

Digital Health and Health Equity in India: Are Digital Interventions Leaving Vulnerable Populations Behind?

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Abstract

India has rapidly expanded digital health infrastructure through telemedicine, mobile health applications, digital public infrastructure, and artificial intelligence-enabled services. While these technologies promise to overcome geographical and resource barriers, their equity implications remain contested. This review synthesises Indian and international evidence to examine whether digital health is narrowing or widening health inequities. We develop a layered equity framework—comprising digital access, ability to use, ability to understand, ability to trust, ability to obtain care, quality of care, and health outcome—as the authors' synthesis, not as an established published framework. Evidence indicates that digital health has demonstrated genuine equity-promoting potential under specific conditions: assisted telemedicine models, community health worker facilitation, and hybrid care pathways. However, digital-by-default service models, low digital health literacy, gender gaps in device ownership, disability accessibility barriers, and privacy concerns systematically disadvantage rural populations, older adults, women, persons with disabilities, and socioeconomically marginalised groups. India's policy architecture has achieved supply-side enrolment equity but remains weak on demand-side equity and algorithmic accountability. Digital health neither universally leaves vulnerable populations behind nor inherently advances equity. Its net effect depends on deliberate design, implementation, and governance decisions. Digital health should generally complement rather than replace non-digital care pathways for populations at risk of exclusion.

Received: 15-09-2026
Accepted: 19-09-2026

Keywords: Digital health, Health equity, India, Telemedicine, Digital divide, Vulnerable populations, Health policy.

Introduction

India's health system is undergoing a rapid digital transformation. Telemedicine platforms, mobile health applications, digital public infrastructure, electronic

health records, and artificial intelligence-enabled services are being deployed at scale across public and private sectors [1]. The Ayushman Bharat Digital Mission (ABDM) has enrolled millions of citizens, and eSanjeevani has facilitated millions of

teleconsultations [2,3]. This expansion is widely framed as a mechanism to overcome India's persistent challenges of geographical access, specialist shortages, and out-of-pocket expenditure [3,4].

The central equity tension is that technologies designed to overcome geographical and resource barriers may simultaneously exclude populations who cannot access, afford, understand, trust, or effectively use them [5]. The same digital infrastructure that connects a rural patient to a specialist in a tertiary hospital may be inaccessible to a woman who does not own a smartphone, an older adult with low digital literacy, a person with a disability whose screen reader cannot navigate the interface, or a linguistic minority who cannot read the language in which the application is designed [6,7,8].

This review critically examines whether India's digital health expansion is improving health equity or inadvertently creating, reinforcing, or widening disparities among vulnerable and digitally excluded populations. We synthesise Indian and international evidence to address six questions: What is the current digital-health landscape in India? Which populations are most vulnerable to digital exclusion? Through what mechanisms can digital health improve or worsen health equity? What evidence exists from India? Which populations appear disproportionately disadvantaged? And what policy and implementation approaches could make digital health more equity-oriented? Rather than assuming that digital health is inherently beneficial or harmful, we develop an analytical framework showing that its equity impact depends on access, affordability, literacy, disability accessibility, gender, age, geography, language, trust, privacy, and the design and implementation of digital interventions.

Digital Health in India: Promise for Health Equity

The theoretical case for digital health as an equity-promoting intervention rests on its capacity to overcome geographical barriers, reduce travel-related costs, enable continuity of care, and extend specialist access to underserved populations [4,5]. In India, where rural populations often travel long distances to access tertiary care, these mechanisms are particularly relevant. A scoping review of two decades of Indian telemedicine services concluded that remote consultation can lower travel-related expenses for patients, although the review called for stronger evidence on diagnostic quality and downstream outcomes [9]. A systematic review of mobile health interventions for hypertension and diabetes demonstrated improvements in blood pressure and glycaemic control, suggesting that mHealth can extend chronic disease care to populations with limited access to regular follow-up [10].

Indian evidence supports these claims under specific conditions. In rural West Bengal, a hybrid telemedicine model embedded in Health and Wellness Centres appears to have strengthened maternal and reproductive care by positioning community health officers as on-site clinical assessors and linking them to consistent remote specialist support [11]. This model was particularly effective for antenatal care follow-up and counselling, reducing the need for repeated travel to district hospitals. Similarly, a Tamil Nadu pilot that placed a trained facilitator alongside patients during teleconsultations reported improvements in blood pressure and glycaemic control, suggesting that human assistance can extend chronic-disease care to patients with limited digital autonomy [12]. Qualitative work in a remote district of Rajasthan illustrates the conditional nature of this promise: clinicians and patients saw telemedicine as a way to reduce distance-related disadvantage, but

unreliable connectivity, insufficient training, and limited digital skills constrained its use [13].

An analysis of Ayushman Bharat Digital Mission enrolment across 28 states describes an equity-corrective pattern: health ID generation became less concentrated among advantaged groups, largely because frontline workers assisted rural residents to enrol rather than because digitally literate users sought registration independently [2]. This finding is significant because it demonstrates that deliberate implementation choices can accelerate equitable access to digital health infrastructure.

However, plausible benefit and demonstrated benefit are not the same. Most Indian evidence on digital health's equity impact comes from well-resourced states—Kerala, Tamil Nadu, Karnataka, West Bengal—and from pilot or early implementation phases [9,12,13]. The Rajasthan study's findings on persistent connectivity and literacy barriers highlight that the promise of digital health is conditional on infrastructure, training, and support systems that are not uniformly available [13]. Furthermore, the enrolment-focused design of the ABDM analysis means that translation into health outcomes remains unexamined [2]. The promise of digital health for equity in India is thus genuine but conditional—and evidence on whether those conditions are being met at scale remains limited.

Who Is at Risk of Digital Exclusion?

Digital exclusion in India is not randomly distributed. It clusters among populations whose social, economic, and geographic positions systematically reduce their access to and benefit from digital health services. Understanding the mechanisms of exclusion—rather than merely listing

vulnerable groups—is essential for designing equity-oriented interventions.

Gender and autonomy. National data indicate a persistent gender gap in internet access, and the associated shortfall in smartphone ownership limits women's independent use of telemedicine and mobile health services [14,15]. A Kerala study of eSanjeevani found that awareness was widespread, yet women—particularly those in rural areas—used the service less often than men, indicating that awareness alone does not translate into equitable use [16]. Qualitative findings from the DIG-EQUITY study in Tamil Nadu indicate that shared or mediated phone access can constrain women's ability to seek digital care autonomously [6]. These barriers reflect gendered norms around technology use, decision-making autonomy, and mobility, not merely technical limitations.

Age and family mediation. In a mixed-methods study of older adults in Aligarh, urban residence, digital literacy, and family support were associated with greater perceived empowerment to use telemedicine and AI-enabled services. The barriers most frequently reported were limited digital skills, cost, and distrust [8]. This finding suggests that age-related exclusion is partially mediated by family support—a factor that may be unavailable to older adults living alone or in households with limited digital capacity.

Disability and accessibility. Qualitative research across five Indian states indicates that persons with disabilities can gain convenience and avoid travel through virtual care, but that these gains are undermined when platforms are incompatible with assistive technologies, sign-language support is inconsistent, and clinicians lack disability-specific training [7]. A scoping review of telehealth for people with disabilities in India cautions that unless

accessibility is designed into platforms from the outset, virtual care may reproduce or deepen existing disadvantage [17].

Digital and health literacy. Digital health literacy is not merely a technical skill but a determinant of whether digital health translates into care-seeking behaviour. In rural Karnataka, 32.1% of adults had low digital health literacy, and low digital health literacy was associated with significantly poorer health-seeking behaviour (adjusted odds ratio 8.33; 95% CI 2.54–27.0) [18]. This finding demonstrates that comprehension barriers can become practical barriers to accessing services.

Rural and frontline worker disadvantage. Evidence from community health workers in Muzaffarpur, Bihar, suggests that digital engagement among frontline staff follows existing social gradients: urban residence, higher income, and more education were associated with greater use, whereas device limitations, lower education, and residence in a flood-affected rural area constrained it [19]. This finding is particularly significant because community health workers are themselves the bridge between digital health systems and the populations they serve; if frontline workers are digitally excluded, the populations they serve are doubly excluded.

Trust and privacy. A systematic review of ethical challenges in digital health data collection during COVID-19 in India identified concerns across privacy, consent, governance, equity, and trust domains, including unclear consent mechanisms and erosion of public trust [20]. In an evaluation of ABDM users, most reported that registration had become easier, but only about half expressed comfort with how their data were protected [21]. These findings suggest that even when access and usability barriers are addressed, trust-related exclusion may persist.

The mechanisms of exclusion are cumulative rather than additive. A woman in rural Bihar who is an older adult with low literacy faces barriers at every layer of the digital health pathway. The intersection of these barriers, not any single characteristic, determines whether digital health reaches her.

How Digital Health Can Widen Health Inequities

The mechanisms through which digital health widens inequities operate at multiple levels: individual, household, community, and system. Understanding these mechanisms requires distinguishing between “having access to technology” and “being able to derive meaningful health benefit from technology.” Access alone is insufficient; the ability to use, understand, trust, and obtain quality care through digital means determines whether technology translates into health benefit.

The digital divide in device ownership and connectivity remains the foundational barrier. Wealth-based inequality in internet use among women in India has been documented, with socioeconomic status predicting both access and usage patterns [14]. Among community health workers in Bihar, limited device functionality and rural location constrained digital engagement [19]. These findings indicate that the digital divide is not closing uniformly; it is being reconfigured along existing axes of inequality.

Digital health literacy operates as a second-order barrier even when access is available. In rural Karnataka, 32.1% of adults had low digital health literacy, and low literacy was associated with significantly poorer health-seeking behaviour [18]. These findings suggest that digital health interventions that assume basic digital literacy will systematically exclude a substantial proportion of the

population, particularly in rural and older age groups.

Gender-related barriers extend beyond device ownership to autonomy, mobility, and decision-making. The DIG-EQUITY study found that shared or mediated phone access can constrain women's ability to seek digital care independently [6]. In Kerala, rural women were the least frequent users of eSanjeevani despite comparable awareness [16]. These patterns reflect broader gendered norms around technology use and healthcare decision-making, not merely technical barriers.

Disability accessibility is a design failure, not an inherent limitation of digital health. Persons with disabilities across five Indian states described a paradox: virtual care reduced travel burdens, yet inaccessible interfaces, inconsistent sign-language support, and limited provider training often made digital services unusable [7]. A scoping review on telehealth for people with disabilities in India warns that without intentional design for accessibility, telehealth risks increasing inequity [17]. This is a solvable problem: accessible design principles exist, but they are not systematically applied in Indian digital health platforms.

Language and usability barriers disproportionately affect linguistic minorities and low-literacy populations. The Karnataka findings link low digital health literacy to reduced care-seeking, indicating that comprehension barriers can become practical barriers to accessing services [18].

Privacy and trust concerns can lead to disengagement even among digitally literate users. The systematic review of ethical challenges during COVID-19 identified erosion of public trust as a consequence of unclear consent mechanisms and data protection risks [20]. Among ABDM users, 45% did not feel comfortable with data

privacy protection [21]. These findings indicate that trust is not a secondary concern; it is a prerequisite for meaningful digital health engagement.

Algorithmic bias is an emergent equity risk in India's AI-enabled health services. A preprint analysis of Longitudinal Ageing Study in India data suggests that machine-learning models trained on raw population data may underestimate healthcare utilisation among disadvantaged groups, thereby risking the reproduction of structural inequities [22]. India's Strategy for AI in Healthcare acknowledges the need for diverse and inclusive datasets but does not specify enforcement mechanisms in available summaries [23]. The risk is that AI-enabled triage, diagnosis, or resource allocation may systematically disadvantage populations who are underrepresented in training data—typically the same populations already excluded by the digital divide.

Digital-only service models represent a system-level mechanism of exclusion. When digital health is deployed as a replacement for in-person services rather than as a complement, populations unable to use digital channels are left without alternatives. The Rajasthan study found that despite telemedicine's potential, poor connectivity and low literacy meant that some patients remained unable to access care [13]. The principle that digital health should complement rather than replace non-digital pathways is therefore not merely a preference but a requirement for equity.

These mechanisms interact to produce a **layered digital-health equity gap**: access → ability to use → ability to understand → ability to trust → ability to obtain care → quality of care → health outcome. At each layer, populations are filtered out based on socioeconomic status, gender, age, disability, geography, literacy, language,

affordability, infrastructure, and system design. The cumulative effect is that the populations most in need of healthcare—the poor, the rural, the disabled, the elderly, women in restrictive settings—are least likely to derive meaningful benefit from digital health interventions. This framework is the authors' synthesis; it is not presented as an established published framework.

The Indian Policy and Implementation Context

India's digital health policy architecture has evolved from the National Health Policy 2017, which recommended strengthening primary health care through Health and Wellness Centres and specific digital technology goals [24], to the Ayushman Bharat Digital Mission (ABDM), which provides building blocks for a national digital health ecosystem [1]. The National Digital Health Blueprint lays out an architecture for interoperability, electronic health records, and digital identity. eSanjeevani, the national telemedicine platform, has facilitated millions of teleconsultations [3]. More recently, the Strategy for Artificial Intelligence in Healthcare (SAHI) has articulated principles for AI deployment, including equitable access, diverse datasets, transparency, and trust [23].

The equity question is not whether these policies exist but whether their implementation adequately addresses the layered barriers identified in the previous section. Evidence from ABDM implementation suggests that assisted enrolment by frontline health workers in rural areas has made health ID generation more equitable [2]. This is a genuine achievement. However, because this equity gain depended on assisted enrolment rather than independent demand, it is unclear whether beneficiaries will continue to use digital health services on their own. Furthermore, the ABDM evaluation found

that while over 80% of users agreed registration was easier, only about half felt comfortable with data privacy protection, and overall digital health literacy was moderate [21]. These findings suggest that the policy architecture has prioritised enrolment over meaningful engagement and trust.

Several equity-relevant implementation gaps persist. **Digital literacy interventions** are not systematically integrated into digital health rollouts; the Karnataka finding that low digital health literacy predicts poorer health-seeking behaviour implies that without literacy support, digital health access will not translate into health benefit [18]. **Multilingual and accessible design** remains incomplete; the disability telehealth study found that eSanjeevani was underutilised by persons with disabilities due to usability issues [7]. **Offline and hybrid alternatives** are not uniformly available; the Rajasthan study found that patients in hard-to-reach areas remained unable to access telemedicine despite its availability due to connectivity and literacy barriers [13]. **Privacy and data governance** remain areas of concern; the DPDPA 2023 provides a regulatory framework, but implementation and enforcement mechanisms remain under development [25]. **Algorithmic accountability** for AI-enabled health services is acknowledged in SAHI but lacks specified enforcement mechanisms in available summaries [23]. **Community-level implementation** varies widely; the Bihar community health worker study found that rural, less-educated, and flood-affected cadres had lower digital engagement, suggesting that frontline worker capacity is unevenly developed [19].

Policy progress has been uneven. India has made genuine advances in creating digital health infrastructure and in achieving

supply-side enrolment equity through assisted onboarding. However, the implementation gaps in literacy support, accessible design, privacy protection, offline alternatives, and algorithmic accountability suggest that the current approach may be better at bringing people into the digital health system than at ensuring they can derive meaningful benefit from it.

Toward Equity-Centred Digital Health in India

Making digital health equity-oriented in India requires action at multiple levels. The evidence reviewed above suggests that equity is not achieved by technology alone but by deliberate design, implementation, and governance choices.

At the technology and design level, digital health platforms should be designed for the populations most at risk of exclusion, not for digitally privileged users. This means multilingual interfaces that accommodate linguistic diversity, accessible design for persons with disabilities, low-bandwidth and offline functionality for areas with unreliable connectivity [13], and privacy-by-design principles that protect user data by default [20]. The DIG-EQUITY study's finding that shared phone access constrains women's autonomy suggests that design should accommodate shared-device use and support autonomy [6].

At the healthcare-provider level, human-in-the-loop models should be prioritised over fully automated digital pathways. The West Bengal model suggests that community health officers can act as on-site assessors, allowing teleconsultation to work for patients with limited digital skills [11]. In Tamil Nadu, a facilitated teleconsultation model was associated with better chronic-disease control, indicating that human assistance can mediate digital access [12]. These models recognise that digital health

benefit often depends on human mediation, not just technology access.

At the health-system level, digital health should complement rather than replace non-digital care pathways. The Rajasthan finding that patients in hard-to-reach areas remained unable to access telemedicine despite its availability underscores the need for maintaining in-person alternatives [13]. Equity monitoring should be integrated into digital health programmes, with routine collection of equity-stratified data on access, utilisation, and outcomes. Inclusion audits—systematic evaluations of whether digital health platforms meet accessibility, language, and usability standards for vulnerable populations—should be mandated for publicly funded digital health initiatives.

At the community level, community health workers should be equipped with digital tools, training, and support to function as digital health navigators. The Bihar community health worker study found that rural, less-educated, and flood-affected cadres had lower digital engagement [19], suggesting that targeted investment in frontline worker digital capacity is essential. Community-level digital literacy interventions, integrated with existing health promotion activities, can address the digital health literacy gap identified in Karnataka [18].

At the policy and governance level, algorithmic accountability mechanisms should be developed for AI-enabled health services. The preprint evidence on algorithmic bias in Indian healthcare utilisation prediction suggests that without such mechanisms, AI may reproduce structural inequities [22]. India's SAHI provides a framework but lacks enforcement mechanisms in available summaries [23]. Privacy protections should be strengthened, with independent oversight and clear redress

mechanisms. Affordability should be addressed through subsidies for devices and data for populations at risk of exclusion [8].

The overarching principle is that digital health should generally complement rather than automatically replace non-digital pathways for populations at risk of exclusion. Digital health is not a substitute for universal health coverage; it is a tool that can either support or undermine it, depending on how it is deployed.

Future Research Priorities

The evidence base on digital health and health equity in India has significant gaps that limit the capacity to draw firm conclusions and design effective interventions.

Longitudinal evidence on equity outcomes is almost entirely absent. Most studies are cross-sectional or cover early implementation phases. Cohort studies that track digital health adoption, utilisation, and health outcomes over time, stratified by equity-relevant variables, are needed.

Disability-specific research is extremely limited. The evidence map for this review identified only one scoping review and one qualitative study directly addressing disability and digital health in India [7,17]. Research on intellectual disabilities and multiple disabilities is essentially non-existent.

Gender-sensitive evidence beyond maternal health is sparse. Most gender-focused digital health research in India centres on maternal and reproductive health. Limited evidence exists on gender and digital health for non-communicable diseases, mental health, or disability. The finding that women in Kerala had lower eSanjeevani usage despite comparable awareness warrants further investigation across states and conditions [16].

Evidence from poorer and rural populations is geographically skewed. Most Indian studies come from Kerala, Tamil Nadu, Karnataka, Telangana, and West Bengal. Evidence from Bihar, Jharkhand, Odisha, Uttar Pradesh, and other high-burden states is scarce.

Implementation research on what works, for whom, and under what conditions is limited. The West Bengal and Tamil Nadu assisted telemedicine models [11,12] provide promising evidence, but it is not known whether these models can be scaled across diverse contexts or sustained over time.

Unintended harms of digital health are rarely documented. There is almost no evidence on whether digital-only service models have excluded patients from care, whether privacy breaches have led to stigma or discrimination, or whether algorithm-driven resource allocation has denied care to vulnerable populations.

AI-related inequities are an emergent research priority. The preprint evidence on algorithmic bias in Indian healthcare utilisation prediction [22] requires peer-reviewed replication and extension to real-world clinical settings. Research should evaluate whether AI-enabled health services reduce or reproduce existing inequities.

Meaningful health outcomes rather than technology uptake alone should be measured. Many studies measure adoption, satisfaction, or usability—not mortality, morbidity, or quality of life. Equity-oriented research should evaluate whether digital health interventions improve health outcomes for the populations most at risk of exclusion [9].

Conclusion

The question posed by this review—are digital interventions leaving vulnerable populations behind in India?—cannot be

answered with a simple affirmative or negative. The evidence shows that digital health has demonstrated genuine equity-promoting potential when deployed as a complement to existing care pathways, with assisted models, community health worker facilitation, multilingual and accessible design, and offline alternatives [2,11,12]. However, digital-by-default service models, low digital health literacy, gender gaps in device ownership, disability accessibility barriers, and privacy concerns systematically disadvantage rural populations, older adults, women, persons with disabilities, and socioeconomically marginalised groups [6,7,8,19].

The conditions under which digital health narrows inequities are now reasonably well understood: human-in-the-loop models, assisted digital services, multilingual interfaces, accessible design, low-bandwidth functionality, community health worker involvement, digital literacy interventions, equity monitoring, privacy-by-design, and the maintenance of non-digital alternatives. The conditions under which it widens inequities are equally clear: digital-only service models, technology designed around digitally privileged users, insufficient attention to disability accessibility, unaddressed algorithmic bias, and weak privacy protections.

India's policy architecture has made meaningful progress on supply-side equity—bringing people into the digital health system—but remains weak on demand-side equity—ensuring they can derive meaningful benefit. The review's central conclusion is that digital health is not a solution to health inequity; it is a tool whose equity impact depends entirely on the choices made in its design, implementation, and governance. Whether India's digital health expansion narrows or widens inequities will depend not on the technology

itself but on whether those choices are made deliberately, inclusively, and accountably.

Source of Funding: Nil

Conflict of Interest: None

Use of Artificial Intelligence (AI)-Assisted Technology for manuscript preparation:

The authors confirm that there was use of AI-assisted technology for grammar assistance in the writing of the manuscript, and no images were manipulated using AI.

References

1. Ayushman Bharat Digital Mission (ABDM) — official government portal. Ministry of Health and Family Welfare, Government of India. Available at: <https://abdm.gov.in>.
2. Sreepada SS. Bridging the digital divide: a longitudinal analysis of health equity in India's Ayushman Bharat Digital Mission (2024-2025). *Int J Community Med Public Health*. 2026;13(7):3380–3385. doi:10.18203/2394-6040.ijcmph20262227.
3. eSanjeevani — National Telemedicine Service of India. Ministry of Health and Family Welfare, Government of India. Available at: <https://esanjeevani.mohfw.gov.in>.
4. Rajkumar E, Gopi A, Joshi A, et al. Applications, benefits and challenges of telehealth in India during COVID-19 pandemic and beyond: a systematic review. *BMC Health Serv Res*. 2023;23(1):7. doi:10.1186/s12913-022-08970-8.
5. Bangla S, Kapoor A, Jeer G. Toward equitable digital health: an integrated framework addressing exclusion, ethics, and implementation across healthcare systems. *Int J Equity Health*. 2026. doi:10.1186/s12939-026-02554-3.
6. Anjana RM, Nitika S, Kuriakose S, et al. Digital divide in diabetes care: qualitative insights from the DIG-EQUITY study, India. *BMC Public Health*.

- 2026;26(1):1316. doi:10.1186/s12889-026-26999-w. PMID: 41832485.
7. Jameel S, Murthy GVS, George E, et al. 'Telehealth for all': capitalising on the power of virtual healthcare for persons with disability in India. *BMC Health Serv Res.* 2026. doi:10.1186/s12913-026-14947-8. PMID: 42310742.
 8. Rafi S. Artificial intelligence and telemedicine in elderly healthcare: A mixed-methods study. *BMC Geriatr.* 2026;26(1):71. doi:10.1186/s12877-025-06872-y. PMID: 41402744.
 9. Ummer O, Sarangi A, Khanna A, Mohan D, Scott K, LeFevre A. Lessons Learned From Over 20 Years of Telemedicine Services in India: Scoping Review of Telemedicine Services Initiated From 2000 to 2023. *J Med Internet Res.* 2025;27:e63984. doi:10.2196/63984.
 10. Huda RK, Chowhan RS, Seervi D. Effectiveness of mobile health technology-enabled interventions to improve management and control of hypertension and diabetes in India—a systematic review. *Prev Med Rep.* 2025;54:103094. doi:10.1016/j.pmedr.2025.103094. PMID: 40741543.
 11. Mandal S, Dhillon P, Das J. Telemedicine as a "digital umbilical" for maternal and reproductive healthcare: a qualitative study from health and wellness centers in rural West Bengal, India. *BMC Health Serv Res.* 2026. doi:10.1186/s12913-026-14916-1. PMID: 42402569.
 12. Jose AP, Kaushik A, Tange H, et al. Redesigning telemedicine: preliminary findings from an innovative assisted telemedicine healthcare model. *BMC Prim Care.* 2024;25(1):380. doi:10.1186/s12875-024-02631-x.
 13. Huda RK, Chowhan RS, Arora S, et al. Perceptions of healthcare workers and patients on the implementation of telemedicine in hard-to-reach areas: A qualitative study from Rajasthan, India. *Digit Health.* 2025;11:20552076251331874. doi:10.1177/20552076251331874. PMID: 40297354.
 14. An analysis of predictors and wealth-based inequality in internet use among women in India: aiming for better digital health outcomes. *BMC Digit Health.* 2024;2:38. doi:10.1186/s44247-024-00090-z.
 15. Srinivasan M, Mathew G, Mathew N, Kumar M, Goyal N, Kamath MS. Technologies that empower women for better access to healthcare in India – A scoping review. *Glob Public Health.* 2024;19(1):2318240. doi:10.1080/17441692.2024.2318240.
 16. Bridging the Gap: Exploring Gender Differences in eSanjeevani Adoption in Kerala. *IEEE Xplore.* 2025. Conference paper.
 17. George E, Jameel S, Attrill S, Tetali S, Watson E, Yadav L, Sood S, Srinivasan V, Murthy GVS, John O, Grills N. Telehealth as a Strategy for Health Equity: A Scoping Review of Telehealth in India During and Following the COVID-19 Pandemic for People with Disabilities. *Telemed J E Health.* 2024;30(6):e1667–e1676. doi:10.1089/tmj.2023.0609. PMID: 38436592.
 18. Zaiba H, Jayan V, Pradeep, et al. Digital Health Literacy and Care-seeking Behavior in Rural India: Evidence from a Community-based Mixed-methods Study in Karnataka. *Indian J Med Spec.* 2026;17(3):204–207. doi:10.4103/injms.injms_296_25.
 19. The Social Epidemiology of the Digital Health Divide: Mixed-Methods Evidence from Community Health Workers in an Aspirational District of India. Preprint. [Preprints.org](https://preprints.org). 2025. doi:10.20944/preprints202507.1082.v1.
 20. Parasuraman SM, Murali A, Panda P, Sruthi KG, Ranjan Mohanty J. Ethical challenges of digital health data collection and surveillance during the Covid-19 pandemic in India: a systematic

- review. *Ethics Med Public Health*. 2026. doi:10.1016/j.jemep.2026.101124.
21. Ranjan A, Singh G, Singh H, Singh M. Adoption, digital health literacy, and patient satisfaction of Ayushman Bharat Digital Mission: an analytical cross-sectional study among outpatient department attendees. *BMC Health Serv Res*. 2026;26(1):512. doi:10.1186/s12913-026-14314-7. PMID: 41787376.
 22. Lee JT, et al. Correcting Algorithmic Bias in Machine Learning Prediction of Healthcare utilization in India. Preprint. medRxiv. 2025. doi:10.1101/2025.09.07.25335256.
 23. Strategy for Artificial Intelligence in Healthcare for India (SAHI). Ministry of Health and Family Welfare, Government of India. February 2026. Available at: <https://www.pib.gov.in>.
 24. National Health Policy 2017. Ministry of Health and Family Welfare, Government of India. 2017. Available at: <https://www.nhp.gov.in>.
 25. Digital Personal Data Protection Act, 2023. Government of India. Enacted 11 August 2023. Available at: <https://www.meity.gov.in>.
- Cite this Article: Mahajan R, Gupta RK. Digital Health and Health Equity in India: Are Digital Interventions Leaving Vulnerable Populations Behind? *International Journal of Public Research in Medicine and Health*. July-September 2026 (2)3: 57-67. <https://doi.org/10.66328/ijprmh.2026.020306>