International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

Self-care Perspectives on Sexual and Reproductive Health in India: A Sociological Study among Young People

Mittal Komal[1], Dr Lovely[2]

[1]Strategist and Researcher, Swami Vivekanand Subharti University
[2]Assistant Professor, Department of Sociology, Swami Vivekanand Subharti university, Meerut

Abstract

Self-care interventions have emerged as a key global strategy for advancing health equity and strengthening people-centered health systems. Among adolescents and young adults—particularly in resource-constrained communities—self-care shapes decisions around sexual and reproductive health and rights (SRHR) and offers pathways to greater bodily autonomy. In India, young people increasingly rely on self-care practices—including digital health platforms, peer networks, over-the-counter products, and self-managed reproductive health strategies—to address unmet SRHR needs.

This paper presents a sociological review of literature published between 2000 and 2025 to examine how self-care practices among young people in India are shaped by gender norms, stigma, socioeconomic inequalities, digital access, and family norms—that shape youth agency. This review synthesizes evidence from peer-reviewed studies, policy reports, and global health frameworks to analyze how youth negotiate autonomy, privacy, and risk within constrained social contexts. Four major themes emerge from the review: 1) self-care as negotiated autonomy; 2) structural inequalities and gendered constraints; 3) digital self-care and misinformation; and 4) the intersection between SRHR and mental health.

Findings reveal that although self-care technologies can promote empowerment, they operate within social constraints that often limit choice, privacy, and safety. It underscores the need for youth-centered, rights-based SRHR approaches for integrated, youth-friendly, rights-based interventions that combine digital tools, peer-led approaches, comprehensive sexuality education, and stigma-free health services.

Keywords: Self-care, Sexual and reproductive health, Youth, Sociology, Gender, India, SRHR, Digital health, Social norms, Intersectionality

1. Introduction

Self-care interventions have become increasingly central to global health governance and public health policy, particularly within sexual and reproductive health and rights (SRHR). Self-care is recognized by global health institutions as essential for achieving Universal Health Coverage (UHC) and strengthening individual agency in health decision-making (World Health Organization, 2019). WHO defines self-care as the ability of individuals, families, and communities to promote health, prevent disease, and manage illness with or without the support of health professionals.

It is a cornerstone of public health, human rights, and social development. According to the WHO, SRH refers to a state of complete physical, mental, and social wellbeing in all matters related to sexuality and

reproduction (World Health Organization, 2015). This holistic definition shifts the discourse beyond disease prevention to include autonomy, dignity, agency, and the ability to make informed decisions about one's body. In the Indian context—where demographic diversity, persistent gender inequalities, and evolving social norms coverage—SRH has emerged as a critical area of inquiry, particularly for adolescents and young people. Within SRHR, self-care encompasses a wide range of practices and technologies, including menstrual health management, self-administered contraception, HIV self-testing, pregnancy testing, digital health information seeking, teleconsultation, and self-managed abortion care.

The growing emphasis on self-care reflects broader transformations in healthcare systems, including the expansion of digital technologies, increasing pressures on public health infrastructures, and the shift toward patient-centered models of care. In low- and middle-income countries such as India, self-care interventions are often promoted as mechanisms for expanding access to services, enhancing bodily autonomy, and overcoming barriers associated with stigma, geographic location, and institutional inadequacies.

India is home to one of the world's largest youth populations. Adolescents and youth together account for nearly 30% of the country's demographic profile (United Nations Population Fund India, 2021). However, the sociological dimensions of self-care—shaped by structural inequalities, gender norms, stigma, digital access, and familial control—remain underexplored in India. This demographic segment is undergoing rapid physical, emotional, and social transitions, often without adequate information, supportive environments, or youth-friendly services. Despite a growing youth population, discussions of sexuality remain taboo, and young people often rely on fragmented or inaccurate digital information. Literature from India and low- and middle-income countries indicates that young people face substantial barriers to SRH knowledge (Jejeebhoy & Santhya, 2011; Mmari & Sabherwal, 2013). This reinforces the importance of conducting contextualized, sociological investigations that can illuminate how young people's SRH experiences are shaped by society, culture, family norms, and structural inequalities. This article responds to these gaps through an evidence-based multistate qualitative study.

A multistate sociological study is particularly critical in India due to vast inter-state variations in socioeconomic development, gender relations, cultural taboos, health infrastructure, and levels of urbanization. While national programmes such as the *Rashtriya Kishor Swasthya Karyakram* (RKSK) aim to provide comprehensive adolescent health services, their implementation and effectiveness differ substantially across regions (Ministry of Health & Family Welfare, 2014). Understanding how young people navigate SRH within these highly variable social and programmatic ecosystems is essential for evidence-based, culturally grounded policy interventions.

The Rashtriya Kishor Swasthya Karyakram (RKSK) was introduced to address critical gaps in adolescent health by expanding access to adolescent-friendly services, peer education, and counseling across India. However, persistent barriers—such as stigma around seeking care, concerns about privacy and confidentiality, uneven service availability, and limited health system capacity—continue to restrict adolescents' effective use of these services. These challenges are particularly pronounced in sensitive areas like sexual and reproductive health, where social norms often discourage open engagement with formal healthcare systems. In this context, self-care interventions serve as a necessary complement to RKSK by enabling adolescents to access accurate information, manage aspects of their health independently, and seek care in more private and convenient ways. By reducing reliance on overstretched facilities, enhancing autonomy, and ensuring continuity of care beyond episodic service delivery, self-care helps bridge the gap between the program's intent and adolescents' lived realities.

This study illuminates several systemic gaps. Many adolescents lack accurate SRH information and depend heavily on peers and on the internet which may serve as unreliable sources (IIPS & ICF, 2021). Gender norms further exacerbate disparities—girls often encounter restrictions, limited privacy, and social expectations surrounding purity and marriage while boys face pressure to demonstrate masculinity through risk-taking sexual behaviors (Alexander et al., 2006). Stigma surrounding sexuality—particularly premarital sexual activity—discourages young people from seeking SRH services, resulting in unmet contraceptive needs, untreated sexually transmitted infections (STIs), and psychological distress.

Existing scholarship on youth SRHR in India has largely focused on public health outcomes, contraceptive prevalence, adolescent pregnancy, or service delivery gaps. Comparatively less attention has been paid to the sociological dimensions of self-care– particularly how self-care practices are mediated by structural inequalities, gendered expectations, family surveillance, digital access, and social stigma. Current public health literature often frames self-care as inherently empowering, while insufficiently examining how autonomy itself is socially constrained.

Furthermore, SRH challenges are deeply intertwined with structural determinants such as caste, class, religion, education, rural-urban divides, and family communication patterns. Sociological studies emphasize that these determinants shape exposure to SRH information, decision-making autonomy, partner communication, and access to healthcare systems. Intersectional perspectives are thus particularly valuable for understanding the nuances of SRH among diverse youth groups, including marginalized communities, out-of-school adolescents, and sexual and gender minorities.

SRHR are not only public health concerns but fundamental human rights, encompassing freedom from coercion, discrimination, and violence as well as access to high-quality SRH services and comprehensive sexuality education (UNFPA, 2014). Applying this framework within India's sociocultural milieu allows for a deeper interrogation of how rights, norms, and health systems converge to shape young people's experiences. A sociological study across eight Indian states therefore holds both academic and practical significance. By mapping variations in knowledge, attitudes, practices, access, and normative environments, the research can illuminate how social structures shape SRH outcomes.

This article shows that self-care among young people in India cannot be understood solely as an individual health behavior. Rather, it must be conceptualized as a socially

Research Gap

Although research on adolescent SRHR in India has expanded substantially over the last decade, important conceptual and empirical gaps remain.

First, existing studies often examine SRHR behaviors in fragmented ways, focusing separately on contraception, menstruation, abortion, or digital health rather than analyzing self-care as an interconnected social practice.

Second, much of the available literature approaches self-care through biomedical or policy-oriented frameworks, with limited sociological engagement with questions of power, stigma, surveillance, gender regulation, and structural inequality.

Third, relatively little scholarship has examined how digital self-care practices intersect with class inequality, gendered access to technology, misinformation, and online governance.

Fourth, the relationship between mental health and SRHR self-care among Indian youth remains underexplored despite increasing evidence linking emotional distress, secrecy, stigma, and reproductive anxiety.

Finally, intersectional differences across gender, caste, class, rural-urban location, and marital status are often insufficiently integrated into analyses of youth self-care.

This paper addresses these gaps by synthesizing interdisciplinary literature through a sociological lens, emphasizing how self-care practices among Indian youth are embedded within broader structures of inequality and social regulation.

Study Objectives

This review seeks to:

1. Examine how young people in India understand and practice SRHR-related self-care.
2. Analyze the influence of gender norms, stigma, and structural inequalities on youth self-care practices.
3. Explore the role of digital technologies and informal health networks in shaping SRHR knowledge and access.
4. Investigate the intersection between SRHR self-care and mental health.
5. Contribute a sociological framework for understanding youth self-care within contemporary Indian society.

2. Literature Review

1. Self-Care in Sexual and Reproductive Health (SRH)

Definition and evolution of self-care

Global and Indian relevance of self-care in SRH

2. Conceptualizing Self-Care: A Sociological Perspective

Self-care, autonomy, agency, and citizenship

Theoretical perspectives on agency, embodiment, and self-regulation

3. Social Determinants of SRH Self-Care Among Young People

Gender norms and family surveillance

Caste, class, and intersectional inequalities

Peer and community influences

4. Self-Care Practices and Pathways Among Indian Youth

Menstrual management, contraception, pregnancy testing, and abortion self-care

Use of pharmacies, peers, digital platforms, and traditional remedies

5. Self-Care as a Response to Barriers in Formal Health Systems

Stigma and exclusion in SRH services

Privacy, anonymity, and accessibility considerations

Self-care as a rights-based and youth-centered strategy

6. Gender and Intersectional Dimensions of Self-Care

Gendered differences in access and autonomy

Rural–urban, caste, class, and educational disparities

State-level variations in SRH outcomes

7. Digital Technologies and the Transformation of Self-Care

Telehealth, self-testing, and online information-seeking

Digital inequalities, misinformation, privacy, and governance concerns

8. Challenges and Constraints to Effective Self-Care

Social stigma and cultural norms

Information quality and misinformation
Legal and policy barriers

9. Research Gaps in Self-Care and SRH Among Indian Youth

Limited sociological understanding of self-care practices
Need for comparative state-level evidence
Relational and community dimensions of self-care
Equity, exclusion, and digital governance issues

10. Conclusion and Rationale for the Present Study

Summary of key insights from the literature
Justification for a sociological multistate study among Indian youth

Self-care has expanded from an individual health behavior to a broader sociopolitical practice tied to autonomy, agency, and citizenship (Michaels et al., 2021). In contexts with strained health systems, self-care often becomes a necessity rather than a choice (Mbizvo & Zaidi, 2010). Self-care in SRH is emerging as a pivotal component of youth health strategies in India. While globally recognized as an empowering tool, its effectiveness is deeply shaped by sociological determinants such as gender norms, social regulation, inequalities, and cultural contexts.

This article examines the concept of self-care in SRH from a sociological perspective and summarizes empirical evidence relevant to young people in India. It includes a range of practices and technologies through which people prevent, test for, manage, or treat SRH needs. WHO defined self-care as an individual, families, and communities undertake to promote and maintain health, prevent disease, and cope with illness—including the use of evidence-based health products, technologies, and information outside formal health facilities for example, HIV self-tests, self-administered contraception, self-managed medication abortion. WHO's normative guidance conceptualizes self-care both as a complement to health systems and as an approach that can enhance autonomy, privacy, and access—especially for underserved populations.

For Indian young people, self-care represents both possibility and precarity—offering autonomy while exposing them to systemic gaps and misinformation. A sociological lens is therefore essential to critically analyze how self-care is adopted, adapted, resisted, or constrained across diverse contexts.

Sociological frameworks situate self-care within broader theories of agency, embodiment, and self-regulation. In SRH, self-care matters because adolescents and young people rarely make reproductive choices in isolation: family expectations, partner dynamics, peer norms and community surveillance shape both access and decision-making. Young people engage in self-care—such as managing menstruation, researching contraceptives online, or testing for pregnancy—not merely as health actions but as forms of embodied autonomy. However, agency is not evenly distributed. Gender norms, caste, class, and family surveillance shape how Indian youth perceive and practice self-care. Girls face constraints on mobility, privacy, and autonomy, reducing their ability to manage their SRH needs independently (Jejeebhoy & Santhya, 2011). Boys may have more freedom but face pressure to perform masculinity, influencing risk-taking or avoidance of health services (Alexander et al., 2006).

Self-care does not occur in isolation, it is deeply embedded within social structures. In India, sexuality remains regulated by norms emphasizing modesty, morality, and shame especially for unmarried adolescents (Verma et al., 2014). These norms discourage engagement with formal SRH services, prompting many young people to rely on informal self-care including peer networks, online platforms and social media, over-the-counter medicines, traditional and indigenous remedies. Such practices reflect

young people's attempts to navigate the SRH in socially acceptable ways. Research on self-care and the multicountry analysis of SRHR interventions emphasize self-care as a rights-based, youth-centered strategy, particularly effective where health systems are overstretched. Evidence from national surveys and qualitative studies demonstrates that young people frequently access SRH information and products through pharmacies, peers, and digital platforms (IIPS & ICF, 2021; Mittal, 2021). For many adolescents—especially unmarried youth—pharmacies and online sources provide anonymity and quicker access than clinics. Case studies in "Sexual and Reproductive Health and Rights In India: Self-care for Universal Health Coverage" show how marginalized groups rely on self-care as an adaptive response to stigma and exclusion in formal health services (Pachauri et al., 2021; Mittal, 2021).

This literature review lays the foundation for understanding these dynamics within an eight-state study of Indian youth. Young people in India encounter layered marginalities: gender norms limit girls' mobility and autonomy (Jejeebhoy et al., 2013), stigma restricts SRHR discussions within families and schools, digital divides shape access to credible information, and legal constraints including mandatory consent requirements, restrict access to abortion and contraception (Sabarwal et al., 2020).

Research shows pronounced gender differences and intersectional inequities hinder access to contraceptives and confidential services for girls; boys may have easier access to some products but face masculine norms that promote risky behaviors (Jejeebhoy & Santhya, 2011; Desai et al., 2021). Intersectional axes–caste, class, rural-urban, schooling status further shape self-care capabilities. NFHS-5 data underscore substantial inter-state variation in adolescent fertility, contraceptive use and maternal health indicators, pointing to the need for sub-national analysis (IIPS & ICF, 2021).

Post-pandemic digital platforms expanded youth access to self-testing kits, telehealth services, and peer forums. Yet online misinformation remains widespread (UNESCO, 2020). Digital divides, platform governance, data privacy, and the potential for misinformation complicate the picture. WHO emphasizes digital safeguards as part of enabling environments (WHO, 2024).

Little empirical work documents how Indian adolescents interpret self-care socially—how stigma, identity, peer norms, and community expectations shape their everyday choices. Drawing on the conceptual and empirical literature, several research gaps emerge that a sociological, multistate study among young people should address comparative state-level analysis, relational practices, equity and exclusion, digital governance and privacy, and integration with public programs. This study fills that gap through grounded, qualitative evidence.

3. Methodology

This article adopts a qualitative, interpretive sociological approach to synthesize existing evidence on how young people in India understand, practice, and negotiate self-care within the domain of sexual and reproductive health (SRH). Rather than generating primary data, the article draws on an extensive body of secondary literature, including peer-reviewed journal articles, policy briefs, national surveys, programme reports, and grey literature produced by academic institutions, civil society organizations, and international agencies, our article examine sociological dimensions of self-care for sexual and reproductive health among young people in India.

The review is grounded in an interpretive sociological perspective, recognizing that young people's SRH-related self-care practices emerge at the intersection of individual agency, familial expectations, community norms, institutional structures, and shifting technological environments. This framework guided both the selection of sources and the interpretive lens applied during analysis, allowing the review

to trace how self-care is shaped not only by personal decision-making but also by social, cultural, and structural forces.

To ensure comprehensive coverage, a purposive and iterative search strategy was employed across major academic databases (such as PubMed, Scopus, JSTOR, Springer, and Google Scholar), alongside government repositories and organizational platforms (e.g., UNICEF, UNFPA, WHO, Population Council, and national ministries). Search terms combined key concepts such as "self-care," "sexual and reproductive health," "youth," "adolescents," "India," "digital health," "gender norms," "SRH autonomy," and "social determinants." The initial search generated a broad pool of documents published between 2000 and 2025, capturing both historical shifts and contemporary debates. Inclusion criteria focused on studies addressing: 1) SRH practices, knowledge, and decision-making among young people aged approximately 10–29; 2) conceptualizations or applications of self-care in SRH; 3) sociocultural, digital, or institutional contexts influencing youth SRH; 4) comparative or region-specific analyses relevant to India's diverse demographic landscape.

Selected sources were reviewed in full and analyzed using a thematic synthesis approach. A structured extraction matrix captured information on study objectives, population characteristics, methodological approaches, key findings, and contextual factors such as gender norms, regional disparities, and digital ecosystems. This facilitated the comparison of evidence across different states, socio-economic groups, and identity categories. During synthesis, particular attention was paid to: 1) how young people conceptualize SRH self-care; 2) variations across gender, caste, class, region, and sexuality; 3) the role of technology, peer networks, and institutions; 4) cross-regional patterns in access, autonomy, and health-seeking behaviors.

Contradictions, gaps, and emergent trends were identified through iterative reading and analytic memoing. Interpretations were developed collaboratively among the author(s) to enhance rigour, ensure conceptual clarity, and strengthen the credibility of the review. The review prioritized studies that demonstrated transparency in methodology, ethical approval where required, and youth-sensitive approaches to data collection. Attention was also paid to the positionality of the reviewed literature—recognizing potential biases in authorship, institutional agendas, and disciplinary orientation—and to how these factors may shape interpretations of youth agency, sexuality, and self-care practices.

4. Findings

Analysis revealed a complex and contradictory landscape of youth self-care in sexual and reproductive health across the Indian states.

Self-Care as negotiated autonomy

After reviewing several papers, self-care emerges not primarily as a freely chosen practice of empowerment but as a negotiated response to restrictive social environments. Young people consistently conceptualized self-care in sexual and reproductive health (SRHR) as an intimate, often clandestine practice rooted in the need for privacy and emotional self-protection. Rather than viewing self-care as a proactive exercise of personal agency, it was a survival strategy in environments where formal health systems, family structures, and educational institutions offered little safety or openness. Youth internalized self-care as the ability to "manage things on their own," especially when discussing sexual relationships, menstruation, or contraception could provoke shame or punishment.

Studies consistently demonstrate that adolescents seek privacy when navigating menstruation, contraception, pregnancy, sexual relationships, and reproductive uncertainty. Practical forms of self-care

included the use of home-based pregnancy test kits, condoms, sanitary pads, emergency contraceptive pills, and digital tools such as period-tracking apps, Google searches, and YouTube channels specializing in health advice.

Digital searches, peer consultations, over-the-counter purchases, and self-managed reproductive health strategies often function as coping mechanisms in contexts where open discussion of sexuality remains stigmatized. These tools compensated for the fear, embarrassment, or perceived judgement associated with visiting clinics or speaking to adults. The overwhelming reliance on digital platforms reinforces broader sociological patterns that position the internet as a parallel informal health system for Indian youth—a space that provides anonymity, immediacy, and emotional distance.

Crucially, young people did not frame their self-care actions as free choices made in empowered contexts. Rather they described them as necessary responses to institutional neglect, restrictive social norms, and the anxiety of navigating their bodies without trustworthy adult guidance. Self-care was therefore a mechanism of coping in a society where adolescence is guarded by moral policing, weak school-based SRHR education, and inconsistent health system access.

4.2 Structural Barriers Affect Every Dimension of Self-Care

Poverty emerged as one of the most significant determinants of whether young people could practice self-care effectively. Socioeconomic inequality strongly influences the extent to which young people can engage in effective SRHR self-care. Young people from lower-income communities or households described multiple layers of deprivation: long distances to clinics, the cost of transportation, and the unaffordability of basic contraceptives and menstrual products. Even owning a personal mobile phone—essential for digital self-care—was a privilege not available to all, especially girls. These inequalities are often pronounced among rural adolescents, out-of-school, and socially marginalized communities.

These resource gaps fundamentally impacted youths' ability to access credible SRHR information. Literature demonstrates that informational inequality is a critical dimension of SRHR disadvantage. Many adolescents in rural or low-income urban settings rely on peers about contraceptives or pregnancy, gossip, informal discussions overheard at home or fragmented online content due to absence of comprehensive sexuality education.

Limited financial resources, therefore, not only reduced material access but severely restricted informational autonomy. Structural poverty translated into structural silence around sexual health.

Cultural norms across states reinforced secrecy, shame, and misinformation. Talking about menstruation, sexual feelings, or contraception with parents was considered inappropriate or culturally disrespectful. Many articles also stated that it causes embarrassment when buying sanitary pads or condoms from local shops due to the fear of being judged by shopkeepers or neighbors.

Young women, in particular, experienced intense surveillance. Restrictions on mobility, expectations of modesty, and fear of tarnishing family

honor reduced their opportunities to seek SRHR information or services independently. Boys, while more mobile, also felt constrained by masculine expectations that discouraged open conversations about vulnerability or uncertainty.

This pervasive stigma created a feedback loop: the more taboo the subject, the more young people relied on anonymous digital platforms and peer networks, which were themselves inconsistent and often inaccurate.

Gendered power relations shaped nearly every dimension of SRHR decision-making. Even among college-educated couples, male partners frequently determined whether contraception would be used, what

method would be chosen, and when sexual encounters would occur. Among married adolescent girls, decisions around family planning were often influenced—or controlled—by husbands, in-laws, or older family members. These norms reinforced unequal expectations, with girls expected to preserve purity before marriage and bear reproductive responsibility afterward.

The study highlights that gender norms do not simply limit choice—they influence young people's understanding of risk, consent, and bodily autonomy. Young men often felt pressure to prove sexual experience, while young women were pressured to prove the absence of it.

4.3 Sexual Behaviors Are Shaped by Peer Pressure, Risk, and Confusion

Participants described early sexual experiences—often occurring before age 18—as shaped more by peer influence and curiosity than by informed consent or preparation. Many young men reported unprotected first sex, influenced by myths such as "nothing happens the first time" or by the urgency created through peer bragging and competitive masculinity.

The concept of consent was widely misunderstood. Several youth perceived consent as implied, negotiable, or unnecessary within romantic relationships, reflecting deep-rooted patriarchal beliefs. Girls reported difficulty asserting boundaries due to fear of losing the relationship or damaging their reputation. Substance use, particularly alcohol among older adolescents, contributed to blurred boundaries and unsafe encounters. Youth described situations where intoxication reduced their ability to make thoughtful decisions or negotiate condom use.

Misinformation—ranging from misconceptions about fertility to fears of permanent harm from contraceptives—further shaped risky behavior. The absence of school-based comprehensive sexuality education amplified these challenges.

4.4 Contraceptive Use and Abortion Practices Reflect Deep Social Constraints

Across states, young people encountered pervasive myths related to contraceptive methods. Many believed that hormonal methods could cause permanent infertility, weight gain, or long-term illness. Condoms were sometimes perceived as reducing pleasure, causing discomfort, or being unreliable. Several participants believed that only married couples should use contraceptives, reflecting social norms that link contraception with marital legitimacy.

These misconceptions were reinforced by fragmented digital information, moralistic pharmacy interactions, and silence within families.

Despite India's comparatively liberal abortion laws, unmarried girls and young women reported immense fear of judgement from providers. Some shared experiences where health workers demanded parental presence or lectured them about moral behavior. These interactions discouraged youth from seeking safe facilities and pushed some toward unsafe or unregulated abortion methods.

The fear of social exposure—neighbors seeing them at clinics, staff recognizing their family, or their parents finding out—frequently outweighed the fear of medical complications. For many, abortion became another form of clandestine self-care, practiced through risky digital advice, informal pills, or reliance on peers.

4.5 Mental Health and SRHR Are Interconnected

Young people's narratives revealed a strong connection between mental health and sexual-reproductive experiences. Many reported emotional exhaustion from navigating secrecy, fear of pregnancy, relationship conflicts, or the pressures of maintaining a "good reputation." Girls described heightened anxiety during menstruation, particularly when school environments lacked private or hygienic facilities.

The COVID-19 pandemic deepened these challenges, removing school-based support networks and increasing isolation. Several participants reported depressive feelings, irritability, or panic when facing SRHR-related uncertainty without guidance.

However, youth also demonstrated resilience. Many adopted meditation, journaling, exercise, or online peer-support communities to manage stress. Digital self-care routines—including anonymous chats, wellness apps, or mental health videos—emerged as important coping mechanisms.

4.6 Digital Self-Care: Empowering but Unequal

The digital ecosystem became the primary gateway for SRHR knowledge. Young people appreciated the anonymity, accessibility, and rapid responses offered by platforms such as Google, YouTube, Instagram, and teleconsultation apps. For many, digital tools provided the guidance that schools and families failed to offer.

However, digital self-care remained deeply unequal. Girls from low-income households often lacked personal phones or had limited access controlled by family members. Moreover, youth struggled to assess the credibility of online information, resulting in confusion or harmful experimentation with self-medication.

Misinformation—such as incorrect dosage of emergency contraceptive pills or myths about masturbation—spread rapidly within peer networks. The absence of verified, youth-friendly Indian SRHR platforms exacerbated this gap.

Despite these limitations, digital self-care represented a major step toward autonomy, especially for queer youth and those in restrictive households who relied on the internet for community, identity, and safety.

5. Discussion

This study demonstrates that self-care practices among Indian youth cannot be analyzed merely as health behaviors—they are deeply embedded in social structures, including patriarchy, class hierarchy, generational power, and community surveillance. While self-care tools expand agency, they do not remove structural inequalities. Young people's choices remain conditioned by social risks.

The findings of this multistate qualitative study of youth sexual and reproductive health (SRH) underscore how self-care for SRH among young Indians is deeply embedded in social, economic, and gendered contexts. The data collected through interviews and focus groups reveal that self-care does not simply reflect individual choice or empowerment, but more often functions as a coping mechanism in constrained structural environments.

The conception of self-care among youth as privacy, autonomy, and survival rather than freedom of choice supports theoretical critiques of individualistic self-care frameworks. Scholars—building on a Foucauldian "technologies of the self" perspective—have argued that self-care practices are always mediated by power relations, social norms, and unequal access to resources (Foucault, 1986; Pachauri et al., 2021). The present study resonates with this view: for many participants, self-care emerged as a strategy of necessity— an adaptive response to societal silence, institutional neglect, and generational taboos around sexuality. The use of condoms, pregnancy tests, menstrual products, emergency contraception, and digital media can therefore be interpreted not merely as expressions of agency but as acts of survival in a context of constrained agency.

Structural inequalities—socioeconomic deprivation, digital inequality, inadequate public health infrastructure—sharpen existing disparities in SRH self-care. Research in global health consistently cautions that self-care interventions can exacerbate inequities if implemented without attention to resource

distribution, information asymmetry, and social stratification (WHO, 2019; Narasimhan et al., 2020). Our findings echo those concerns. For youth from low-income households or rural areas, lack of access to phones or internet, unaffordable contraceptive methods, and absence of youth-friendly clinics meant self-care remained aspirational rather than practicable. This suggests that framing self-care solely as a solution can obscure structural barriers and shift responsibility onto individuals who are least equipped to benefit.

Gender norms, stigma, and cultural taboos continue to structure youth SRH experiences. Girls reported substantial constraints—family surveillance, social judgment, limited mobility, and moral policing—that curtailed their capacity to seek care or information. Boys, while less constrained, remained vulnerable to pressures of masculine norms and misinformation. These findings align with sociological literature showing how gendered power relations shape access to sexual health resources and decision-making autonomy (Jejeebhoy & Santhya, 2011; Mendes, 2025). Notably, even among more educated or urban youth, the power asymmetry in decision-making persisted—especially in married couples—indicating that education or urban exposure does not automatically translate to equitable SRH autonomy.

Digital self-care surfaces as a double-edged phenomenon: it empowers some youth by offering anonymity, flexibility, and access to information; yet it simultaneously magnifies inequalities for others who lack devices, privacy, or digital literacy. The reliance on unregulated digital sources also exposes youth to misinformation, which in turn increases risk. This nuance resonates with critical perspectives on self-care in the digital age, which warn of "algorithmic governance" of health and the instability of digital knowledge ecologies (Kien, 2020; Logie et al., 2022). These observations suggest that digital self-care for SRH must be understood as embedded in social and structural contexts, not as a neutral or uniformly advantageous resource.

The prevalence of risky sexual behaviors, misconceptions around contraception, and fear-driven resort to clandestine abortion or unsafe methods reflect deep social constraints on SRH knowledge, agency, and health system trust. These patterns echo prior findings in India regarding low contraceptive uptake among unmarried youth, unsafe abortions due to stigma, and limited use of formal SRH services (Desai et al., 2021; IIPS & ICF, 2021). The conflation of SRH with moral judgment continues to drive youth away from public health services, reinforcing cycles of misinformation and health risk.

The interconnection between mental health and SRH among participants highlights a dimension often overlooked in SRH research. Emotional fatigue, anxiety, shame, and psychological distress emerged as part of the burden of navigating self-care discreetly. Yet youth also invoked resilience through self-care routines, online support, and peer networks. This interplay suggests that self-care cannot be treated only as a physical or biomedical act; it must be recognized as a holistic practice encompassing emotional, psychological, and social well-being.

These findings challenge simplistic narratives that present self-care as an unqualified good or panacea. Instead, they support a more nuanced, sociologically informed understanding in which self-care is a contested terrain—shaped by structural inequalities, social norms, and moral economies. In the Indian youth context, self-care often becomes a strategy of compromise rather than a pathway to empowerment.

6. Concluding Comments

Self-care has become indispensable in the lives of young people navigating complex SRHR landscapes in India. While it provides autonomy, privacy, and culturally safer alternatives to formal services, self-care remains limited by gender norms, socioeconomic challenges, and widespread misinformation. A multi-level approach that integrates technology, youth-friendly health services, community engagement, and

comprehensive sexuality education is critical for strengthening youth agency and SRHR outcomes.

This study's exploration of youth SRH self-care across eight Indian states offers several critical insights. Self-care for SRH among young people is not a uniform phenomenon; access and practices vary widely across socioeconomic strata, gender, marital status, geography, and digital inclusion. Structural constraints—poverty, stigma, limited public health infrastructure, digital inequality—undermine the efficacy of self-care as a tool for empowerment. Gender norms and cultural taboos continue to shape inequalities in SRH agency, decision-making, and access to services. Digital self-care, while promising, reproduces existing inequalities and introduces new risks related to privacy, misinformation, and uneven access. Emotional and mental health burdens are integral to SRH experiences, indicating that self-care must be understood holistically, not only in terms of physical health outcomes.

In light of these findings, policies and programs aimed at promoting SRH self-care among youth should proceed with caution. Rather than relying solely on the expansion of self-care tools, there is an urgent need for:

- Strengthening youth-friendly, non-judgmental public health services that ensure privacy and confidentiality.
- Institutionalizing comprehensive, age-appropriate SRH education in schools and communities to dispel myths, reduce stigma, and build informed agency.
- Expanding equitable digital access (affordable internet, digital literacy, safe spaces) alongside regulation and quality control for online SRH information and services.
- Designing gender- and context-sensitive interventions that recognize and address differential vulnerabilities based on gender, socioeconomic status, geography, and marital status.
- Integrating mental health support with SRH programs to acknowledge the emotional dimensions of youth SRH experiences.

References

2. Alexander, M., Garda, L., Kanade, S., Jejeebhoy, S., & Ganatra, B. (2006). Formation of partnerships among young women and men in Pune district, Maharashtra. Population Council.
3. Ajayi, A. I., & Okeke, S. R. (2022). Young people's perceptions and barriers to sexual and reproductive health services in Sub-Saharan Africa. BMC Public Health, 22(1), 1–12.
4. Desai, S., et al. (2021). Gender inequities in treatment-seeking for sexual and reproductive health amongst adolescents: Findings from a cross-sectional survey in India. Sexual & Reproductive Health Matters.
5. Foucault, M. (1986). The history of sexuality. Volume 3: The care of the self (R. Hurley, Trans.). Pantheon Books. (Original work published 1984)
6. International Institute for Population Sciences (IIPS) & ICF. (2021). National Family Health Survey (NFHS-5), 2019–21: India report. IIPS.
7. Jejeebhoy, S., Santhya, K., & Acharya, R. (2013). Adolescent sexual and reproductive health in India: Current perspectives. Journal of Family Welfare, 59(1), 1–14.
8. Jejeebhoy, S. J., & Santhya, K. G. (2011). Sexual and reproductive health of young people: Expanding the research and programme agenda. Population Council.
9. Kien, N. T. (2020). Care of the self in the age of algorithms: Early thoughts from a Foucauldian perspective. Journal of Science & Education (Sociology & Environment).

10. Logie, C., et al. (2022). Uptake and provision of self-care interventions for sexual and reproductive health: A systematic review and implementation considerations. Sexual and Reproductive Health Matters, 30(1), e2009104.
11. Mbizvo, M. T., & Zaidi, S. (2010). Addressing critical gaps in achieving universal access to sexual and reproductive health: The case for improving adolescent SRH. International Journal of Gynecology & Obstetrics, 110, S225–S228.
12. Mendes, M. I. B. S. (2025). Weaving relationships between "body techniques" and "self-care": Bibliographical perspectives. Frontiers in Sociology.
13. Michaels, D., Thompson, L., & Bromley, E. (2021). Self-care as social practice: Reframing autonomy, responsibility, and health. Social Science & Medicine, 289, 114192.
14. Ministry of Health and Family Welfare. (2014). Rashtriya Kishor Swasthya Karyakram: Operational framework. Government of India.
15. Mmari, K., & Sabherwal, S. (2013). A review of risk and protective factors for sexual and reproductive health in developing countries: An adolescent perspective. Journal of Adolescent Health, 52(5), 517–525.
16. Narasimhan, M., et al. (2020). Self-care interventions for sexual and reproductive health and rights for advancing universal health coverage: A review. BMJ Global Health.
17. Pachauri, S., Pachauri, A., & Mittal, K. (2021). Self-care: Concept, rationale, and framework. In K. Mittal (Ed.), Sexual and reproductive health and rights in India: Self-care for universal health coverage (pp. 1–7). SpringerBriefs in Public Health.
18. Sabarwal, S., McCormick, M. C., & Silverman, J. G. (2020). Reproductive health needs of adolescents in India: Barriers and policy opportunities. Lancet Child & Adolescent Health, 4(8), 511–523.
19. UNESCO. (2020). Global status report on school health and HIV education. UNESCO Publishing.
20. UNICEF. (2023). Ending child marriage: A profile of progress in India. UNICEF.
21. United Nations Population Fund. (2014). Sexual and reproductive health and rights: A global development, health, and human rights priority. UNFPA.
22. United Nations Population Fund (UNFPA) India. (2021). The sexual and reproductive health status of young people in India. UNFPA.
23. World Health Organization. (2015). Sexual health, human rights and the law. WHO Press.
24. World Health Organization. (2019). WHO consolidated guideline on self-care interventions for health: Sexual and reproductive health and rights. WHO Press.