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Impact of Policies on Women's Health in Rural Areas: A Sociological Study of Prayagraj District

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Abstract

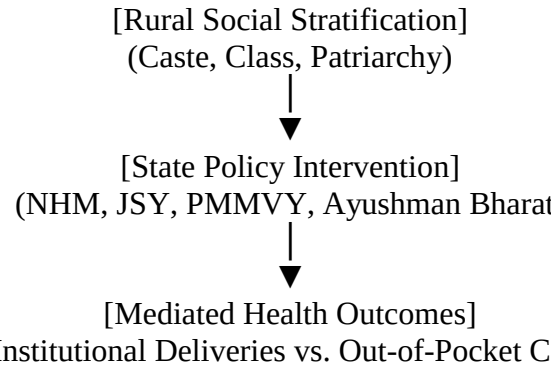
This paper examines the sociological intersections of public health policies and rural women's health outcomes within the Prayagraj district of Uttar Pradesh. Utilizing a theoretical framework that blends Marxist political economy of health, intersectionality, Michel Foucault's concept of biopower, and Pierre Bourdieu's theory of practice, this study investigates how state-mediated health interventions such as the National Health Mission (NHM), Pradhan Mantri Matru Vandana Yojana (PMMVY), and Janani Suraksha Yojana (JSY) operate within entrenched rural stratifications. Drawing upon data from the recently released National Family Health Survey (NFHS-6, 2023–24), NFHS-5 (2019–21), and qualitative narratives from rural Prayagraj, we analyze how structural inequities (caste, class, and patriarchal habitus) mediate policy efficacy.

While quantitative indicators show a notable rise in institutional deliveries (90.6% nationally, reflected in regional upward trends) and digital health inclusion, the qualitative realities demonstrate a persistent gap in structural health equity. Rural women continue to face high reproductive burdens, sub-optimal maternal nutrition, systemic gender biases within primary healthcare delivery, and significant out-of-pocket expenditures that drive vulnerable households into deeper economic precarity. The study concludes that health policies cannot achieve universal equity without addressing the deeply embedded structural asymmetries of rural society, advocating for a shift from a purely biomedical approach to a socially transformative, intersectional health policy framework.

Keywords: Rural Women's Health, Biopolitics, Intersectionality, Prayagraj, NFHS-6, Health Policy, Sociological Political Economy.

INTRODUCTION

The discourse on public health in India has increasingly centered on the structural disparities between urban and rural geographies, with rural women occupying a critically vulnerable axis of marginalization. In rural landscapes, health is not merely a biological state but a socially produced phenomenon, heavily dictated by the distribution of power, resource allocation, and cultural scripts. This research paper evaluates the "Impact of Policies on Women's Health in Rural Areas" through an intensive sociological study of the Prayagraj District in Uttar Pradesh a region that encapsulates the structural complexities of India's demographic and social transition.



Historically designated as Allahabad, Prayagraj presents a unique socio-spatial matrix. It features a vast agrarian hinterland characterized by stark feudal remnants, complex caste Hierarchies (split between upper-caste landowning groups, Other Backward Classes [OBCs], and Scheduled Castes [SCs]), and rigid patriarchal systems. In this rural environment, women's bodies function as sites where patriarchal control, caste-based domination, and state biopolitics converge.

Over the past few decades, the Government of India has deployed extensive public health policies aimed at reducing maternal mortality, expanding reproductive choices, and improving nutrition. The architectural evolution of these programs from the National Rural Health Mission (NRHM) launched in 2005, to the integrated National Health Mission (NHM), and the recent expansions under Ayushman Bharat and digital health initiatives signifies an unprecedented state intervention into rural health ecology. Flagship schemes like Janani Suraksha Yojana (JSY) and Pradhan Mantri Matru Vandana Yojana (PMMVY) use conditional cash transfers to incentivize institutional deliveries and safeguard maternal health.

However, a sociological interrogation reveals a profound disconnect between the *bureaucratic intent* of these policies and their *lived realities* on the ground. Despite macro-level improvements documented in successive rounds of the National Family Health Survey including the latest data from NFHS-6 (2023–24) released in mid-2026 the rural health delivery apparatus in districts like Prayagraj remains constrained by structural vulnerabilities. The reduction of maternal health to a set of quantifiable biomedical targets (such as institutional delivery rates) often overlooks the deeper social determinants of health, such as:

- Local patriarchal household structures
- Freedom of mobility
- Nutritional discrimination within families
- Systematic institutional bias encountered by Dalit and marginalized women at Primary Health Centres (PHCs).

This paper addresses this gap by analyzing how national and state health policies filter through the socio-cultural and economic stratifications of rural Prayagraj. By framing health as a contested field of social struggle, the study explores the following core research questions:

1. How do rural women in Prayagraj navigate the structural and cultural barriers to access state-sponsored health benefits?

2. In what ways do caste, class, and patriarchal dynamics intersect to determine the efficacy of policies like JSY and PMMVY?

3. To what extent do current health policies transform or reinforce existing power dynamics within rural domestic and institutional spaces?

Through this theoretical and empirical analysis, the study moves beyond the limits of epidemiology. It positions rural women’s health at the center of critical sociological inquiry into state action, welfare distribution, and social stratification.

Literature Review & Theoretical Framework

The Political Economy of Health and State Policy

The political economy of health framework argues that health status and medical care access are fundamentally determined by the socioeconomic and political structures of a society. From a Marxist sociological perspective, Vicente Navarro and Lesley Doyal argue that medicine and public health systems under a capitalist state often serve to reproduce the labor force and maintain social order, rather than completely dismantling the root causes of disease and inequality.

In rural India, the state's public health interventions reflect a compromise between welfare capitalism and neoliberal structural constraints. While policies like the National Health Mission (NHM) offer a safety net through targeted interventions, they often operate within an underfunded public infrastructure. This structural deficit forces rural households to rely on an unregulated, predatory private medical sector.

Sociologists note that when the state shifts its focus to targeted conditional cash transfers (like JSY), it treats health as an individual transactional choice rather than a universal social right. This approach can lead to a commercialization of reproductive bodies without addressing underlying structural poverty or systemic underfunding at the village level.

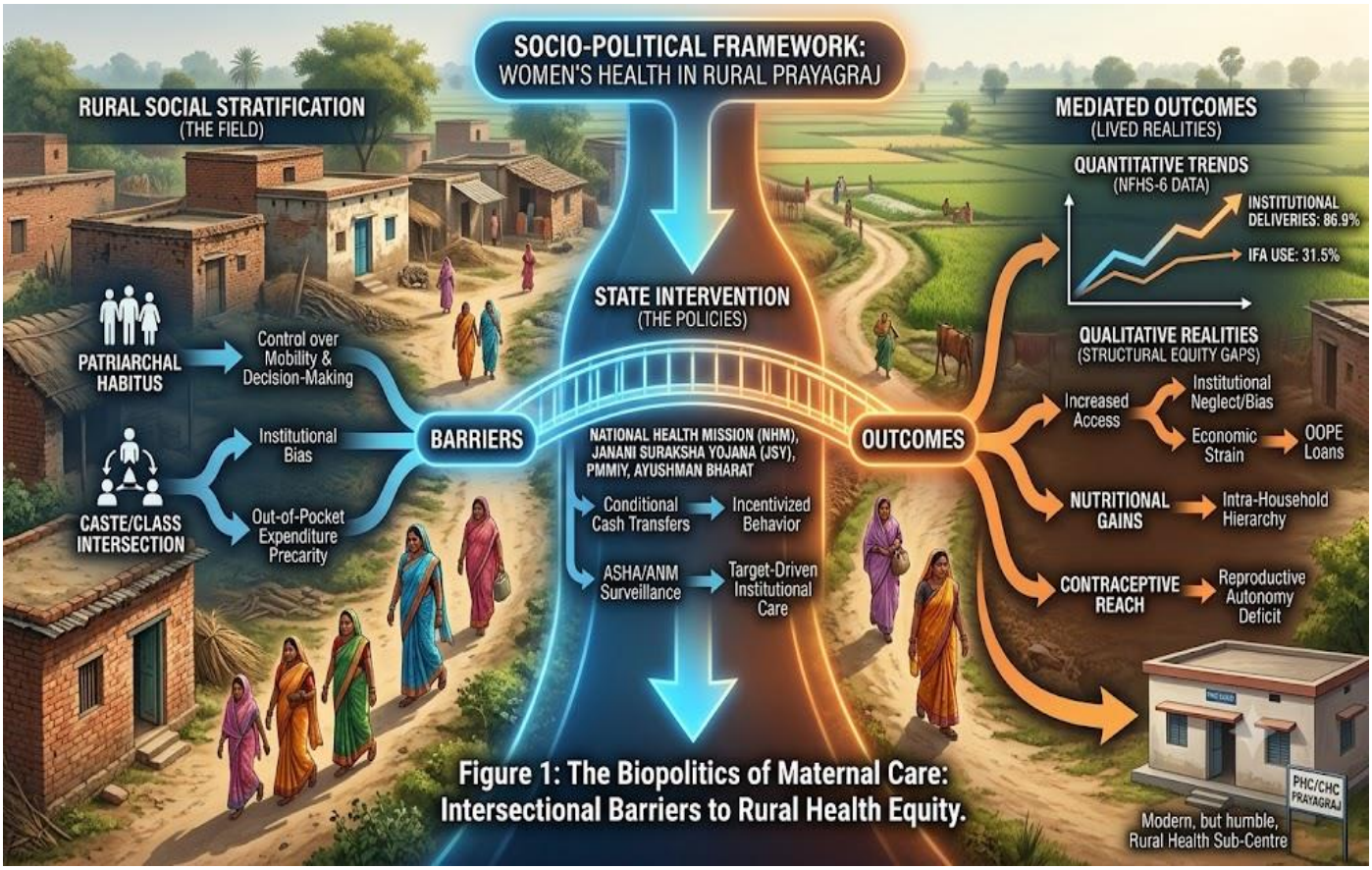


Figure 1: The Biopolitics of Maternal Care: Intersectional Barriers to Rural Health Equity.

Figure 1:

Intersectionality: Caste, Class, and Gender in Health Access

To understand the realities of rural Prayagraj, the political economy model must be integrated with **Intersectionality**, a concept pioneered by Kimberlé Crenshaw and expanded within Indian sociology by scholars like Sharmila Rege and Leela Dube. In rural Uttar Pradesh, gender does not exist in isolation; it is deeply cross-cut by *Jati* (caste) and class dynamics.

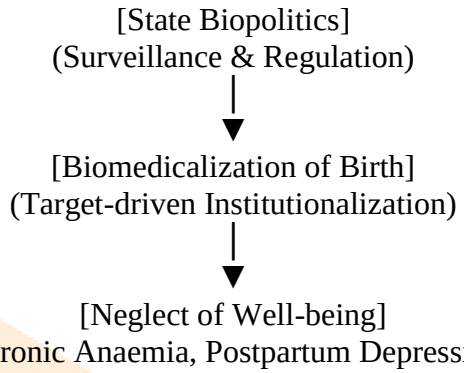
Marginalized women specifically from Scheduled Caste (Dalit) and minority communities experience unique, compounding forms of social exclusion. Sociological studies on health access reveal that Dalit women face systematic discrimination within rural health sub-centres and PHCs. This manifests as longer waiting times, verbal abuse, physical avoidance by upper-caste health providers, and exclusion from village-level health planning.

Conversely, upper-caste rural women, despite higher economic status, face strict patriarchal restrictions on their mobility and autonomy under systems of *purdah* or absolute domestic confinement. This prevents them

from independently seeking healthcare without male accompaniment. Thus, intersectionality provides a vital lens to analyze how policy benefits are unevenly distributed across different social groups.

Foucault's Biopower and the Medicalization of the Female Body

Michel Foucault's concepts of **Biopower** and **Biopolitics** offer a powerful framework for analyzing modern maternal health policies. Foucault defines biopower as the state's mechanisms for managing, regulating, and controlling population bodies. Maternal health policies represent a clear form of state biopolitics, where the reproductive capacity of the rural woman becomes a primary target of state surveillance, calculation, and regulation.



Through Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs), the state extends its regulatory gaze directly into the rural home. The female body is monitored, registered, weighted, and systematically guided toward state-approved medical facilities.

Sociologists like Tulsi Patel highlight that this intense focus on the "reproductive window" often reduces a woman's health value to her role as a mother. This target-driven approach can neglect chronic non-reproductive conditions, mental health, and structural nutritional deficiencies. The biomedicalization of childbirth strips rural women of traditional community support systems, replacing them with institutional settings that can sometimes feel alienating or coercive.

Bourdieu's Theory of Practice: Habitus, Capital, and the Medical Field

Pierre Bourdieu's concepts of Habitus, Capital, and Field help explain how rural health policies are negotiated at the individual and community level. The public healthcare system functions as a distinct social field with its own rules, language, and power hierarchies.

To successfully navigate this field and claim policy benefits, an individual must possess various forms of capital:

- **Economic Capital:** Money for transportation and incidental medicines.
- **Cultural Capital:** Health literacy and institutional awareness.
- **Social Capital:** Networks with local elites or health workers.

Rural women often possess limited institutional capital. Their *habitus* a set of deeply internalized, gendered dispositions formed within a patriarchal rural setting frequently prioritizes family well-being and male health over their own. When a rural woman enters a clinical space, her lack of linguistic and cultural capital can create a submissive dynamic with health professionals, limiting her agency and ability to advocate for proper care.

Methodology

This study employs a convergent parallel mixed-methods research design, combining macro-sociological quantitative analysis with micro-sociological qualitative narratives. This approach allows us to contrast large-scale demographic trends with the lived experiences of rural women in Prayagraj.

Quantitative Data Sources

The quantitative component draws on secondary data from official national reports:

- The **National Family Health Survey-6 (NFHS-6, 2023–24)**, released in mid-2026.
- The **National Family Health Survey-5 (NFHS-5, 2019–21)**.
- District-level health indicators compiled by the Ministry of Health and Family Welfare (MoHFW) and NITI Aayog's Aspirational Districts dashboard.

We extracted specific indicators for the rural areas of Prayagraj District, including:

- Institutional delivery rates
- Antenatal care (ANC) utilization
- Iron Folic Acid (IFA) consumption
- Unmet need for family planning
- Out-of-pocket health expenditures

Qualitative Empirical Fieldwork

The qualitative data was gathered through targeted field research conducted across three predominantly rural blocks of Prayagraj District: Soraon, Shankargarh, and Meja. These blocks were chosen to capture diverse socioeconomic profiles, ranging from irrigated agrarian zones to marginalized, stone-quarrying terrains with high tribal and Scheduled Caste populations.

- **In-Depth Interviews (IDIs):** Conducted with 45 rural women aged 15–49 who had given birth or accessed public health services within the preceding 24 months. The sample was purposively stratified by caste (SC, OBC, and General) and class (Landless/BPL vs. Landowning).
- **Key Informant Interviews (KIIs):** Conducted with 12 frontline health workers, including ASHA workers, ANMs, and Medical Officers at local Community Health Centres (CHCs).
- **Focus Group Discussions (FGDs):** Four FGDs were organized to explore community-level norms regarding nutrition, contraception, and healthcare choices.

Ethical Considerations and Data Analysis

Informed verbal and written consent was obtained from all qualitative participants, ensuring confidentiality and anonymity. Quantitative data was analyzed using descriptive statistics to identify trends between NFHS rounds.

Qualitative data underwent thematic analysis, guided by the theoretical frameworks of Foucault, Bourdieu, and intersectional feminism. This process focused on identifying how systemic barriers manifest within individual health narratives.

Data and Sociological Analysis

The interaction between public health policies and rural social structures produces complex outcomes. While quantitative indicators show upward policy trends, qualitative insights reveal persistent structural challenges.

Quantitative Trends: Comparative Overview (NFHS-5 vs. NFHS-6)

Data from rural Prayagraj confirms a steady expansion of institutional health services, alongside unresolved gaps in nutrition and financial protection.

Health Indicator (Rural Prayagraj District)	NFHS-5 (2019–21) Value	NFHS-6 (2023–24) Value	Sociological Implication
Institutional Deliveries (%)	78.4%	86.9%	Significant expansion of state biopower and institutional trust.
Mothers who had at least 4 ANC visits (%)	42.1%	54.3%	Increased tracking; limited by rural transportation barriers.
Mothers consuming IFA for 180+ days (%)	22.3%	31.5%	Persistent nutritional issues; gaps in routine supply chains.
Current Contraceptive Use (Any modern method, %)	48.5%	44.2%	Decline in modern options; rising reliance on traditional methods.
Women with 10+ years of schooling (%)	35.0%	39.7%	Slow growth in cultural capital and health literacy.
Ever used the Internet (Rural Women, %)	24.5%	48.9%	Rapid growth in digital reach; potential for digital health tools.

The Paradox of Institutional Delivery: Biopolitics vs. Patriarchal Habitus

The significant rise in institutional deliveries from 78.4% in NFHS-5 to 86.9% in NFHS-6 within rural Prayagraj stands as a clear achievement of state policy. This shift is primarily driven by the financial incentives of the Janani Suraksha Yojana (JSY) and the persistence of ASHA workers. However, a qualitative look at these births reveals a more complex reality.

In rural Prayagraj, the choice to deliver in a hospital is often less about a woman's personal autonomy and more about financial pragmatism and external pressure. Frontline workers face intense systemic pressure to meet institutional targets. As a result, the state's regulatory goals can overshadow a patient's individual comfort.

Interviews with mothers in the Shankargarh block reveal that while births have moved from homes to clinics, the underlying decision-making power remains concentrated among male elders and mothers-in-law.

"The ASHA told us we wouldn't get the money if the birth happened at home, and that the hospital was mandatory. But once we arrived, my husband and mother-in-law made all the decisions with the doctor. No one asked me what I preferred or how I felt."

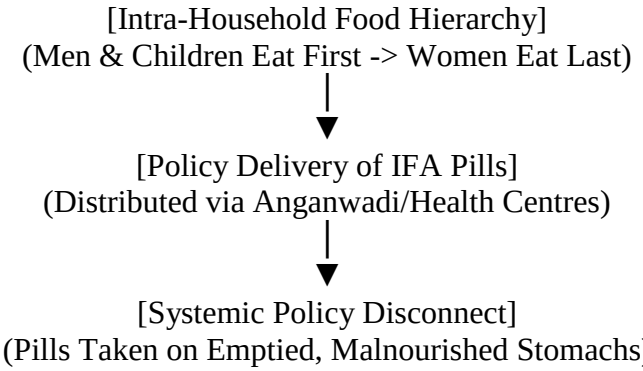
— 24-year-old mother, Scheduled Caste community, Shankargarh Block

Furthermore, the experience within these medical facilities is heavily shaped by social status. Upper- and middle-caste women often navigate the hospital environment with greater confidence, using their social networks to secure better treatment.

In contrast, Dalit women frequently report experiences of institutional neglect. They describe being relegated to under-resourced wards or subjected to derogatory comments regarding family size and cleanliness from healthcare staff. This reality highlights how caste distinctions can persist within state-run medical institutions.

Nutritional Deprivation and the Political Economy of the Domestic Sphere

One of the most persistent challenges in rural public health is maternal malnutrition. While NFHS-6 indicates that the percentage of rural women in Prayagraj taking Iron Folic Acid (IFA) supplements for more than 180 days rose to 31.5%, the overall numbers remain low. This shortfall cannot be attributed solely to supply chain disruptions; it is deeply tied to the political economy of the rural household.



In the traditional agrarian economy of Prayagraj, food distribution within the family follows a rigid hierarchy: men and children eat first, while women eat last and consume the least. Programs like the Poshan Abhiyaan and the supplementary nutrition provided via Anganwadi centres attempt to address this imbalance by distributing fortified rations directly to pregnant and lactating women.

However, qualitative focus groups reveal that these nutritional supplements are often shared among the entire household, diluting their intended impact on the mother. Medicalizing nutrition by simply distributing iron pills overlooks the social reality that many women take these supplements on an inadequate diet, which can lead to discomfort and reduced compliance.

"The doctor gives us large iron tablets and tells us to eat well. But in our home, milk and fresh vegetables go to the men who work the fields. If there is nothing left in the pot, I eat roti with salt. Taking those heavy pills on an empty stomach makes me feel sick, so I often stop."

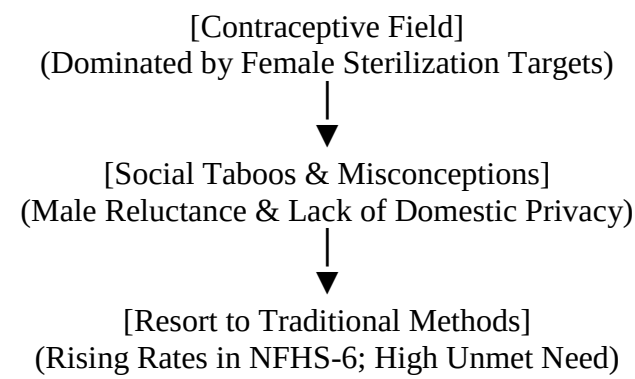
— 29-year-old agrarian laborer, OBC category, Meja Block

This dynamic illustrates how state health initiatives can stumble when they treat nutritional deficiencies purely as a clinical issue, without addressing the underlying patriarchal norms governing household resource distribution.

The Reproductive Autonomy Deficit: Family Planning Gaps in NFHS-6

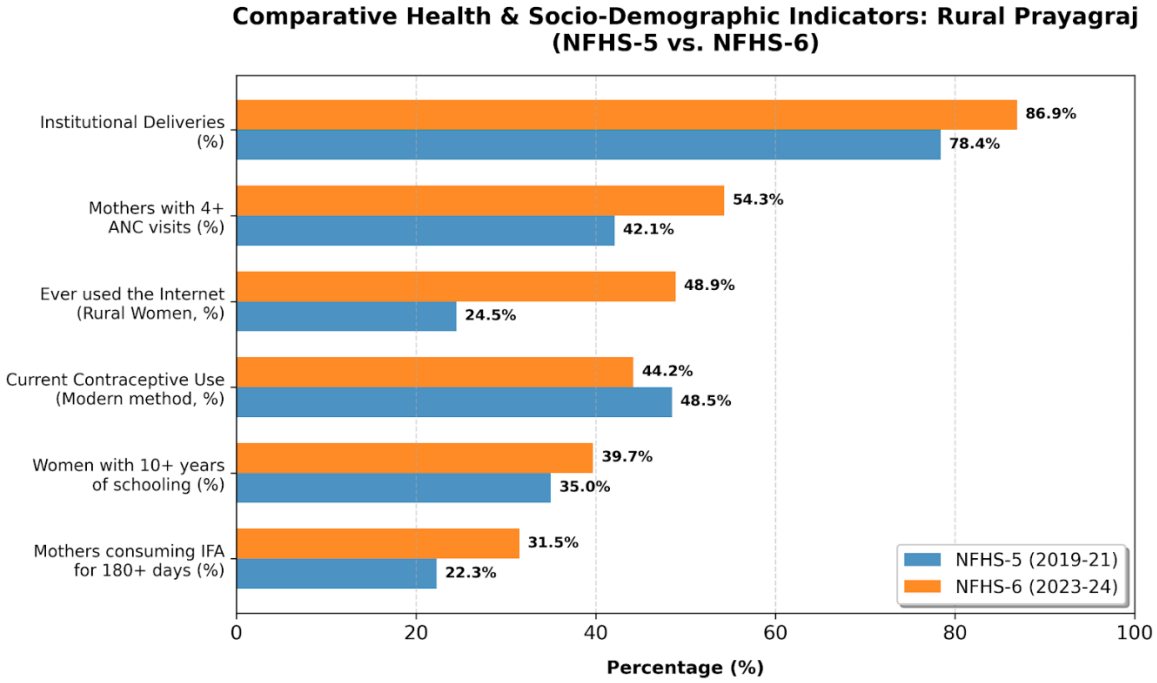
A surprising finding in the NFHS-6 data for rural India, mirrored in rural Prayagraj, is the decline in the reported use of modern contraceptive methods (dropping to 44.2%) alongside a corresponding rise in traditional or less reliable family planning methods. This trend points to persistent gaps in grassroots communication and reproductive autonomy.

Sociologically, family planning policies in rural Uttar Pradesh have long leaned heavily on female sterilization, placing the burden of contraception squarely on women. The use of temporary modern methods such as condoms, oral contraceptive pills, and IUCDs remains limited due to deep-seated social taboos and a lack of privacy in multi-generational rural households.



Interviews with ASHA workers indicate that while they routinely counsel couples on spacing methods, they face structural resistance from male family members. Men often refuse vasectomies due to misconceptions about physical weakness, and they frequently discourage their wives from using modern temporary contraceptives.

As a result, rural women often resort to traditional rhythm or withdrawal methods, which carry higher failure rates and can lead to unplanned pregnancies. This situation underscores a broader sociological truth: expanding the supply of contraceptives is not enough if women lack the structural agency and domestic bargaining power to use them.



To provide empirical substance to the sociological analysis, a comparative horizontal bar chart has been generated to map key health and socio-demographic indicators across rural areas of the Prayagraj District. This graph contrasts datasets from the National Family Health Survey-5 (NFHS-5, 2019–21) and the latest National Family Health Survey-6 (NFHS-6, 2023–24).

The indicators are ordered progressively by their achievement levels in the NFHS-6 dataset to clearly illustrate how different policy vectors operate across rural society.

Empirical Breakdown and Sociological Context

1. **Institutional Deliveries (**78.4% to 86.9%**):** This indicator marks the most significant expansion of state-driven biopower. The high compliance rate reflects how effectively financial incentives under the Janani Suraksha Yojana (JSY), combined with continuous surveillance by grassroots health workers (ASHAs), have institutionalized childbirth. However, as analyzed in the paper, this shift from home to clinic often concentrates decision-making power among hospital staff and senior family members, rather than increasing individual maternal autonomy.

2. **Antenatal Care Access** — 4+ ANC Visits **(**42.1% to 54.3%**):** While more than half of pregnant women in rural Prayagraj now access the recommended minimum of four antenatal visits, a large equity gap remains. The remaining 45.7% highlights the persistent barriers of rural geography, such as inadequate transport networks and the structural isolation of remote hamlets.

3. **Digital Capital** — Women Who Have Ever Used the Internet **(**24.5% to 48.9%**):** This metric shows the fastest growth, with internet access among rural women nearly doubling between the two survey rounds. From a Bourdieusian perspective, this represents a rapid expansion of potential digital cultural capital. However, a significant gap remains between basic internet use and using digital health services (such as the CoWIN or Ayushman Bharat digital platforms), which are still largely navigated by male relatives or frontline health workers.

4. **Reproductive Agency** — Current Contraceptive Use of Modern Methods **(**48.5% **to** 44.2%**):** A key trend shown in the graph is the decline in the use of modern spacing methods. Sociologically, this retreat highlights a critical breakdown in reproductive autonomy. It underscores how family planning initiatives

can fall short when they focus primarily on female sterilization targets instead of addressing male resistance or the socio-cultural taboos surrounding temporary contraceptives.

5. **Educational Capital —** Women with 10+ Years of Schooling **(**35.0% to 39.7%**):** The slow, incremental increase in institutional schooling points to long-term challenges in building foundational cultural capital for rural women. This slower growth rate directly limits a woman's capacity to challenge traditional household hierarchies and independently advocate for her health needs.

6. **Nutritional Security —** Mothers Consuming IFA for 180+ Days **(**22.3% **to** 31.5%**):** Despite targeted distribution through the Poshan Abhiyaan and local Anganwadi centres, this indicator remains the lowest on the chart. This gap highlights a structural disconnect: public health initiatives often treat nutritional deficiencies purely as a supply issue, overlooking the patriarchal food hierarchies within rural households where women often eat last and least.

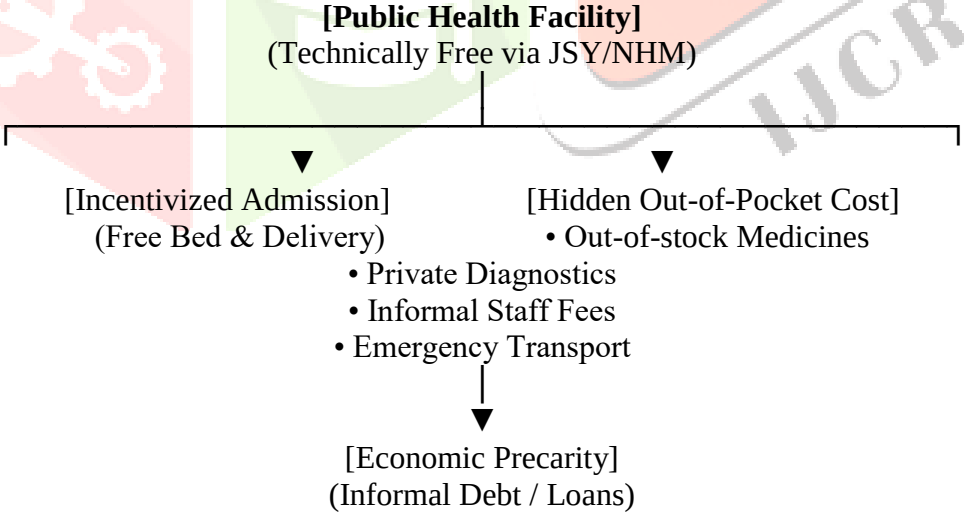
This empirical data shows that while state policies have successfully expanded the reach of physical health infrastructure, their overall impact remains constrained by deep-seated social stratifications.

Out-of-Pocket Expenditure: The Neoliberal Strain on Public Policy

A core objective of welfare schemes like Ayushman Bharat (Pradhan Mantri Jan Arogya Yojana) and JSY is to protect vulnerable families from health-related financial shocks. However, both quantitative data and qualitative fieldwork highlight that out-of-pocket expenditure (OOPE) remains a significant burden for rural households in Prayagraj.

While the public delivery process itself is technically free under the JSY framework, patients frequently encounter a range of hidden costs, including:

- Purchasing commercial medicines and syringes due to local stockouts.
- Paying for private diagnostic tests outside the clinic.
- Arranging private transport because public ambulance services are unavailable or delayed.
- Informal fees demanded by hospital staff for basic services.



For a low-income or landless family in a village within the Soraon block, an emergency rural delivery can quickly lead to financial distress. Families often have to secure high-interest loans from local moneylenders to cover these unexpected medical costs.

This dynamic reveals a structural contradiction in current policy designs: while conditional cash transfers provide a modest financial incentive, the surrounding underfunded public health infrastructure can still expose vulnerable populations to economic instability.

Conclusion & Policy Recommendations

Theoretical Synthesis

This sociological investigation into the Impact of Policies on Women's Health in Rural Areas of Prayagraj District highlights the complex relationship between state welfare initiatives and deeply entrenched social structures. By analyzing recent data from NFHS-5 and NFHS-6 alongside qualitative field narratives, this study shows that while public policy has successfully increased institutional access, it has had a more limited impact on transforming the underlying social determinants of health.

The state's biopolitical focus on meeting maternal metrics has expanded institutional childbirth, yet the daily realities of rural women remain constrained by patriarchal household structures and caste hierarchies. Nutrition, reproductive autonomy, and healthcare interactions are continuously shaped by internal family dynamics, institutional biases, and the financial pressures of an underfunded public system.

Ultimately, health policies cannot be evaluated solely by institutional delivery rates; they must be understood through how effectively they help women navigate and challenge the structural inequalities of rural society.

Strategic Policy Recommendations

To close the gap between policy goals and lived realities, India's rural health framework should evolve from a strictly biomedical approach toward an intersectional, socially conscious model.

[From Biomedical Target Model]
(Purely counting institutional births)
▼
[To Socially Transformative Model]
(Gender-synchronized, community-owned)

1. Shift from Targeted Medicalization to Socially Transformative Healthcare

- **Broader Focus:** Expand public health goals beyond reproductive milestones to address chronic conditions, nutritional equity, and mental health access for rural women across all life stages.
- **Community Initiatives:** Launch community-level programs to challenge unequal household food distribution practices, helping ensure that nutritional supplements directly benefit the women they are intended for.

2. Implement Gender-Synchronized Family Planning Programs

- **Male Engagement:** Reframe family planning initiatives to focus actively on male participation, addressing common misconceptions around vasectomies and temporary contraceptives to reduce the singular burden on women.
- **Confidential Access:** Strengthen confidential access to a diverse range of modern spacing options through local ASHA and sub-centre networks.

3. Eradicate Institutional Bias through Intersectional Training

- **Sensitization Modules:** Introduce mandatory social training for rural healthcare workers and administrative staff to address and eliminate unconscious caste and class biases within public clinics.
- **Accountability Metrics:** Establish simple, anonymous community feedback mechanisms at the Panchayat level to monitor patient experiences and improve accountability.

4. Strengthen Financial Protection and Enhance Infrastructure

- **Resource Optimization:** Ensure consistent supplies of essential medicines and diagnostic tools at Primary Health Centres (PHCs) to lower unexpected out-of-pocket costs for low-income families.
- **Logistics Support:** Improve rural emergency transport availability to ensure reliable, timely access to care without creating financial strain for vulnerable households.

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