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Sexual and Reproductive Justice at the Margins

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A set of studies explores how marginalised women in India navigate health systems. The essays advance a broader understanding of sexual and reproductive justice and case studies show how patriarchy and material inequalities embed injustice in access to health care, and restrict sexual autonomy.

As the title suggests, this edited volume examines sexual and reproductive justice, and goes beyond a narrow focus on reproductive rights. Sexual and reproductive justice expands the human rights framework to include women's decision-making over reproductive health, including rights related to contraception and abortion (Onwuachi-Saunders et al. 2019; Rebouché 2017).

> It argues for a broader understanding of sexual and reproductive justice that includes universal access to health services and the conditions necessary to exercise sexual and reproductive rights.

The concept of sexual and reproductive justice was coined by women of colour in the US, who sought to link reproductive rights with a broader agenda of social justice. It emerged from the realisation that mainstream reproductive rights organisations, especially in the US, ignored the experiences of marginalised women (Price 2010 as cited in Rebouché 2017).

In the introductory chapter of this volume, the editors draw on Fricker (2007), who identifies such exclusion in academic and research discourse and terms it "epistemic injustice". This volume, therefore, adopts an intersectional approach that foregrounds the voices of women who experience multiple forms of vulnerability, but who are not always passive victims and have been able to negotiate their circumstances.

Asian communities too have engaged with the concept of reproductive justice, including in India (ACRJ 2005; Shahida 2025). Asian Communities for Reproductive Justice (ACRJ), an Oakland-based advocacy group, defines reproductive justice as "the complete physical, mental, spiritual, political, economic, and social well-being of women and girls will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction" (ACRJ 2005 as cited in Shahida 2025).

This book examines how the social realities of marginalised women in India interact with health systems. It argues for a broader understanding of sexual and reproductive justice that includes universal access to health services and the conditions necessary to exercise sexual and reproductive rights. Unlike earlier research that relies on large national data sets or micro-level field studies to document unequal health outcomes, the chapters here ask why these inequalities arise and how they shape women's life experiences (Ravindran and Balasubramanian in this volume, p. 70).

Using this expanded lens on sexual and reproductive justice, the chapters highlight women's experiences of surveillance over their mobility, almost no control over marital choices or sexual autonomy, lack of awareness about contraceptive methods and sexual intimacy, and very limited access to disease diagnosis. Case studies also show that even girls educated up to class 12 were married against their will and had unplanned pregnancies.

Several case studies underline the critical role of civil society, especially where public health services barely reach those at the margins. The editors also present a novel methodological effort to co-produce knowledge in order to understand how gender, economic marginality and social marginality actually play out in women's lives. Gender norms may severely constrain women's agency and their sexual and reproductive choices; their marginalised social and economic position further deepens these vulnerabilities.

> The authors show how economic precarity compounds lack of access to basic needs, lack of awareness of sexual and reproductive changes in the body, and restricted agency over sexual and reproductive choices.

The five chapters cover five states-Delhi, Gujarat, Tamil Nadu, Maharashtra and Odisha-and show diverse experiences of women differentiated by location (rural/urban), caste, religion, migration status, occupation, and physical ability or disability. The groups

discussed include Muslims, economically marginalised Hindus (General Caste), tribal migrants, Dalits, Particularly Vulnerable Tribal Groups, women with disabilities, and sex workers.

Cases in this volume from Delhi (Arora et. al.) and Vadodara (Sheth et. al.) depict the vulnerability of marginalised women in urban areas whose families migrated for work. The women discussed are Muslims, economically marginalised Hindus (general caste), and tribal migrants. The authors show how economic precarity compounds lack of access to basic needs, lack of awareness of sexual and reproductive changes in the body, and restricted agency over sexual and reproductive choices. They also point to the absence of adolescent health programmes in underprivileged urban areas.

In addition, women faced inadequate toilet facilities and related hardships. In this context, non-governmental organisations (NGOs) played an important role in building awareness about sexuality and gender. Women were closely monitored in their relationships, and men in romantic relationships often did not respect their sexual choices.

Some women also stated that economic empowerment is essential for being able to make life choices. This is echoed in narratives of sex workers from Pune (essay by Contractor and Sevekari) who reported a lack of access to services such as safe abortion and proper diagnosis for many illnesses, along with experiences of intimate partner violence.

At the same time, these case studies shed light on the "choice" dimension of sex work. Although many women were sold into sex work or entered it out of economic desperation, they navigated these hardships and redefined notions of family and relationships.

Ravindran et al. (in this volume) note that despite a long history of caste movements, higher female literacy, and economic growth, Dalit women in Tamil Nadu continue to face domestic violence, and both infant and under-five mortality rates among them are higher than the state average. They also acknowledge that relatively well-functioning health facilities have enabled Scheduled Caste women to fare better on indicators such as deliveries in public hospitals and use of contraceptives.

However, the narratives point to an "inequality-blind" health system that undermines access to sexual and reproductive services such as affordable and accessible abortion and dignified childbirth. Women experienced sexual violence and were not given information about contraceptives. These accounts show that affirmative action has not translated into sexual and reproductive justice, and the authors argue that economic deprivation and violence can be read as a form of male backlash.

The book (essay by Atkuri and Rautray) also discusses the heightened vulnerability of tribal women who face patriarchy and Sanskritisation alongside physical disability. At the same time, some case studies show that women are not always passive victims and are able to exercise agency, whether after periods of surveillance or later in married life. Young girls continue to interact with men through digital media, and married women resolve to seek contraceptive methods after their third child.

> Beyond access to sexual and reproductive health services, patriarchal control and economic deprivation also need to be taken into account.

It is argued that the public health system must pay attention to adolescent health (including in urban areas), awareness about menstruation and sexual intimacy, dignified childbirth, diagnosis of chronic illnesses such as sickle cell anaemia, and the healthcare needs of sex workers without prejudice.

The editors also develop a framework for sexual and reproductive justice. This framework sets out the factors and channels that shape sexual and reproductive justice. In discussing gendered experiences of marginalisation and social exclusion, they distinguish between individual factors (such as education) and contextual factors (such as NGO support and policy), and foreground the importance of embodiment.

Drawing on Krieger (2005), they define "embodiment" as the process through which the social and physical environments in which we live become embedded in our biology (p. 137). Beyond access to sexual and reproductive health services, patriarchal control and economic deprivation also need to be taken into account. Since women are not viewed only as victims, their resistance and their ability to navigate extreme situations inform the idea of "negotiating" sexual and reproductive justice. The editors thus present an expanded understanding of sexual and reproductive justice, which includes the ability to:

a) Choose to have or not have children

b) Carry a wanted pregnancy to term

c) Choose the conditions under which to give birth or start a family

d) Care for children with the necessary social support in a safe and healthy environment

e) Control their own body and self-expression, free from any form of sexual and reproductive oppression

f) Benefit from enabling conditions that make the enjoyment of sexual and reproductive rights possible, ranging from access to basic needs and resources to changes in laws and policies

g) Have universal access to sexual and reproductive health services, with special measures to ensure that no one is left behind (pp. 143-144).

The existing literature shows that relatively better-off women also face violence and patriarchal control in the name of performing "respectability" (Twamley and Sidharth 2018; Sahoo and Raju 2007). However, this volume specifically foregrounds the processes through which material inequalities, together with other forms of social marginality, produce sexual and reproductive injustice.

This is an important read for practitioners, policymakers and researchers, as it underscores the need to move beyond macro-level statistics and towards grounded epistemologies that reveal how inequalities are embedded in health systems.

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