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Women And Health: Nutrition And Reproductive Rights in Northeast India

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Abstract: *Women's health is an indicator of social development and gender equality, shaped by access to nutrition, healthcare, and reproductive autonomy. In Northeast India, women and most importantly, those from tribal communities continue to experience disproportionate health vulnerabilities rooted in geographical isolation, socio-economic marginalisation, cultural norms, and uneven health benefits. This paper examines women's health in the region through the interconnected lenses of nutrition and reproductive rights, highlighting how nutritional deficiencies and constrained reproductive autonomy reinforce adverse health conditions. Based on secondary literature and national health data, the chapter analyses patterns of undernutrition, anaemia, and the emerging dual burden of malnutrition alongside reproductive health challenges such as early marriage, early childbearing, low contraceptive uptake, and limited access to reproductive healthcare services. Despite progressive legal frameworks and welfare schemes supporting maternal health, family planning, and reproductive rights, a persistent gap between awareness and utilisation of services, particularly among tribal women is most evident. Deeply embedded cultural beliefs, gendered responsibilities, societal norms, socio-economic disadvantage and inadequate health literacy further restrict women's ability to utilise their full potential.*

Keywords*: Women's Health, Nutrition, Reproductive Rights, Welfare Schemes, Northeast Studies.*

1. INTRODUCTION

Women's health is an essential measure of mapping development and gender equality. In the year 2023, the World Health Organisation (WHO) defined six priorities for women's health in an attempt to overcome the several challenges women and girls face to obtain proper health care (The World Health Organisation 2023a) [1]. In Northeast India, women belonging to tribal communities counter conspicuous health disparities that are ingrained in socio-economic marginalisation, time-honoured customs, and deficient health services. These interconnected components create an intricate setting where women's well-being is compromised. This chapter examines two interrelated aspects of women's health: nutrition and reproductive rights. It highlights how widespread dietary deficiencies and anaemia enervate women's physical health, while social practices such as early marriage and early childbearing place additional burdens on their reproductive systems. Additionally, the poor family planning knowledge limits women's autonomy over their reproductive choices, leading to detrimental reproductive health outcomes. Together, these interconnected issues accentuate the urgent need for a unified intervention that addresses both nutritional deficiencies and reproductive health challenges to improve the overall health status of women in this region.

2.BACKGROUND

Northeast India is a geographically and culturally diverse region marked by difficult terrain and historical marginalisation. Despite rich indigenous systems, infrastructural gaps shape health outcomes. Women's nutrition, reproductive health, and healthcare access are constrained by poverty, remoteness, and sociocultural norms. Thus, women's health must be understood within its regional context, as many in developing regions continue to face poor health outcomes (Kennedy & Meyers, 2005) [2]. Nutritional deficiencies among women of reproductive age (15-49

years) represent a public health concern due to their impact on both maternal health and offspring outcomes. Some highlight the persistent burden of these deficiencies globally, with variations influenced by geographic, economic, and sociocultural factors (Jiang et al, 2022) [3].

Anaemia among women of reproductive age represents a critical health threat due to its deep influence on maternal health outcomes. It is one of the key players in maternal morbidity and mortality, with over 115,000 maternal deaths annually attributed to anaemia worldwide. The global burden of anaemia is substantial, affecting nearly two out of every five pregnant women and one out of every three non-pregnant women. The prevalence of anaemia is disproportionately higher in low and middle-income countries (Hasan et al, 2022) [4]. The reproductive rights of women are often violated along with societal norms, practices, cultural beliefs, and gender gaps that restrict women's sexuality and autonomy. Due to limited access to information, resources, and services necessary to exercise reproductive rights, women's rights are threatened (Buser, 2022) [5]. The progress of reproductive rights in India is notably advanced compared to some developed countries. India has implemented progressive policies to protect women's reproductive and bodily autonomy, yet significant challenges persist, particularly in awareness and access to services (Jakhar, 2025) [6]. Women in urban areas, unmarried women, and those with higher education have greater awareness of sexual and reproductive rights, especially family planning and safe abortion. Still, low awareness persists due to personal hesitations, perceived irrelevance, and societal influence (Joshua, 2025) [7]. Despite some progress, malnutrition remains a major challenge in Northeast India, driven by disparities in food security, healthcare access, and socio-economic conditions. Undernutrition among women and children persists, requiring targeted interventions. Among Scheduled Tribes, especially women of reproductive age, economic vulnerability is closely linked to poor nutritional and health outcomes, highlighting a complex public health issue.NFHS report 2019-2021 states that half of the tribal women reside in rural area with little or no education. This paper focuses on the nutritional level of women and reproductive rights from the perspective of North East India and the challenges faced by women from various region.

Women and Health in Northeast India: An overview

Women's health in northeastern states is shaped by persistent inequalities in nutrition, reproductive care, and access to health services, driven largely by broader social and structural determinants (WHO, 2009) [8]. Women's health particularly in Northeast India must be understood against a backdrop of socio-cultural diversity, geographical isolation, and uneven development. Access to healthcare remains a significant challenge, exacerbated by entrenched gender norms and economic disparities (Borah et al, 2023) [9]. The region hosts a large amount of indigenous and tribal populations, whose health practices are shaped by traditional food systems, customary beliefs, and community-based livelihoods.

Women in Northeast India face persistent undernutrition, anaemia, and micronutrient deficiencies, especially during adolescence, pregnancy, and lactation. Healthcare access is limited by difficult terrain, poor infrastructure, and staff shortages. Cultural beliefs around diet, pregnancy, and childcare further influence women's health behaviours and nutritional outcomes.(Upadhyay et al) [10]. Several states in the region lag behind national averages in health outcomes such as antenatal care coverage, immunisation, and infant mortality and significant inter-state disparities persist, with states such as Assam, Meghalaya, and Tripura performing poorly, while Sikkim and Mizoram show comparatively better health outcomes (Das, 2024) [11].

This highlights the need to view women's health in Northeast India through an integrated lens that links nutrition, reproductive health, and socio-economic conditions. Understanding this background is essential for contextualising the discussion on women's nutrition and reproductive rights that follows.

Women's Nutrition in Northeast India

Women's nutritional status in Northeast India reflects persistent inequalities shaped by geography, livelihood patterns, gender relations, and state capacity. Data from the National Family Health Survey (NFHS-5) reveal that a significant proportion of women aged 15-49 years across the Northeastern states suffer from nutritional deficiencies, particularly anaemia and micronutrient inadequacy (IIPS & ICF, 2021) [12]. States such as Assam, Tripura, Meghalaya, and Arunachal Pradesh report high anaemia prevalence among women, indicating chronic nutritional stress despite regional variations in dietary practices. A study among the Chakhesang community in Nagaland demonstrates that the use of Indigenous agrobiodiversity and wild foods contributes to comparatively better nutritional outcomes despite the presence of undernutrition and micronutrient deficiencies. The findings highlight the importance of preserving

Indigenous food systems within nutrition and food security policies (Longvah et al, 2017) [13]. This shows that despite higher cases of nutritional deficiencies among women, some communities are doing better with traditional knowledge.

While undernutrition remains a major concern, the northeast is also witnessing an emerging dual burden of malnutrition and increasing levels of overweight and obesity, particularly in urban and semi-urban areas of states like Mizoram and Manipur. This trend reflects changing food environments, reduced physical activity, and greater reliance on market-based and processed foods (Salam et al., 2013) [14]. Studies highlight Meghalaya and Nagaland facing issues of undernutrition, obesity, and rising hypertension, with pre-hypertension particularly high in Nagaland (Meshram et al, 2022) [15]. Anaemia constitutes one of the most critical nutritional challenges faced by women in Northeast India along with iron deficiency, inadequate intake of folic acid, vitamin B12, and poor dietary absorption, contributes to high anaemia prevalence among women of reproductive age (IIPS & ICF, 2021) [16]. Anaemic women experience fatigue, reduced work capacity, and heightened risks during pregnancy and childbirth. Research shows that anaemia is prevalent across states and districts, shaped by dietary diversity, socioeconomic status, and access to health services. Tribal and rural women are particularly vulnerable due to limited access to iron-rich foods, healthcare facilities, and supplementation programs (Rahman & Talukdar, 2025) [17]. A substantially higher reliance on self-medication and traditional healers among the Scheduled Tribe population along with adverse living conditions, minimal access to safe drinking water and the absence of household sanitation facilities is a determinant contributing to heightened morbidity levels (Bharati, 2017) [18].

The Northeast has traditionally diverse diets such as rice, fish, meat, leafy vegetables, bamboo shoots, fermented foods, and forest produce that have supported nutrition, especially among tribal communities. However, women's access to these foods is increasingly limited by environmental degradation, declining jhum cultivation, land alienation, and climate-related disruptions such as floods and landslides (Tantri et al., 2023) [19]. Studies on the Idu Mishmi tribes show nutritional inadequacies and a lack of obesity (Wright & Gupta, 2017) [20]. In Assam, recurrent flooding affects agricultural production and food security, disproportionately impacting women who bear primary responsibility for food provisioning. Seasonal food shortages often result in reduced dietary diversity for women (Salam et al., 2013) [21]. Research on the Boro Kachari tribe of Assam highlights a highly diverse traditional food system sustained by women's agricultural and culinary knowledge. However, environmental degradation, weakening intergenerational knowledge transfer, and increased reliance on market-based foods threaten the sustainability of these practices and women's nutritional well-being (Gogoi, 2019) [22]. Government interventions such as the Integrated Child Development Services (ICDS), POSHAN Abhiyaan, Public Distribution System, and National Health Mission aim to improve women's nutritional outcomes ensuring welfare and wellbeing but face significant implementation challenges due to difficult terrain, staffing shortages, and monitoring gaps (IIPS & ICF, 2021) [23]. Moreover, nutrition programs often frame women primarily as mothers rather than as autonomous individuals with nutritional rights. This instrumentalist approach limits attention to women's dietary needs outside pregnancy and lactation, thereby reinforcing gendered neglect (Cornwall & Rivas, 2015) [24].

Reproductive Rights

Reproductive rights are integral to autonomy and personal liberty, linked to rights such as life, equality, privacy, and health. They ensure individuals can decide whether and when to have children and maintain reproductive health. In India, constitutional provisions and judicial interventions have recognised and strengthened women's reproductive autonomy within a patriarchal context (Agarwal, 2023) [25]. The Constitution provides Fundamental Rights to protect individual rights, including the Directive Principles of state policy that detail how the State should implement these rights. Article 47 of the Directive Principles sets the State's duties to raise and improve public health, nutrition and the standard of living; however, Directive Principles, unlike Fundamental Rights, are not enforceable in court (Kaur, 2012) [27]. The government has brought different acts and laws for safeguarding the reproductive rights of women. MTP Act, 1971 amended in the year 2021, is considered as a historic and most progressive legislation initiated by the Indian parliament ever. It played a role in legalising abortion and asserting the reproductive and bodily autonomy of Indian women (Ferguson, 2022) [28]. With the advancement of Assisted Reproductive Technology, surrogacy has been commonly accepted as a method of reproduction. Surrogacy in India is regulated through a legislative provision of the Surrogacy Act of 2021, which aims at safeguarding the rights of surrogates (Priyam, 2024) [29]. The issue of menstrual leave in recent decades has gained huge momentum globally as well as at a state level, though still an undiscussed topic at a societal level. Certain progressive steps have been taken by states like Bihar and Kerala for menstrual leaves (Aggarwal, 2024) [30]. Marital Rape Exception (MRE) which is a colonial relic originating from the "doctrine of

coverture" in English common law, severely curtails the legal autonomy of a married women assuming that after marriage men and women are transformed into a single entity ending the legal existence of women (Bhaumik, 2024) [31]. Major hindrance towards criminalisation of marital rape lies in the argument by the government that it violates "sanctity" of marriage, rooted conservatively and traditionally of thinking of Indian society (Akram, 2023) [32]. Recently the constitutional validity of Exception 2 to Section 375 of the Indian Penal Code and the Exception 2 of Section 63 of the Bharatiya Nayaya Sanhita (BNS), 2023 has been challenged in the Supreme Court for granting legal immunity to Indian husbands by stipulating that "sexual intercourse or acts by a man with his wife, provided she is not under 18 years of age, do not constitute rape" (Bhaumik, 2024) [33]. Despite the legal and welfare support towards reproductive rights the problem persists. The scenario in Northeast India is different from the rest of India. According to the NFHS report (2019-2021) conducted under the Ministry of Health and Family Welfare, the status of reproductive health seems dismal.

Key Reproductive Indicators	Assam	Meghalaya	Sikkim	Mizoram	Nagaland	Arunachal Pradesh	Manipur	Tripura
Total Fertility Rate	1.9	2.9	1.1	1.9	1.7	1.8	2.2	1.7
Contraceptive Prevalence Rate CPR%	45.3	23.3	50.8	45.4	25.3	45.3	30.6	65.5
Women with anaemia (15-49)	66..4	59.5	39.5	46.5	36.6	40.3	43.6	54.5
Menstrual Hygiene	66.0	75.8	95.6	95.8	85.0	84.8	83.2	89.2
Institutional Birth	84.1	63.3	95.8	92.5	46.0	79.2	76.5	91.5

Data Source: NFHS-5 State Fact Sheet, (2019-2021)

Key Observation

The reproductive health indicators across the North-Eastern states reveal considerable inter-state variation, reflecting uneven progress in reproductive and maternal health outcomes. Total Fertility Rate (TFR) is below the replacement level in most states, notably in Sikkim (1.1) and Assam (1.5), while Meghalaya records a comparatively higher fertility level (2.9), indicating differential fertility transitions within the region. Contraceptive Prevalence Rate (CPR) varies widely across states. Tripura reports the highest CPR (65.5%), followed by Sikkim (50.8%) and Mizoram (45.4%), suggesting better access to and utilization of family planning services. In contrast, Meghalaya (23.3%) and Nagaland (25.3%) exhibit notably low contraceptive use, pointing to persistent gaps between awareness and adoption of contraception. Anaemia among women aged 15-49 remains a serious public health concern across all states, with Assam recording an alarmingly high prevalence (66.4%). Although relatively lower levels are observed in Nagaland (36.6%) and Sikkim (39.5%), the burden of nutritional deficiency continues to affect women across the region, indicating that improvements in fertility control and institutional care have not translated into better nutritional outcomes. Menstrual hygiene practices show relatively high coverage across most states, particularly in Mizoram (95.8%) and Sikkim (95.6%), reflecting improved access to sanitary facilities and products. However, comparatively lower levels in Assam (66.0%) suggest persistent socioeconomic and awareness-related barriers. Institutional birth rates demonstrate stark contrasts within the region. Sikkim (95.8%), Mizoram (92.5%), and Tripura (91.5%) show high institutional delivery coverage, whereas Nagaland (46.0%) and Meghalaya (63.3%) lag significantly behind, highlighting infrastructural limitations and possible sociocultural resistance to institutional maternal care. Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) launched in 2016 is a flagship scheme under the Ministry of Health and family Welfare provides free antenatal care to all pregnant women on the of every month with Extended PMSMA (E-PMSMA) offering follow-up and incentives (PIB, 2025) [34]. The Janani Suraksha Yojana (JSY) offers cash incentives for institutional deliveries for women from below-poverty-line families, while the Janani Shishu Suraksha Karyakram (JSSK) ensures free delivery, including C-sections, and transport in public health institutions (NHM). The Labour Room Quality Improvement Initiative (LaQshya) focuses on improving care in labour rooms and maternity Ots (NHSRC) [35]. Mission Pariwar Vikas (2017) aims to improve access to family planning services in high-fertility districts. The government offers an Expanded Contraceptive Basket providing free access to various methods, including injectables (MOHFW) [36]. The Medical Termination of Pregnancy (Amendment)

Act & Rules, 2021 expanded legal access to safe abortion services, including extending the gestation limit for vulnerable groups.

3. CHALLENGES

Limited awareness of reproductive health, family planning, and reproductive rights persists even among educated women, indicating significant gaps in health literacy. Within the Khasi community, deeply rooted cultural beliefs and superstitions continue to influence reproductive health practices. Moreover, although the matrilineal social structure accords women a central role in family and lineage, it often places a dual burden of economic responsibility and caregiving on women, adversely affecting their reproductive health and well-being. The use of contraception in Northeast India remains low, with tribal women disproportionately relying on traditional methods and showing significantly lower uptake of modern contraception than non-tribal women. This persistent gap between knowledge and use reflects structural barriers to reproductive autonomy (Mog et al, 2020) [38]. A community-based cross-sectional study among 1,056 Mishing tribal women aged 15–45 years in Assam examined the relationship between early marriage, childbearing, contraceptive use, and reproductive health outcomes. The findings revealed a high prevalence of reproductive complications, including miscarriage, abortion, and stillbirth, with early marriage, early age at first birth, oral contraceptive use, and low income significantly associated with adverse outcomes (Mondal, 2021) [39]. The Dibongiya Deori community exhibits limited awareness of reproductive health issues, due to strong religious beliefs. Despite the availability of government healthcare services, many women continue to experience untreated gynaecological and obstetric problems, indicating poor health-seeking behaviour (Sengupta, 2017) [40]. Altogether, the most challenging aspect of uneven health standards is the distinct geographical differences between northeast India and mainland India, which exacerbate levels of awareness and access to proper healthcare facilities.

4. CONCLUSION

Women's health in Northeast India is shaped by the intersection of nutrition and reproductive rights, influenced by structural, cultural, and socio-economic factors. Persistent anaemia and undernutrition, along with early marriage and repeated pregnancies, heighten reproductive health risks, especially among tribal women. Despite growing awareness, the use of modern healthcare remains low, reflecting a gap between knowledge and practice. Women's autonomy is further constrained by limited access to services, social norms, and economic challenges, as well as by geographical isolation, which restricts healthcare delivery. A rights-based, integrated approach focusing on nutrition, healthcare access, education, and culturally sensitive policies is essential to improve health outcomes and promote gender equity. Hence, addressing women's health in Northeast India requires an integrated and rights-based approach that simultaneously prioritises nutritional security, reproductive health services, education, and community-specific interventions. Strengthening healthcare accessibility, promoting female literacy, expanding informational awareness and counselling services, and ensuring culturally sensitive policy implementation are essential for enabling women to exercise informed reproductive choices and achieve improved health outcomes.

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