social networks. Consequently, welfare jurisprudence

[24] ICF & IIPS, *National Family Health Survey (NFHS-4), India, 2015–16* (DHS Progr.), https://dhsprogram.com/pubs/pdf/FR375/FR375.pdf
[25] Gopal Guru & Sundar Sarukkai, *The Cracked Mirror: An Indian Debate on Experience and Theory* (Oxford Univ. Press 2012).
[26] Nikolas Rose & Carlos Novas, *Biological Citizenship*, in *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems* 439 (Aihwa Ong & Stephen J. Collier eds., Blackwell Publ'g 2005).
[27] Suchita Srivastava and Ors. Vs. Chandigarh Administration: MANU/SC/1580/2009

prioritizes access to services while neglecting entrenched structural inequities. The Constitutional commitment to substantive equality via Articles 14 and 15 stays largely unfulfilled, as judicial and policy interventions emphasize service delivery over profound institutional reform.

An intersectional analysis therefore exposes the limits of a redistributive welfare model that equates healthcare access with justice. True reproductive justice requires recognition that caste, gender and poverty are co-constitutive axes of marginality. Without embedding enforceable anti- discrimination mechanisms, dignity- centred standards and accountability frameworks within healthcare governance, welfare jurisprudence risks perpetuating that very graded inequalities it seeks to remedy. Reproductive health in India must thus be reimagined through a transformative Constitutional lens; one that moves beyond formal inclusion toward structural redress of caste- based marginality.

THE STRUCTURAL LIMITS OF WELFARE CONSTITUTIONALISM

The Constitutionalisation of reproductive health in India has emerged through an expansive interpretation of Article 21, wherein the Supreme Court has recognised healthcare, dignity and reproductive autonomy as intrinsic to right to life. In the case of Paschim Banga Kher Mazdoor Samity vs State of West Bengal,[28] the court affirmed that the State's obligation to provide timely emergency medical care; in the case of Suchita Srivastava vs Chandigarh Administration[29] reproductive choice was recognized as a dimension of personal liberty; and in Devika Biswas case, coercive sterilization practices were condemned and procedural safeguards reinforced. Collectively, these decisions reflect what may be termed welfare Constitutionalism, a jurisprudential orientation that expands socio- economic entitlements through positive state obligations, often read alongside Directive Principles such as Articles- 38, 39 and 47 of the Indian Constitution. Yet, despite its doctrinal progressiveness, this framework reveals structural limitation when confronted with caste- based marginality in reproductive health.

The limitation lies less in the acceptance of rights than in how they are articulated and enforced. Welfare law views reproductive health primarily as an issue of access, infrastructure, and

[28] Paschim Banga Khet Mazdoor Samity and Ors. vs. State of West Bengal and Ors. (06.05.1996 - SC) : MANU/SC/0611/
[29] Suchita Srivastava and Ors. Vs. Chandigarh Administration: MANU/SC/1580/2009

administrative compliance. Judicial scrutiny often assesses whether facilities exist, plans are implemented, or procedural protections are followed. What remains unexplained is the structural operation of caste in healthcare facilities. Although Articles 14 and 15 ban discrimination, reproductive health adjudication seldom addresses caste as a structural factor of uneven treatment. The rights-bearing individual conceived in these rulings is usually abstract and global, divorced from India's hierarchical social structures. Consequently, caste- based humiliation, segregated maternity wards, denial of adequate pain management, and coercive population control measures disproportionately affecting Dalit and Adivasi women are treated as an episodic administrative failure, rather than manifestations of entrenched institutional inequality.

Empirical data highlights this constitutional flaw. The National Family Health Survey (NFHS-5, 2019-21) finds persistent disparities in antenatal care, anaemia prevalence, institutional delivery quality, and maternal health outcomes among Scheduled Castes and Scheduled Tribes compared to socially advantaged groups, even after controlling for income and education. Human rights data, including Human Rights Watch investigations, reveals extensive patterns of discrimination and verbal abuse in public healthcare institutions. Despite this, judicial interventions have primarily aimed to improve scheme execution and regulatory compliance rather than incorporating enforceable anti-discrimination standards into hospital governance. In consequence, welfare constitutionalism is redistributive which is aimed at expanding services, but inadequately transformative in eliminating caste systems that shape the care experience.

In essence, welfare constitutionalism's structural shortcomings arise from its formalistic focus, which treats justice as mere service delivery and assumes facilities alone guarantee equality. Yet substantive equality goes beyond access, necessitating the dismantling of social structures that make access uneven in reality. While reproductive autonomy is affirmed in legal doctrine, it is undermined by caste positioning, healthcare provider biases, geographic isolation, and administrative barriers. Absent a cohesive framework fusing Articles 14, 15, and 21, one that openly acknowledges caste discrimination in medical institutions and imposes binding accountability, welfare jurisprudence may entrench the hierarchical inequities it aims to eradicate. Thus, in reproductive health, the Constitution's emancipatory potential stays incompletely fulfilled, limited by a welfare paradigm that reallocates resources without reshaping power dynamics.

ACCOUNTABILITY DEFICITS AND THE ABSENCE OF STRUCTURAL REMEDIES

Caste discrimination in reproductive healthcare rarely manifests as explicit refusal of service. Instead, it appears through differential urgency, dismissive communication, reluctance to provide pain management, segregation in wards, or informal hierarchies of attentiveness. These practices are often normalised as routine clinical discretion rather than recognised as caste-coded conduct. Because discrimination operates diffusely, it escapes the evidentiary thresholds required for constitutional adjudication. The legal system is designed to address discrete violations; caste hierarchy functions through cumulative micro-practices that rarely leave documentary trace.

The accountability deficit thus reflects a mismatch between the structure of law and the structure of social power. Judicial remedies in reproductive health cases tend to focus on procedural compliance such as consent forms, sterilisation guidelines, compensation for negligence. Yet sociologically, reproductive injustice is sustained by institutional cultures rather than isolated procedural failures. Even after the Supreme Court's intervention in Devika Biswas vs. Union of India, reports from rural districts continued to document coercive sterilisation practices disproportionately affecting economically and caste-marginalised women. This persistence suggests that guidelines alone cannot transform entrenched bureaucratic incentives and local power relations.

Caste also shapes accountability through spatial segregation. Dalit and Adivasi communities are often located in peripheral hamlets with limited transport, delayed ambulance access, and weaker administrative oversight. When maternal deaths occur in such contexts, they are frequently attributed to logistical delay rather than understood as consequences of structural exclusion. The absence of structural remedies thus mirrors the invisibility of marginal spaces within policy imagination.

Understanding accountability sociologically reveals why welfare jurisprudence, even when progressive, struggles to dismantle caste-based reproductive injustice. Law can mandate facilities and issue guidelines, but it cannot, without structural oversight, recalibrate the social relations embedded within those institutions. Reproductive healthcare in India operates at the intersection of constitutional promise and social stratification; where caste continues to organise intimacy, authority, and bodily contact, the absence of structural remedies ensures

that inequality persists beneath the surface of formal compliance.

CONCLUSION

The constitutional recognition of reproductive health as an integral component of the right to life under Article 21 represents one of the most significant achievements of Indian welfare jurisprudence. Through decisions such as Suchita Srivastava vs. Chandigarh Administration, Devika Biswas vs. Union of India, and Paschim Banga Khet Mazdoor Samity vs. State of West Bengal, the Supreme Court has expanded the contours of dignity, autonomy, and positive state obligation in the domain of healthcare. Yet, as this paper has argued, the expansion of entitlements has not translated into the dismantling of structural caste-based inequality. Welfare constitutionalism, in its prevailing form, remains largely redistributive and access-oriented; it evaluates compliance through the availability of schemes and infrastructure while insufficiently interrogating how caste hierarchies shape the lived experience of reproductive care within institutions.

The persistence of disparities in maternal health outcomes among Scheduled Castes and Scheduled Tribes, despite decades of welfare programming, reveals a constitutional paradox: formal inclusion without substantive equality. Reproductive autonomy, doctrinally affirmed, is mediated by caste location, provider bias, spatial segregation, and bureaucratic power. In this context, the failure to explicitly integrate Articles 14, 15, and 21 into a substantive equality framework allows caste discrimination within healthcare to remain constitutionally under-addressed. What appears as administrative inefficiency is often a manifestation of graded social power embedded within public institutions.

If the transformative vision of the Constitution is to be meaningfully realised, reproductive health governance must move beyond the paradigm of service delivery toward structural accountability. This requires recognising caste not merely as a socio-economic disadvantage but as a systemic determinant of reproductive injustice. Embedding enforceable anti-discrimination standards, dignity-centred institutional norms, and robust accountability mechanisms within healthcare governance is essential to aligning welfare policy with constitutional morality. Until welfare jurisprudence confronts the structural dimensions of caste in reproductive healthcare, the promise of reproductive justice will remain partial in redistributing resources without reconstructing power.