

Godmen, Guilt, and Ghar Ki Izzat: A Review of Barriers to Clinical Help-Seeking for Substance Use Disorders in India

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ABSTRACT

Substance use disorders represent a growing public health concern in India, complicated by pervasive stigma at the social, internal, and structural levels, that deters treatment engagement. Cultural narratives attributing addiction to moral failings, karma, or supernatural causes often divert individuals toward spiritual or traditional healers, resulting in delayed access to evidence-based care and reinforcing reduced self-efficacy and hopelessness. Systemic challenges, such as inadequate mental health training among primary care providers, fragmented service delivery, and regulatory gaps, further hinder effective intervention. The objective of this paper is to critically examine the multifaceted psychological, cultural, and systemic barriers impeding access to effective clinical treatment for substance use disorders (SUDs) in India, and to explore culturally sensitive, integrative strategies that can enhance help-seeking and recovery outcomes. Emerging models emphasize community-based, culturally aligned approaches, that combine biomedical treatments with spiritual understanding, leveraging psychoeducation, family involvement, and lay health workers to bridge treatment gaps. Addressing these psychological and systemic barriers through culturally attuned, evidence-based strategies is critical for advancing SUD treatment outcomes in the Indian context.

Keywords: *Substance Use Disorder, Substance Abuse in India, Healthcare Access, Barriers to Treatment*

Substance use disorders (SUDs) have emerged as a significant public health concern in India and are increasingly prioritized in national policy discourse (Sarkar & Ghosh, 2019). The *National Survey on Extent and Pattern of Substance Use in India*, commissioned by the Ministry of Social Justice and Empowerment, systematically examined the prevalence and patterns of substance use across all states and union territories. Findings from the survey indicated that, after alcohol, cannabis and opioids are the most frequently used substances (Ambekar et al., 2019).

With the increasing magnitude of SUDs in India, the associated physical and psychological health burdens are expected to rise correspondingly. Alcohol, for instance, is a leading contributor to hospital admissions, yet its role is often underrecognized by primary care physicians (Benegal, 2005).

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Additionally, substance use is closely linked to various psychiatric morbidities; cannabis use has been associated with the onset or exacerbation of psychotic disorders, while opioid misuse significantly increases the risk of overdose-related morbidity and mortality (Ksir & Hart, 2016). Beyond clinical consequences, SUDs carry substantial social and economic costs, including reduced productivity, familial conflict, criminal behavior, and increased expenditure on law enforcement (Patel et al., 2015).

SUD has been conceptualized as a chronic relapsing medical illness with relapses and remissions and a strong genetic component similar to diabetes type II and hypertension (Johnson et al., 2020). Risk for relapse is heightened as the neurobiological alterations in brain pathways resulting from prolonged alcohol and/or drug use do not fully normalize following detoxification. Given the chronic nature of substance use disorders, coupled with the elevated relapse risk and reduced capacity for independent functioning, the timing, process, and quality of intervention become critical determinants of treatment outcomes, significantly impacting both short-term and long-term outcomes.

Historically, addiction treatment has focused primarily on achieving abstinence, which is bringing about complete cessation of drug consumption. However, evolving understanding of addiction's underlying mechanisms has broadened treatment goals to include clinically meaningful outcomes such as reduced substance use, improved sleep, mood, and executive function, all of which can lower relapse risk. A dynamic, personalized approach that integrates pharmacological, behavioral, and neuromodulation strategies offers a more comprehensive path to recovery. For instance, Pasareanu et al. (2015) found significant improvements in quality of life following intensive, personalised, in-patient treatment. Thus, early engagement combined with high-quality, tailored care is essential to prevent further neurobiological and psychosocial harm and to promote sustained recovery.

However, an unsettling disparity emerges related to treatment gaps. The *National Mental Health Survey of India* highlighted the systemic challenges in addressing SUDs, reporting treatment gaps of 86% for alcohol use disorders and 73% for drug use disorders. Alarming, treatment retention for alcohol use disorders was found to be the lowest among all psychiatric conditions assessed (Gururaj et al., 2016).

In India, help-seeking for substance-use disorders is impeded by a web of structural and psychosocial barriers. Cultural beliefs, family obligations, and gender norms discourage open discussion of substance problems, while stigma surrounding mental-health care magnifies reluctance to seek help. Low mental-health literacy, weak public messaging about available services, and chronic shortages of trained clinicians, especially outside urban centers, further limit access (Ashtankar & Talapalliwar, 2017). At the individual level, fears of losing confidentiality, disappointing significant others, failing in treatment, or being judged a “failure” by one’s community further compound these obstacles (Nebhinani et al., 2012).

This review aims to synthesize existing literature on the psychological, cultural, and systemic barriers to clinical help-seeking for substance use disorders, with a particular focus on the Indian context. By integrating empirical findings and theoretical perspectives, the review seeks to shed light on the complex interplay of individual, social, and structural factors that hinder access to treatment, and to highlight the urgent need for culturally sensitive and contextually grounded interventions.

METHODOLOGY

This review synthesizes literature using sources from PubMed, the Indian Journal of Psychiatry, APA PsycNET and official publications from the Ministry of Social Justice and Empowerment. A systematic search was conducted with keywords such as “substance use disorder in India,” “barriers to treatment,” “access to treatment” and related Boolean combinations to capture both clinical and policy perspectives. The inclusion criteria comprised English-language publications focusing on the Indian context, drawn from scientific, peer-reviewed journals, institutional reports, and government documents.

DISCUSSION AND ANALYSIS

1. Stigma and Shame in the Indian Context

Stigma remains one of the most pervasive barriers to help-seeking for individuals with substance use disorders (SUDs) in India. This stigma manifests in various forms, including social stigma from the public, self-stigma experienced by individuals, and structural stigma within healthcare and professional settings, all of which collectively discourage treatment engagement and contribute to the persistent treatment gap (Panda et al., 2020).

Vilifying attitudes often portray people with SUDs as dangerous or irresponsible, even among healthcare providers, which leads to discrimination and reluctance to access care (Kumar, 2021). This public stigma in India surrounding substance abuse is deeply entrenched in moral and cultural narratives, where substance use is often viewed as a sign of personal weakness, lack of willpower, or moral failure (Kermode et al., 2009; Keyes et al., 2010). This perception fosters punitive and exclusionary responses, such as social ostracism and ridicule, to denial of housing, employment, and healthcare. The criminalization approach embedded in policies like the Narcotics Drugs and Psychotropic Substances Act of 1985, further reinforces these moral judgments, creating a framework where addiction is seen as willful misconduct rather than a treatable disorder. Studies have shown that the fear of being publicly judged or socially excluded often outweighs the perceived benefits of treatment, resulting in underutilization of available services and prolonged untreated illness (Livingston et al., 2012; Schomerus et al., 2011).

This external stigma is frequently internalized, leading individuals to experience profound guilt, shame, hopelessness, and diminished self-worth, which further deters them from seeking clinical support (Corrigan et al., 2006). Research from Indian tertiary care centers reveals that 65.7% of substance users experience severe internalized stigma (Sarkar et al., 2017), with scores significantly higher than those found in similar populations globally. In Chennai, 67% of respondents felt compelled to hide their drug use, and 70% experienced shame (Khalid et al., 2020). The resulting shame, discrimination, and social exclusion negatively impact individuals' willingness to seek timely treatment and adhere to it, reducing overall recovery rates (Yang et al., 2017). Individuals begin to perceive themselves as morally flawed or fundamentally “broken,” which not only deteriorates self-esteem, but also erodes the motivation to seek help. Hopelessness, in particular, has been found to be a strong predictor of poor treatment retention and reduced engagement in recovery-oriented behaviors (Schomerus et al., 2011).

In the Indian context, where collectivist values and familial honor play an integral role in identity formation, these internalized emotions are often magnified, and family-based stigma becomes especially salient. Substance use is seen as a source of dishonor, raising concerns around family *izzat* (honor) and social standing, resulting in shame, social isolation, and

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pressure to conceal the substance use to protect family reputation (Nebhinani et al., 2012). Qualitative research in Odisha identified “social fragmentation and shame” among caregivers, with families engaging in secrecy to protect *izzat*, but experiencing isolation and emotional distress (Bhowmick et al., 2025). The fear of losing *izzat* can discourage families from seeking help or disclosing substance use issues, further complicating access to treatment and support (Kaur et al., 2022). Women, in particular, face “double stigma”, due to both their addiction and the transgression of traditional gender norms, and their substance use is often met with harsher judgment and social exclusion (Fox et al., 2024), making them even less likely to seek or receive adequate treatment. For instance, in Punjab, female drug users faced public, structural, and self-stigma, including family rejection, threats to marriage prospects, childcare responsibilities, and fear of societal judgment, that collectively hindered help-seeking and limited access to de-addiction programs (Shiri et al., 2021; Monika & Gupta, 2025).

2. Spiritual and Non-Medical Healing Practices

The etiology of mental illness has been attributed to various causes across cultures, including supernatural beliefs, which in turn influence help-seeking behaviors and pathways to care (Grover et al., 2014). In India, these beliefs are deeply embedded in the country's pluralistic religious milieu, where charismatic gurus, tantriks, temple priests, Sufi pirs, and Christian clergy occupy culturally sanctioned roles as healers who offer relief from both psychiatric distress and compulsive substance use.

Across diverse communities, addiction is often not seen as a biomedical issue, but rather interpreted through spiritual lenses. It is viewed as the result of supernatural causes, such as black magic, spirit possession, or divine punishment. One dominant framework is karma theory, which posits that maladaptive behaviors in prior lives bring about suffering in the present. This belief, shared across Hindu, Buddhist, and Jain communities, frames addiction as a consequence of past sins rather than a present-day behavioral disorder (Narayanan, 1986).

In qualitative interviews conducted in Uttar Pradesh and Tamil Nadu, 58% of family caregivers interpreted alcohol dependence as punishment for past sins, leading to the perception that recovery efforts are futile, since destiny, not personal effort, is considered decisive (Halliburton, 2004). Such beliefs externalize responsibility, shifting the focus away from individual agency and reducing the urgency or perceived legitimacy of clinical treatment (Burrows, 1991; Pickard, 2016).

Spiritual explanations often frame addiction as spiritual contamination, which can diminish self-efficacy and impede recovery. Attributing relapse to karma or spirits has been shown to undermine relapse-prevention planning, reinforce denial, and reduce motivation to change (Darban et al., 2023). These beliefs may also foster stigma and shame, contributing to social isolation and reluctance to seek professional help (Sansom, 2018).

Studies have shown that blaming relapse on evil spirits reduces self-efficacy and impedes the development of coping strategies (Medlock et al., 2017). For example, regression analyses among inpatient detox clients revealed that negative religious coping correlated with lower abstinence self-efficacy ($\beta = -0.23$, $p < .05$) and higher craving scores (Lucchetti, 2018). Conversely, positive religious coping predicted fewer days of substance

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use and greater participation in 12-step programs (Galanter et al., 2014), indicating the potential of spirituality to either hinder or help recovery, depending on how it is framed.

These culturally grounded supernatural beliefs heavily influence help-seeking behaviors. Many individuals and families in India turn first to spiritual healers, including godmen, tantriks, and religious leaders (Raguram et al., 2002; Kareem & Yoganandham, 2022). In a Kerala outpatient cohort, 64.3% of participants initially consulted a healer, resulting in an average delay of 28.2 months in accessing psychiatric care compared to those who sought medical help first (Jalal et al., 2020).

Similarly, the National Mental Health Survey (2016) found that 45% of rural respondents but only 22% of urban respondents, first consulted spiritual practitioners. Studies from India and other developing countries confirm that patients with mental disorders frequently consult traditional healers first, causing significant treatment delays (Gureje et al., 1995; Jain et al., 2012). These patterns are particularly pronounced in rural and low-income populations, where access to formal psychiatric services is limited, and spiritual healers remain more accessible and culturally resonant (Sukesh & Nair, 2020).

The primary factors guiding these choices include trust, referrals from relatives and others, and belief in supernatural causes (Chadda et al., 2001). In these contexts, spiritual healers not only offer therapeutic relief but also provide psychological comfort, social support, and a sense of belonging, contributing to their sustained popularity even as modern psychiatry grows (Dalal, 2007; Ramakrishnan et al., 2014).

3. Primary Care Misdirection and Clinical Systemic Gaps

India continues to face a significant clinical treatment gap for Substance Use Disorders (SUDs), with many individuals not receiving the care they need. Research suggests that this gap is also due to poor accessibility and underutilization of services, particularly inpatient care, as well as the limited integration of SUD treatment into primary healthcare (Avasthi & Ghosh, 2019; Ghosh et al., 2024). An estimated 83% treatment gap exists for mental health conditions, including substance use, and this is partly the result of a weak public health infrastructure and a shortage of trained mental health professionals (Singh, 2018; Grover, 2023).

Barriers Within Primary Care

One of the biggest concerns is the low level of engagement with primary healthcare services. A recent multicenter study conducted across nine tertiary centers in India (n = 998) found that only five patients, less than one percent, sought SUD treatment first at a primary health center (Ghosh et al., 2024b). This finding reflects broader issues with how primary care is structured and staffed. Many general physicians lack formal training in mental health and addiction medicine. Although the 2019 competency-based MBBS curriculum increased exposure to psychiatry, psychiatric skills are still not required for medical licensure. As a result, medical graduates often lack training in the clinical management of SUDs. Physicians may mistake signs of substance use for general physical ailments and focus primarily on physical symptoms (Ambekar et al., 2019). This often leads to inappropriate prescriptions, such as sedatives or painkillers, instead of referrals to mental health professionals (Rao et al., 2022).

Human Resource and Capacity Constraints

In addition to training gaps, India faces a shortage of qualified mental health professionals. The psychiatrist-to-population ratio is less than one per 100,000, which is well below global norms (Hariharan, Krishnaprasanth, Stephen, & Aljin, 2020). At the same time, challenges in medical education, such as uneven faculty distribution, a lack of practical training, and high stress among trainees, make it difficult to develop a strong and effective addiction care workforce (Raju, 2022). These limitations have a direct impact on the treatment gap and the overall quality of care.

Quality and Regulation of Treatment Facilities

The quality of treatment facilities also raises serious concerns. Many government-supported de-addiction centers have had only partial success. This is often due to shared responsibilities between central and state governments, along with limited funding and inadequate staff training (Dhawan et al., 2017). In addition, a large number of unauthorized de-addiction centers operate without accreditation or oversight. These facilities may engage in unethical practices or even violate patients' rights (Ghosh et al., 2024). Many of them do not meet the basic standards for infrastructure, staffing, and clinical care, resulting in poor or harmful treatment experiences (Gautam et al., 2022).

Fragmentation of Services

SUD treatment services in India are often fragmented because different programmes operate in isolation. For example, the Drug De-addiction Programme (DDAP) and the Integrated Rehabilitation Centers for Addicts (IRCAs) function separately from the District Mental Health Program (DMHP), with very little coordination between them (Rao et al., 2021). This lack of integration has created significant gaps in service delivery. Even though the World Health Organization recommends integrated care, primary health centers and district hospitals in India rarely offer outpatient SUD services (Ghosh et al., 2024c). Access to psychotropic medication and psychosocial support is often inconsistent at the primary level, and referral systems to higher centers are weak or poorly managed (Math et al., 2021b). These issues result in disjointed care that can discourage people from seeking or continuing treatment.

Efforts to integrate mental health services into general healthcare have had mixed results. The National Mental Health Program (NMHP), launched in 1982, and the District Mental Health Program (DMHP) were designed to bring mental health into the broader healthcare system. However, implementation remains uneven. Studies show that nearly 75 percent of DMHP districts struggle due to lack of political will, weak leadership, limited access to funds, and poor coordination between departments (Kumar et al., 2023; Math et al., 2021). Systemic issues such as the lack of on-the-job training, absence of refresher courses for primary care staff, and poor monitoring and data-sharing practices have further undermined the effectiveness of these programs (Gupta & Sagar, 2018).

Gaps in Implementation

The National Action Plan for Drug Demand Reduction (NAPDDR) 2018–2025, launched by the Ministry of Social Justice and Empowerment, aims to address substance use through prevention, treatment, rehabilitation, and capacity building. Despite these goals, the program has faced major challenges. An evaluation by Development & Research Services Pvt. Ltd. (2024) showed that only 155 out of the 398 Integrated Rehabilitation Centers for Addicts (IRCAs) and 212 opioid substitution clinics were surveyed, with wide variations in coverage

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across different states. While the program's budget increased from ₹100 crore in 2018–19 to ₹450 crore in 2024–25, many community-based interventions remain underfunded, and partnerships with the private sector are limited (IMPR, 2025). According to a parliamentary report by the Ministry of Social Justice and Empowerment (2025), the number of beneficiaries increased from 3,39,588 in 2022–23 to 5,81,813 in 2023–24. While this growth is encouraging, it still reflects a slow rollout that continues to be held back by stigma, infrastructure limitations, and administrative delays.

Legal and Policy Barriers

Legal and policy challenges also play a role in limiting access to care. The Narcotic Drugs and Psychotropic Substances (NDPS) Act (1985) and the Mental Healthcare Act (2017) include provisions that criminalize drug use, which contributes to stigma and fear of prosecution. These laws also impose strict regulations on the use of medications like buprenorphine and methadone, making it harder for people with opioid dependence to access treatment (Gautam et al., 2022). While the law does offer immunity from prosecution for individuals who voluntarily seek treatment, these protections are rarely used in practice due to legal ambiguities and bureaucratic delays.

4. What Lies Ahead: Reimagining Recovery

Given the wide treatment gap, fragmented service systems, and persistent stigma SUDs in India, emerging models are increasingly turning to integrative, community-based, and culturally sensitive approaches to bridge these deficiencies. Efforts to address SUDs in India are shifting from institution-centric models toward more community-based, culturally-responsive care. These innovations aim to align care with the lived realities of affected individuals, particularly in rural and marginalized communities where formal mental health infrastructure remains scarce.

While the District Mental Health Program (DMHP) has encountered several operational challenges, such as inconsistent service quality, staffing shortages, and limited integration of addiction services, it remains a foundational initiative for public mental health care in India. When implemented effectively, the DMHP can create important access points for substance use disorder (SUD) treatment within existing government healthcare infrastructure. According to the Ministry of Health & Family Welfare, the program is structured around district hospitals and primary health centers (PHCs), aiming to deliver accessible and community-based services. Support from the National Institute of Mental Health and Neurosciences (NIMHANS) has been instrumental in strengthening the program. Through structured training, mentoring, and tele-supervision initiatives, NIMHANS helps build the capacity of mental health professionals at the district level. Additionally, the expansion of digital tools such as the Tele-MANAS platform is enabling remote psychiatric support in areas where specialist services are otherwise unavailable. With sustained collaboration between NIMHANS and state health departments, and by integrating addiction services into DMHP's broader mental health framework, the program holds promise to become a more inclusive and effective system of care.

Accredited Social Health Activists (ASHAs) act as lay health workers bridging rural populations and primary care. While their core focus is maternal and child health, health education and disease prevention, Accredited Social Health Activists (ASHAs) have been trained and mentored effectively to conduct mental health screening, counselling, and referrals, resulting in a significant reduction of treatment gaps for severe mental disorders

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and substance use disorders in rural communities (Gakkhar et al., 2023). The Sangath's MANAS project is another well-known example, where non-specialist lay workers provide community-based counselling integrated with primary care services, where treatments ranged from psychoeducation to pharmacotherapy and interpersonal therapy, tailored by severity. (Chatterjee et al., 2008; Pereira et al., 2011)

A pragmatic integration of spirituality and psychiatry is increasingly seen as a viable strategy for enhancing SUD treatment in India. Given the dual role of spirituality as both a barrier and a resource, emerging models now advocate for integrative approaches that respect cultural beliefs while ensuring timely clinical care. Recent efforts in regions like Northeast India have begun to combine traditional wisdom, including psycho-spiritual healing and the use of medicinal plants, with evidence-based therapies such as opioid substitution and behavioral interventions (Saha et al., 2025).

State-led initiatives further support the case for such collaboration. Gujarat's Dava-Dua model offers a compelling example by co-locating psychiatric clinics within the Mira Datar Dargah. This approach led to a 29 percent increase in biomedical referrals and a 50 percent reduction in harmful restraint practices (Saha et al., 2021). Similarly, in Erwadi, Tamil Nadu, initiatives replaced shackling with supervised medication protocols, marking significant progress in human rights and care delivery (Al Jazeera, 2015).

Non-pharmacological modalities like spirituality, family support, hobbies, yoga, and meditation have also shown promise in promoting recovery within Indian SUD contexts (Mahajan et al., 2020; Kuppili et al., 2018). These approaches help with emotional regulation and can effectively supplement formal treatment. For instance, in Bangalore, Alcoholics Anonymous (AA) groups reported that spiritual beliefs mediated longer abstinence durations and higher quality-of-life scores when compared to hospital-only programs (Arthur & Pandian, 2015).

Indian spiritual epistemologies, therefore, simultaneously hinder and support addiction recovery. While beliefs in karma or spirit possession may delay help-seeking and undermine personal agency, when approached constructively, spirituality can also facilitate healing, foster community support, and enhance emotional self-regulation.

A balanced and compassionate treatment approach that protects human rights while leveraging the supportive dimensions of spirituality may offer one of the most culturally consonant and clinically effective responses to India's addiction crisis. By meeting individuals within spaces, they already trust, India has the opportunity to turn longstanding spiritual traditions into vital sources of healing and hope. Clinicians can further strengthen this approach by incorporating culturally sensitive explanatory-model interviews, exploring how patients conceptualize ideas such as karma, possession, or sorcery, and how these beliefs shape their treatment expectations (Kleinman, 1980).

Furthermore, psychoeducation plays a vital role in advancing future treatment opportunities for substance use disorder. It has been shown to reduce self-stigma, enhance knowledge, and increase social support and acceptance among both patients and caregivers (Bahrami & Khalifi, 2022). Structured family therapy models are now increasingly adopted in community settings and outreach clinics to address family-level stigma related to "izzat," facilitate supportive disclosure, and improve treatment adherence (Avasthi, 2010). Meta-

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analytic reviews involving thousands of cases have consistently demonstrated that family therapy is more effective in treating substance use problems in both adults and adolescents (Stanton & Shadish, 1997; Farrell & Strang, 1998). At the community level, psychoeducation and family engagement form central pillars of district and NGO-led programs. These are often implemented in collaboration with schools, employers, and local leaders, reinforcing the importance of collective involvement in supporting recovery.

Educational and psychosocial interventions such as public awareness campaigns, media reform, family and community involvement, and contact-based training are effective in reducing self, public, and structural stigma related to substance use disorders (Livingston et al., 2012; Ghosh et al., 2025; Kumar, 2021). Despite supportive government policies and NGO efforts, ongoing reforms and culturally tailored strategies are needed to address persistent stigma in India, in order to facilitate better treatment of SUDs (Parmar et al., 2023; Ganesh & Sarkar, 2024; Hayek et al., 2024).

CONCLUSION

In conclusion, the treatment landscape for substance use disorders in India is shaped by a complex convergence of cultural, structural, and systemic barriers that significantly delay and dilute access to effective clinical care. Deep-rooted stigma, whether societal, familial, or internalized, discourages disclosure and reinforces silence, often pushing individuals away from formal treatment pathways. Cultural beliefs that attribute addiction to moral failings, karma, or supernatural forces frequently divert individuals toward traditional or spiritual healers, creating detours that delay timely psychiatric intervention. Systemic gaps in the health infrastructure, including the underdevelopment of primary care, lack of trained personnel, and fragmented services, further restrict access to consistent and coordinated treatment. Despite the presence of government initiatives, inadequate implementation and limited integration across care levels continue to pose challenges.

Yet, within these constraints lie promising pathways for reform. Strengthening clinical responses through capacity-building of primary care providers, ensuring specialist support through tele-mental health, and scaling district-level models can help bring structured, accessible treatment closer to those in need. Equally important is the cultural integration of clinical care, where partnerships with community leaders, traditional healers, and families can reduce delays by bridging belief systems and encouraging treatment-seeking. By aligning culturally resonant approaches with robust, evidence-based medical care, India has the opportunity to reduce harmful detours and foster recovery environments rooted in both scientific rigour and cultural sensitivity. The future of addiction care in India must prioritize timely clinical intervention while acknowledging and constructively engaging with the cultural landscapes that shape people's choices.

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