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Integrating Sexual and Reproductive Health into Primary Healthcare in India: A Narrative Review of Historical, Cultural and Rights-Based Perspectives

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ABSTRACT

Background: Sexual and reproductive health (SRH) outcomes in India remain shaped by deep-rooted historical, cultural and socio-political forces that continue to influence healthcare-seeking behaviour within primary care. Despite policy commitments to universal SRH coverage, persistent stigma and restrictive social norms limit uptake of preventive SRH services, particularly among adolescents, unmarried individuals and sexual minorities.
Aim: This review aimed to trace the historical evolution of sexual attitudes in India, identify barriers and enablers to SRH service access within primary healthcare, and propose strategies for integrating comprehensive, rights-based SRH services into primary care systems.
Materials & Methods: A narrative evidence synthesis, reviewed the existing evidence such as published articles, national surveys, and historical texts to trace shifts in sexual norms and their impact on access to preventive services was conducted.
Result: The findings reveal persistent stigma, provider biases, access limitations, and gaps in sexual health literacy that restrict the uptake of preventive SRH services, particularly for unmarried individuals and marginalized groups. Integrating comprehensive sexuality education, enhancing non-judgmental primary care services, and leveraging digital platforms to improve SRH outcomes is essential.
Conclusion: Aligning with preventive medicine goals, strengthening SRH services at the primary care level is essential for improving equity and population health in low- and middle-income countries. Programmatic interventions such as provider training and community outreach, can transform the SRH landscape towards a more inclusive, rights-based approach.

Keywords: sexual & reproductive health, sex positivity, sexuality, Indian culture

INTRODUCTION

A comprehensive sexual and reproductive health (SRH) services is a core component of preventive healthcare [1]. However, deeply rooted cultural taboos in India restrict open dialogue, thereby hindering access to sexually transmitted infection (STI) screening, family planning, and counselling services, exacerbating health inequities [2]. Societal attitudes towards sexuality directly influence healthcare-seeking and uptake of preventive as well as curative services [2]. Evidence from the National Family Health Survey-5 (NFHS-5; 2019-21) highlights that only 23% of young women and 28% of young men (aged 15–24 years) possess

comprehensive knowledge of HIV/AIDS [3], while only 47% of women (aged 15–49 years) report the ability to make informed sexual and reproductive health decisions. [4] These gaps in knowledge and agency have significant implications for preventive health outcomes, delayed care-seeking and disease transmission.

India's contemporary sexual attitudes have been shaped by a historical shift from ancient permissiveness to colonial moral policing. [5] It continues to influence current discourse and practices. Despite expanded access through digital platforms and targeted programmes, significant gaps persist in SRH services availability and utilization, especially for adolescents, unmarried individuals, and sexual minorities [6,7,8]. Addressing these barriers is crucial for achieving universal access to SRH services. The present study synthesizes the historical evolution of sexual attitudes in India and examines their implications for access to SRH services. It further proposes policy and programmatic strategies for integrating comprehensive SRH services within primary healthcare systems to improve preventive care uptake and promote equitable sexual health rights.

MATERIALS & METHODS

Present review employed a comprehensive evidence synthesis methodology to map the available evidence on the historical evolution of sexual attitudes in India and their impact on access to sexual and reproductive health (SRH) services within primary care settings.

Search Strategy: A comprehensive search strategy was developed, employing a combination of controlled vocabulary (e.g., MeSH terms) and free-text keywords related to sexual attitudes, sexuality, sexual behaviour, reproductive health, family planning, contraception, abortion, sexually transmitted infections (STIs), healthcare access, primary healthcare, cultural factors, and the Indian history. The search terms were adapted for each database to maximize retrieval.

Databases: The literature search was conducted across five major electronic databases: PubMed, BASE (Bielefeld Academic Search Engine), Epistemonikos, Scopus, and Google Scholar. The evidence base comprised a diverse range of documents, including peer-reviewed articles published in academic journals, national health surveys conducted by governmental and non-governmental organizations, relevant historical texts (including sociological and anthropological accounts), and pertinent grey literature (such as policy documents, reports from advocacy groups, and conference proceedings).

Literature Search: The search timeframe spanned from the earliest available records up to December 2024 to provide a comprehensive overview of the existing literature on the topic. No language restrictions were initially applied, but the final synthesis focused on English-language publications for feasibility within the scope of this review.

Screening and selection: The retrieved records underwent a two-stage review process. First, titles and abstracts were screened by two independent reviewers. Second, the full texts of the selected records were examined against the inclusion criteria, which encompassed peer-reviewed articles, national health surveys, relevant historical texts (sociological and anthropological accounts), and pertinent grey literature (policy documents, reports, conference proceedings) that addressed the relationship between sexual attitudes and SRH service access in India's primary care setting. Discrepancies between reviewers were resolved through discussion and consensus with a third reviewer.

Data extraction: A data extraction tool was developed and piloted to systematically chart key information from the included sources. This included, but was not limited to, the type of source, publication year, study design (if applicable), geographical focus within India,

key themes related to sexual attitudes discussed, aspects of SRH service delivery examined in primary care, and any reported impact of attitudes on access. Data extraction was performed by one reviewer and cross-checked by a second reviewer for accuracy.

Data synthesis: The extracted data from the identified literature was synthesized using a thematic analytic approach. The synthesis aimed to provide a descriptive overview of the existing evidence, map the key concepts, identify gaps in the literature, and highlight potential areas for future in-depth research. Thematic mapping was utilized to identify recurring patterns, key trends, and significant associations between historical shifts in sexual attitudes and contemporary challenges in SRH service delivery within the primary healthcare framework. This analytical approach allowed for a nuanced understanding of the complex interplay between societal norms and healthcare access, ultimately informing the development of evidence-based recommendations for policy and programmatic interventions. The findings are presented narratively, supported by illustrative examples from the included literature.

Ethical considerations: This research utilized publicly available secondary data and did not involve the collection or analysis of primary data from human participants. As such, formal ethical approval was not deemed necessary.

RESULT

The synthesis revealed a historical trajectory from sex-positive traditions to colonial impositions of sexual conservatism, resulting in persistent stigma and healthcare barriers. This section is organized under the following two sub-headings: (1) evolution of sexual attitudes in India; and (2) key barriers to access SRH in primary care.

Evolution of Sexual Attitudes in India

Bell and Binnie's seminal work, "The Sexual Citizen," challenges traditional understandings of citizenship by asserting that "all citizenship is sexual citizenship" [12]. This perspective highlights how sexualities fundamentally shape the experiences and rights of all citizens, regardless of their sexual orientation or gender identity.

The synthesis demonstrates that sexual attitudes in India have undergone a marked transition across historical periods, with direct consequences for healthcare practices and public health outcomes. As summarized in Table 1, ancient Indian traditions reflected a largely sex-positive worldview rooted in Tantra and classical texts, where sexuality was integrated into holistic concepts of health and well-being. This period emphasized balance, pleasure, and bodily awareness, aligning closely with contemporary preventive health principles.

Table 1. Sexual attitudes across historical periods and its consequences for healthcare practices and its impact on public health

Period	Sexual Attitudes	Healthcare Practices	Public Health Impact
Ancient (Pre-800 CE)	Sex-positive approach through Tantra and Kama Sutra	Holistic healing approaches	Comprehensive wellness focus
Medieval (800-1700 CE)	Orthodox religious influence	Ayurvedic treatments	Limited documented outcomes
Colonial (1700-1947)	Victorian morality introduced	Western medicine introduced	Increased stigmatization of sexual health
Post-Independence (1947-2010)	Colonial laws and moral policing	Public health programmes	Variable effectiveness

Contemporary (2010 onwards)	Continued influence of colonial laws and moral policing	Efforts towards making sexual health services accessible for adolescent girls Emerging digital platforms for sex education and awareness	Privacy concerns in small communities Limited access of unmarried individuals

Classical text such as "Kama Sutra," illustrate a comparatively permissive approach to diverse sexual expressions, including same-sex sexuality ('swarinis', who were lesbians who raised children together, and 'klibas', who were gay men) and non-binary gender identities ('tritya prakriti', the third nature) **[10]**. Overtime, however, this openness transitioned into a more restrictive landscape, where sexuality became heavily policed by families, religious institutions and the state. Medieval India, though not culturally homogenous, witnessed a flourishing of tantric practices that intertwined sex and spirituality. Enlightenment was perceived as a "cosmic orgasm," and erotic art forms in temples like Khajuraho and Konark reflected this sexually fluid and inclusive worldview **[11, 12, 13]**. While some scholars attribute these erotic art forms to Hindu concept of 'Kama', which is essential and central to human life **[10, 13,14]**. However, the influence can be traced to the Tantra school of thought as the Chandela kings promoted these doctrines **[10,15]**. These traditions increasingly came into conflict with the rise of orthodox Brahminical Hinduism, which emphasized hierarchy, asceticism, and puritanical ideals, leading to the marginalization of tantric practices and the suppression of more liberal sexual attitudes **[14, 15]**.

The colonial era marked a significant clash, introducing Victorian moral frameworks and legal mechanisms that sought to regulate sexuality. Colonial governance institutionalized stigma around sexual health, reshaped healthcare through Western biomedical models, and entrenched moral policing—effects that persist in contemporary healthcare interactions. The criminalization of homosexuality under laws like Section 377 **[16]** exemplifies this shift, reflecting broader State efforts to control sexuality, in ways that resonate with Foucauldian and Durkheimian notions of power, discipline and social regulation **[16-18]**. Colonialism also marginalized traditional Indian understanding of sexuality and gender, leaving a lasting legacy of sexual regulation and moral policing that continues to influence contemporary society **[13, 19-22]**.

Post-independence, public health initiatives expanded reproductive & maternal health services; however, as summarized in Table 1, these efforts were constrained by inherited colonial laws and conservative social norms, largely neglected comprehensive discussions of sexuality **[23, 24]**. Deeply ingrained stigma – evident in euphemisms like "gupt rog" and in popular media portrayals – continues to hinder open conversations on sexual health **[24, 25]**. The term 'gupt rog', commonly used in magazines and newspapers, reflects the cultural expectation that sexual health concerns should remain private. Cultural reticence has considerable consequences, particularly for women, contributing to delayed care-seeking, unsafe abortions and timely diagnosis & treatment of sexually transmitted infections **[26]**.

Despite this increased openness, access to comprehensive sexual healthcare remains limited due to persistent conservative social norms, moral surveillance and structural barriers within healthcare system [27, 28]. Sexuality continues to be subject to moral policing and censorship, particularly when expressions deviate from heteronormativity. Creating inclusive, non-judgemental spaces for diverse sexual expressions and equitable access to sexual health services is therefore critical, especially in light of ongoing challenges such as privacy concerns in small communities and limited access for unmarried individuals and sexual minorities, who remain disproportionately affected by these barriers **[29]**.

Key Barriers to Access Sexual Health Services in Primary Care

The synthesis identified multiple, interrelated barriers that restrict access to SRH services at the primary care level, summarized in Table 2. Cultural stigma, characterized by fear of judgment from healthcare providers and social restrictions on discussing sexual health, emerged as a dominant barrier leading to delayed care-seeking behaviour, missed prevention opportunities, and reliance on informal or unsafe sources of information.

Table 2: Key Barriers to Access Sexual Health Services in Primary Care

Barrier	Impact on Care	Intervention strategy
Cultural Stigma Cultural stigma and judgment from healthcare providers Social restrictions on discussing sexual health	Delayed Care	Community Education
Provider Bias Inadequate training of healthcare providers in sexual health counselling	Poor Communication	Professional Training
Access Limitations Lack of privacy in healthcare settings	Missed Prevention	Mobile Clinics
Knowledge Gaps Limited sexual health literacy among patients	Risk Behaviours	Digital Resources

Provider-level barriers were also prominent. Inadequate training in sexual health counselling and prevailing moral biases among healthcare providers adversely affect communication quality, resulting in suboptimal preventive and curative SRH services delivery. Structural access limitations such as lack of privacy within healthcare facilities and constrained service availability, further discourage utilization of SRH services, particularly among adolescents, unmarried individuals, and marginalized populations. Moreover, knowledge gaps among service users regarding sexual health, contraception and STI prevention can increase their risk of engaging in high-risk behaviours. Economic factors, such as limited insurance coverage, high out-of-pocket costs, further compound inequities in access and continuity of care.

Addressing these barriers requires a multi-pronged approach. As summarized in Table 3, effective strategies include community education to combat stigma, provider capacity building (on soft-skills such as attitude and communication), structural improvements in primary care settings, digital health interventions to improve health literacy, enhance privacy & confidentiality, increase reach through initiatives like mobile clinics, and expanded insurance coverage to ensure equitable access to sexual health services.

Table 3: Recommendations for Improving Sexual Health Services

Level of Intervention	Action Points	Expected Outcomes
Primary Care	Capacity building of healthcare providers in gender sensitivity, sexual diversity, rights based and non-judgmental care Inclusive SRH services for women, men, adolescents, LGBTQIA+ persons, and persons with disabilities Equity-focused and life-course approach to SRH Routine sexual health screening protocols at Health & Wellness Centres (Ayushman Arogya Mandir)	Improved provider-patient communication and trust Increased early detection and prevention of SRH conditions Enhanced uptake of counselling, follow-up and referral Improved patient reported experiences and health outcomes

	Standardized risk assessment tools for STIs, unintended pregnancy, gender-based violence, and mental health Integrated SRH counselling, referral, and follow-up services	
Community / School	Comprehensive awareness and health literacy programmes Social and behaviour change communication addressing stigma, myths, and harmful norms Age-appropriate, inclusive sexuality education in schools and community settings Engagement of parents, teachers, peer educators, and community leaders	Reduced stigma and misconceptions related to sexuality and SRH Improved help-seeking behaviour and timely utilization of preventive services Strengthened life skills, agency, and responsible decision-making among young people
Digital	Youth-friendly and inclusive online SRH knowledge platforms (websites, mobile applications, chatbots) Telemedicine and tele-counselling for SRH, mental health, and relationship concerns Anonymous consultation and referral services	Increased reach of SRH services Improved access to SRH services Increased service utilization Improved confidentiality and anonymity for SRH queries Enhanced continuity of care
Policy	Systematic gender and equity analysis of SRH policies and programmes Gender-transformative and rights-based programming Institutionalization of comprehensive sexuality education across formal and informal systems Strengthened monitoring, accountability, and financing for SRH services	Reduced gender- and sexuality-based barriers to SRH access More inclusive, equitable, and responsive health systems Sustainable improvements in population-level sexual and reproductive health outcomes

DISCUSSION

This evidence synthesis highlights how deeply embedded sexual attitudes in India continue to shape access to sexual and reproductive health (SRH) services, with direct implications for preventive medicine and primary healthcare systems in India. The findings demonstrate that stigma, moral regulation and provider-level biases –rooted in historical transitions from sex-positive traditions to colonial moral policing – remain key determinants of delayed care-seeking, under-utilization of preventive services and inequitable access to SRH services **[30,31]**. These barriers undermine core preventive medicine goals –early detection of sexually transmitted infections (STIs), prevention of unintended pregnancies, and promotion of informed sexual decision-making across the life course.

From preventive medicine perspective, SRH cannot be treated as a peripheral service; rather, it must be integrated into mainstream primary care. The evidence from rural central India reveals that young women's pregnancy planning is often constrained by limited access to SRH education and counseling services, highlighting an urgent need for strengthened preventive outreach at the primary care level **[32]**.

In India, where the burden of preventable SRH conditions remains high and health systems are often the first—and sometimes only—point of contact for care. The expansion of Health and Wellness Centres (now Ayushman Arogya Mandirs) offers a critical platform for embedding comprehensive, rights-based SRH services within preventive care, as emphasized by Lahariya (2020) **[33]**. Integrating SRH into primary care packages aligns with preventive medicine principles by enabling systematic risk assessment, counselling, screening, and early intervention across adolescence, reproductive years, and beyond.

Implications on Primary Healthcare

Healthy and positive attitude towards sexuality, promoting open communication, and body acceptance are core part of sexual and reproductive healthcare service delivery. Within preventive medicine and primary

healthcare context, it fosters reduced stigma, encouraging individuals to seek necessary care like STI screenings. By providing accurate information, sex positivity empowers individuals to make informed sexual health decisions, reducing risks like STIs and unintended pregnancies. However, current sexual health education in India often prioritizes disease prevention over pleasure and satisfaction, neglecting the diverse needs and desires of individuals, particularly women. This approach, often rooted in traditional and conservative values, can limit sexual expression and perpetuate harmful stereotypes.

Table 3 presents a multi-level strategy to strengthen sexual health services through coordinated interventions across primary care, community, policy, and digital domains. Capacity building of healthcare providers in gender sensitization, communication, and leadership can improve patient comfort and patient-reported outcomes. Health literacy initiatives and social and behaviour change communication help reduce stigma and promote open dialogue on sexual health. Policy actions, including gender analysis, gender-transformative programming, and comprehensive sexuality education, support informed decision-making, while digital interventions enhance access and reach, especially in remote and underserved settings.

Strengths and limitations of the study

This evidence synthesis provides a comprehensive, interdisciplinary exploration of SRH in India, combining historical, socio-cultural, and healthcare system perspectives. It offers a nuanced understanding of the barriers and enablers to preventive SRH service delivery. The study highlights the intersectionality of cultural stigma, healthcare access, and provider biases, offering multi-level policy and programmatic recommendations relevant for primary healthcare strengthening in India and low- and middle-income countries (LMICs).

As an evidence synthesis, there are inherent limitations such as potential publication bias and variability in study quality among included sources. The synthesis relies primarily on secondary data without conducting a systematic quality appraisal and meta-analysis, which may affect the generalizability of findings. Moreover, the sociocultural context of sexual health in India is highly heterogeneous; thus, findings may not fully capture local nuances across diverse regions and marginalized communities. Future research should investigate how societal forces shape sexual attitudes, behaviours, and identities. It is crucial to examine how technology and media both liberate and constrain sexuality, sexual health, and rights.

CONCLUSION

Sexual and reproductive health is a cornerstone of preventive medicine and primary healthcare. Addressing historical legacies, social stigmas, and system-level barriers through policy reforms, community engagement, and provider training is essential. Strengthening SRH services within the preventive healthcare framework offers an equitable path forward, particularly in India, to promote sexual well-being, dignity, and health for all. Training healthcare providers in non-judgmental SRH services, gender sensitization, counselling and integrating digital tools can improve patient trust, service uptake, and clinical outcomes in primary care.

Declaration by Authors

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