Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

Reproductive Autonomy of Women as a Human Right: An Empirical Study with special reference to the State of Punjab

Jaspreet Kaur

jrandhawaa2000@gmail.com

Lovely Professional University

Mandeep Kaur

Lovely Professional University

Research Article

Keywords: Reproductive Autonomy, Human rights, Women's Health, Punjab, Bodily integrity, Gender equality.

Posted Date: June 15th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-9557027/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License.
Read Full License

Additional Declarations: No competing interests reported.

Abstract

Reproductive autonomy is a vital part of women's human rights. It is closely linked to dignity, control over one's own body, equality, and health. International human rights frameworks recognise that women have the right to make free and informed decisions about their reproductive lives. These decisions should be made without pressure, discrimination, or fear. Although the Indian Constitution provides protection for women's rights, many women still face serious limitations when it comes to reproductive autonomy. Social expectations, lack of awareness, and legal and structural barriers continue to restrict women's choices. This paper explores reproductive autonomy as a human right through an empirical study carried out in selected urban and rural areas of Punjab. The study uses both legal analysis and field-based research methods. It examines constitutional provisions, statutory laws, international human rights instruments, and survey responses to understand women's awareness and decision-making power in reproductive matters. The findings show that reproductive rights are often understood in a very limited way. Important aspects such as contraception, informed consent, and access to reproductive healthcare are often overlooked by women. The study also highlights how education levels, family pressure, patriarchal attitudes, and state regulation strongly influence women's reproductive choices. The paper argues that reproductive autonomy can only be strengthened through a human rights-based approach in social work, meaningful legal reforms, and continuous awareness and sensitisation efforts. Such measures are essential to ensure that women in North India can truly exercise their reproductive rights.

Introduction

The recognition and enforcement of rights provide hope and assurance, emphasizing the need for awareness and protection. Rights are universally granted, although certain groups, such as women, receive additional safeguards. Globally, women have often been subject to control by male-dominated systems, limiting their freedom and autonomy. The Indian Constitution addresses this concern by prohibiting discrimination and providing specific protections for women against physical and sexual abuse (Shakuntala & Raj, 2020). However, such violations continue to undermine women's control over their bodies, particularly their reproductive rights, which include healthcare, family planning, and bodily privacy (UN, 1994). Cultural, religious, and societal norms, as well as crimes targeting women, further challenge their reproductive autonomy (Ajay Kumar, n.d.).

Reproductive autonomy refers to a woman's ability to make informed and voluntary decisions regarding reproduction, including decisions related to contraception, pregnancy, and childbirth (Cook, 1994). It is a foundational aspect of women's human rights, directly linked to dignity, bodily integrity, privacy, and equality (United Nations, 1979). In contemporary human rights discourse, reproductive autonomy is no longer viewed as a private or moral issue but as a matter of state responsibility and social justice (United Nations, 1995).

Despite India establishing legal frameworks ensuring access to abortion and contraception, women still face barriers such as inadequate healthcare and restricted decision-making authority (Merriam-Webster,

n.d.; Singh, 2012). Reproductive autonomy allows individuals and couples to make informed, free, and responsible decisions regarding the number, spacing, and timing of children without coercion or harassment (Centre for Reproductive Law and Policy, 1998). Women's reproductive freedom is crucial, yet coercion, forced sterilization, or pressures based on gender bias remain prevalent (WHO, 2013). Socioeconomic and cultural inequities further impede access to reproductive healthcare (NFHS-5, 2022; University of Delhi, 2000). Article 21 of the Indian Constitution and international instruments, such as CEDAW, protect women's rights to privacy, dignity, and informed reproductive choices (CEDAW, 1978). Although Indian law permits women above 18 to access abortion independently, practical implementation challenges continue to limit these rights (Sibasish, 2013).

Background

Reproductive autonomy is grounded in the broader framework of reproductive rights, which affirm individuals' freedom to decide whether, when, and how to reproduce (Cook, 1994). International human rights law recognises reproductive autonomy as an integral component of the right to health, equality, privacy, and freedom from discrimination (United Nations, 1979). The Convention on the Elimination of All Forms of Discrimination against Women obligates states to ensure women's access to healthcare services and decision-making related to reproduction (United Nations, 1979).

The recognition of reproductive autonomy evolved through global advocacy movements and international consensus-building processes. The International Conference on Population and Development marked a significant shift by framing reproductive decision-making as a human right rather than a demographic concern (International Conference on Population and Development, 1994). This approach was further reinforced by the Beijing Platform for Action, which emphasised women's control over their reproductive health as essential to gender equality (United Nations, 1995).

Reproductive autonomy extends beyond the right to abortion and includes access to contraception, reproductive healthcare, informed consent, and freedom from coercive medical practices such as forced sterilisation (World Health Organization, 2014). However, reproductive rights are frequently misunderstood and narrowly interpreted, leading to limited recognition of their broader human rights dimensions (Rao, 2004).

In the Indian context, reproductive autonomy is often compromised by intersecting factors such as gender inequality, socio-economic dependence, and cultural norms (Mahajan, 2019). Although legal frameworks acknowledge women's rights, societal expectations and familial pressures continue to undermine women's decision-making power (Rao, 2004). Understanding reproductive autonomy as a human right therefore requires not only legal recognition but also structural and social transformation to ensure meaningful autonomy for women (Cook, 1994).

Reproductive Autonomy as a Human Right

Reproductive Right is considered part of Human Rights not directly but being part of human rights principles such as liberty, dignity, health, privacy, equality, non-discrimination and freedom. As human right, these were already recognized in national laws, international human rights documents, and various treaties. For the first time, it was acknowledged by the International Conference on Population and Development (ICPD) in 1994. Every couple and individual have the fundamental right to choose the number and spacing of their children in a free and deliberate manner. One of the rights is to be aware of normal sexual and reproductive health. They also have a right to be free from discrimination, coercion, and violence. The issue of reproductive choice has been regarded as an indispensable aspect of "personal liberty". In *Suchita Srivastava v. Chandigarh Administration*, the SC established that a woman is entitled to make reproductive decisions including the right to give life or not as long as they fall within the structure of the Medical Termination of Pregnancy Act, 1971.

Reproductive health is described as "a state of complete physical, mental, and social well-being and not just the absence of sickness or bad condition" in the ICPD Programme of Action. Consequently, it addresses matters concerning the system, its functioning, and its process. Reproductive rights are born out of the established human rights protections. They are also essential in educating people about the range of fundamental rights. The Reproductive Rights Act expressly guarantees women's access to essential sexual and reproductive health information and services.

Legal and Constitutional Framework in India

In India, the constitutional basis for reproductive autonomy comes from Article 21, which guarantees the right to life and personal liberty. Over time, courts have interpreted this right to include dignity, privacy, and control over one's own body, all of which are essential for making reproductive choices (Suchita Srivastava v. Chandigarh Administration, 2009). In this landmark case, the Supreme Court clearly recognised that a woman has the right to make her own reproductive decisions as part of her personal liberty.

Reproductive rights are also regulated by the Medical Termination of Pregnancy Act, 1971. This law was a shift away from treating abortion as a crime under the Indian Penal Code. However, it still sets conditions and limits on pregnancy, which can restrict women's freedom to make decisions (Mahajan, 2019). These restrictions reflect the state's attempt to balance women's rights with the perceived interest in protecting fetal life (Rao, 2004).

The Judicial responses to reproductive autonomy have not always been consistent. Some court decisions support women's freedom to decide, while others emphasise family consent or societal norms, which can undermine individual choice (Mahajan, 2019). When compared to the U.S., Indian courts have been less willing to remove consent requirements that interfere with women's reproductive freedom (Rao, 2004).

India's obligations under international law also support reproductive autonomy. The treaties like CEDAW and the Beijing Platform for Action require the state to eliminate discrimination and ensure access to

reproductive healthcare (United Nations, 1979; United Nations, 1995). However, poor implementation and weak enforcement often prevent these obligations from being fully realised (Cook, 1994).

Overall, the legal framework shows a gap between formally recognising reproductive rights and actually ensuring that women can exercise them in practice.

Research Methodology

This study involved a mixed-method approach, integrating both doctrinal and empirical components. In the doctrinal method, relevant legal provisions, case laws, books, scholarly articles, reports were analysed. This provided the theoretical framework relating to reproductive autonomy.

On the other hand, the empirical part consists of an online questionnaire-based survey. This includes primary data from women across four major urban centres representing Punjab's regions: Amritsar (Majha), Chandigarh (Puadh), Ludhiana (Malwa), and Jalandhar (Doaba). The cities were selected in order to represent the entire state. The number of respondents were selected by applying Rule of Thumb. The collected responses were analysed using basic statistical tools to identify patterns and actual scenarios of reproductive autonomy. The factors such as age, education, job, and marriage were used to select the participants to represent various socio-economic groups both in urban and rural settings. The research involved married women between the age of 25–48 since they provided pertinent information about reproductive health.

Empirical Findings and Analysis

The empirical findings of this study are based on responses collected from women across different age groups, educational backgrounds, occupations, and rural-urban settings in Punjab. The analysis reveals that while legal and constitutional recognition of reproductive rights exists in India, women lived experiences continue to be shaped by patriarchal family structures, social expectations, economic dependence, and institutional practices.

Awareness of Reproductive Rights and Legal Frameworks

A majority of respondents stated that they had *heard* about women's reproductive rights. However, their explanations revealed varying depths of understanding. Educated respondents, particularly professionals and postgraduate women, were more likely to describe reproductive rights as encompassing the right to abortion, family planning, and access to healthcare.

One respondent explained that reproductive rights mean *"having full information, consent, and dignity in all reproductive health decisions."*

In contrast, several rural and semi-urban respondents expressed uncertainty or restricted reproductive rights only to abortion. A homemaker from a rural area openly stated that she was “not aware” of reproductive rights, while another respondent mentioned that she had “heard but does not know the details.” This reflects that awareness remains fragmented and uneven, often dependent on education and exposure rather than systematic rights-based dissemination.

Similar to how religious or cultural ideologies regulate women’s roles in patriarchal institutions, the lack of accessible legal knowledge places women in a position where their rights exist largely on paper, mediated through family members or health professionals rather than being directly exercised.

Understanding Reproductive Autonomy and Control Over One’s Body

When asked whether reproductive autonomy means control over one’s own body, most respondents agreed in principle. However, their lived experiences often contradicted this understanding. One young respondent agreed that autonomy means bodily control but later stated that she was “consulted but did not have the final say” in reproductive decisions. Another respondent acknowledged that although autonomy sounds empowering, “elders of the family usually decide.”

This contradiction highlights a critical finding: women may intellectually recognise autonomy but socially surrender it. Much like women in patriarchal religious systems internalise submission as virtue, many respondents appeared to accept restricted autonomy as a normal part of married life rather than a violation of rights.

Decision-Making Power in Family Planning and Childbirth

One of the most significant findings of the study concerns who actually makes reproductive decisions within families. One positive aspect of the responses is that couples decide on family planning together. As a result, partners communicate with one another to make decisions on their own. According to the data, a healthy relationship in which the husband and wife make decisions together is demonstrated by cooperative decision making. In addition, it might be summed up as follows: women have very little freedom and yet depend on others to make decisions about their own bodies. While a few respondents reported making decisions independently, the majority indicated that decisions were taken jointly or by husbands and elders. However, qualitative responses suggest that “joint decision-making” often masks unequal power relations.

A respondent from a semi-urban area shared that she was “involved in discussions but the final decision was not mine.” Another respondent stated clearly that “elders of the family take major decisions regarding childbirth.” Even among educated women, reproductive decisions were often negotiated within limits set by family expectations.

Pressure related to the timing of childbirth was also evident. Some respondents acknowledged being pressured to have children earlier than they wanted, while others admitted that although no one openly

forced them, they felt compelled to comply to maintain family harmony. One respondent described how refusing family expectations would “create tension and conflict at home.”

These findings resonate with the idea that coercion is not always explicit. Instead, it operates subtly through emotional dependence, cultural obedience, and fear of social disapproval mechanisms similar to ideological enforcement seen in patriarchal religious contexts.

Women’s Voice in Healthcare and Medical Decision-Making

Several respondents shared experiences where their opinions were ignored during medical consultations. One professional respondent narrated that treatment options were decided “without clearly explaining alternatives or seeking informed consent,” making her feel excluded from decisions affecting her own reproductive health.

Other respondents highlighted discomfort in visiting doctors freely, especially without family permission. Some admitted avoiding hospitals due to embarrassment, fear of judgment, or family pressure. A young respondent rated access to healthcare as difficult and stated that “sometimes it is easier to stay silent than to explain.”

This indicates that healthcare spaces, rather than being sites of empowerment, often reproduce power hierarchies. Similar to how religious authority monopolises interpretation, medical authority frequently sidelines women’s voices, treating them as passive recipients rather than rights-bearing individuals.

Social Norms, Stigma and Community Influence

An overwhelming number of respondents agreed that social norms and community expectations influence women’s reproductive decisions. Many admitted feeling judged for their choices related to childbirth, spacing of children, or family planning. One respondent explicitly identified “social stigma” as the biggest barrier to independent reproductive decisions. The majority of respondents appear to believe that community factors and societal norms have an impact on the unrestricted exercise of reproductive rights.

The results in this study show that the views on social problems have impact on the transaction of reproductive rights by the respondents such that a considerable proportion of them hold this view. The majority of respondents are influenced by these variables either on a regular or an infrequent basis. But the precise kind and degree of their impact can vary in accordance with individual outlook and society conditions. As seen in patriarchal religious institutions where doctrine legitimises male dominance, social norms in Punjab legitimise reproductive control by framing obedience, sacrifice, and silence as virtues of womanhood.

Economic Dependence, Education and Autonomy

Financial dependence emerged as a critical structural barrier. Homemakers and economically dependent women consistently reported lower autonomy and confidence. One respondent clearly stated that “education and earning capacity decide how freely a woman can exercise her reproductive rights.”

In contrast, professionally employed respondents reported greater confidence in discussing reproductive health, negotiating decisions, and accessing healthcare. Education was almost unanimously recognised as empowering, enabling women to question authority and seek information.

This reinforces the finding that reproductive autonomy is not merely a legal issue but is deeply tied to economic and educational empowerment.

Aspirations for Equality and Full Autonomy

Despite constraints, most respondents strongly supported the idea that women should have full reproductive autonomy and equal decision-making power with men. However, a few respondents expressed concern that men might “lose control” if women become aware of their rights, reflecting anxieties around shifting power dynamics.

While many believed that women today have more freedom than earlier generations, they described this progress as partial and uneven. Self-assessment scores of reproductive autonomies varied widely, indicating that autonomy is stratified across class, education, and geography.

Analytical Reflection

The empirical findings demonstrate that reproductive autonomy in Punjab exists primarily as an aspirational ideal rather than an everyday reality. Women’s bodies continue to be regulated through family authority, social norms, economic dependence, and institutional practices. Similar to patriarchal religious systems where doctrine legitimises male dominance, social and cultural norms in Punjab legitimise reproductive control by framing it as tradition, morality, and family responsibility.

Thus, reproductive autonomy cannot be realised through legal recognition alone. It requires sustained rights-based education, gender-sensitive healthcare practices, economic empowerment, and social transformation that challenge deeply embedded structures of control over women’s reproductive lives.

Fieldwork Reflections

During the course of fieldwork conducted for this empirical study on women’s reproductive autonomy in Punjab, researchers encountered multiple lived realities that revealed subtle yet persistent violations of women’s reproductive rights. While most participants were not subjected to overt physical coercion, the data clearly reflected systemic constraints operating through family structures, social norms, economic dependence, and information asymmetries. Before reflecting on the actions undertaken by the researchers in response to participants’ concerns, it is important to contextualise the socio-cultural setting within which these violations occur.

The fieldwork revealed that reproductive decision-making in Punjab is deeply embedded in patriarchal family arrangements, where husbands, elders of the family, or joint family systems often exercise decisive control. Although a significant number of respondents acknowledged awareness of women's reproductive rights in principle, this awareness rarely translated into actual autonomy in practice. Several participants reported that decisions related to family planning, spacing of children, or continuation of pregnancy were either taken by elders or negotiated in ways that limited women's final say. In rural and semi-urban areas in particular, social expectations regarding early childbirth, preference for family approval, and fear of social stigma continued to shape women's reproductive choices.

Researchers also observed that health-care settings, which are expected to function as sites of empowerment, often reproduced power imbalances. Some respondents shared experiences where medical decisions were taken without adequate explanation, informed consent, or respect for women's preferences. The reluctance of women to freely visit gynaecologists without seeking permission, avoidance of hospitals due to embarrassment or fear of judgment, and lack of transparent communication by health workers emerged as recurring concerns. These experiences indicate that institutional practices sometimes reinforce, rather than challenge, the denial of reproductive autonomy.

During interactions, a few participants actively sought guidance and support from the researchers. In response, researchers provided information regarding legal rights under the Medical Termination of Pregnancy Act, access to contraception, and available government schemes related to maternal health. Where participants expressed immediate needs or distress, researchers guided them towards appropriate institutional mechanisms, including public health facilities, legal aid services, and women-centric welfare schemes. Such referrals were made strictly based on the nature of the concern expressed and with respect for participants' consent and comfort.

However, it was equally notable that some participants normalised restrictions on their reproductive autonomy. A few respondents expressed the belief that family pressure or limited choice was a natural and inevitable part of womanhood, particularly within marriage. Others indicated that while they personally lacked autonomy, they accepted this arrangement as necessary for family harmony or social acceptance. Researchers respected these perspectives, recognising that autonomy cannot be imposed externally and must be understood within individuals' own social and emotional contexts.

Overall, the fieldwork highlighted that violations of reproductive autonomy in Punjab are not always dramatic or visible but are often embedded in everyday practices, silence, and internalised norms. The reflections from the field underscore the gap between legal recognition of reproductive rights and their realisation in women lived experiences. These observations reinforce the need for sustained rights-based education, gender-sensitive health-care practices, and social work interventions that empower women while engaging families and communities in transformative dialogue.

Recommendations for State

This study proposes several recommendations for state and non-state actors in Punjab to strengthen women's reproductive autonomy as a fundamental human right. The Government should strengthen the implementation of reproductive health policies and ensure that women have easy access to family planning services, contraceptives, maternal healthcare and safe abortion facilities under the Medical Termination of Pregnancy Act. Particular attention should be given to rural and semi-urban areas of Punjab where awareness and healthcare accessibility remain uneven.

Social workers employed by government and non-governmental organisations should undertake sustained community-based awareness and advocacy programmes to enhance understanding of reproductive rights beyond their limited association with abortion (UN, 1994; CEDAW, 1979). Given their community-oriented professional role, social workers should promote informed consent, contraceptive choice, access to reproductive healthcare, and bodily autonomy through platforms such as community health centres, Anganwadi services, and women's self-help groups (WHO, 2013).

The Government of Punjab, through departments such as Health and Family Welfare and Women and Child Development, must ensure effective implementation of constitutional protections under Article 21 and statutory frameworks such as the Medical Termination of Pregnancy Act, 1971, as amended. Monitoring mechanisms should be strengthened to address coercive practices including forced pregnancies, denial of contraceptive access, sex-selective pressures, and reproductive violence within marital and familial settings (NFHS-5, 2022). Where violations are identified, timely legal action is necessary to ensure accountability and deterrence (Shakuntala & Raj, 2020).

Healthcare institutions and frontline workers should receive regular sensitisation and training to deliver reproductive healthcare using a rights-based and non-judgmental approach that prioritises consent, confidentiality, and privacy (CEDAW, 1979; Sibasish, 2013). Strengthened collaboration among social workers, healthcare providers, legal aid authorities, and local governance institutions is essential to identify women facing reproductive coercion and facilitate access to justice and support services (Centre for Reproductive Law and Policy, 1998).

Finally, the deployment of trained social workers at the community level, particularly in underserved and rural areas of Punjab, is crucial for identifying violations, assisting affected women, and promoting reproductive autonomy as an integral component of personal liberty and human dignity (WHO, 2013).

Implications for future research

Given that the present study was limited to married women aged 25–48 years residing in four major urban regions of Punjab – Majha, Malwa, Doaba, and Puadh – future research should extend to rural and semi-urban areas to capture region-specific variations in reproductive autonomy. Further studies may also include unmarried women, adolescents, older women, and marginalized groups to examine how age, marital status, education, economic dependence, and social norms intersect to shape reproductive decision-making related to pregnancy, contraception, and broader reproductive health issues. The limited understanding of reproductive autonomy observed among respondents highlights the need for

qualitative and mixed-method approaches to explore women lived experiences, perceptions of consent, and negotiation of choices within familial and social contexts. Longitudinal research and studies assessing the impact of legal literacy, social work interventions, and community-based rights education would further contribute to bridging the gap between legal recognition and the lived realities of reproductive autonomy.

Conclusion

This study shows that reproductive autonomy is a fundamental human right. It is closely connected to women's dignity, health, and equality. Although Indian laws and the Constitution recognise reproductive autonomy, the reality is different. The evidence from the State of Punjab shows ongoing gaps in awareness, access to services, and women's ability to make their own reproductive choices. The Supreme Court, in *Suchita Srivastava v. Chandigarh Administration (2009)*, affirmed reproductive autonomy as a constitutional right, yet many women still struggle to exercise it in practice. A major challenge is the misunderstanding that reproductive rights only relate to abortion. Social expectations, family pressure, and restrictive legal practices further limit women's freedom to decide about their own bodies.

The study highlights the need for stronger legal reforms, better education, and rights-based social work practices. These steps are necessary to close the gap between legal recognition and actual implementation. Strengthening reproductive autonomy is essential for protecting women's human rights and promoting social justice in India. Ongoing tensions between women's rights and foetal interests, along with limited access to quality reproductive healthcare, show the need for balanced and rights-affirming approaches.

Recognising reproductive autonomy as a human right requires more than laws alone. It calls for effective policies, social change, and empowerment at the community level. By combining real-world findings with human rights principles, this study offers a clearer understanding of the challenges surrounding reproductive autonomy in India. Improving awareness, access, and women's decision-making power is crucial to ensure that women can exercise meaningful reproductive choices and advance human rights and social justice in Punjab.

Declarations

All authors confirm that the study was conducted in compliance with relevant ethical and academic guidelines. The authors take full responsibility for the content of this manuscript.

Acknowledgement of People

The authors sincerely thank all the women participants from Amritsar, Chandigarh, Ludhiana, and Jalandhar for their valuable time and honest responses, as well as the academic mentors and colleagues who provided guidance and support during the design and execution of this research.

Author Contributions

Both authors jointly contributed to the conceptualisation, data collection, analysis, and writing of the manuscript. After the initial draft was prepared, both authors critically reviewed, revised, and approved the final version of the manuscript. The manuscript was proofread multiple times by the authors to ensure clarity, accuracy, and consistency.

Funding

The study was conducted using the author's own academic and institutional resources.

Data Availability

The data supporting the findings of this study are available from the authors upon reasonable request. However, the data are not publicly available as they contain sensitive information. Access to the data will be granted in accordance with ethical research standards.

Ethical Approval

The ethical approval for this study was obtained from Lovely Professional University, Punjab (India), prior to the commencement of data collection. All research procedures were carried out in accordance with approved ethical standards.

Consent to Participate

All authors were actively involved in every stage of the research process, including the design of data collection tools, data collection, analysis, and manuscript preparation. Their participation in the study was entirely voluntary.

Informed Consent

Informed verbal consent was obtained from all participants before their inclusion in the study, and participants were clearly informed about the purpose of the research. The participants were also made aware of their right to withdraw from the study at any stage without any consequences.

Conflicts of Interest

The authors declare that there are no conflicts of interest related to this study. The authors affirm that the research was conducted with complete academic independence and integrity.

References

1. Bhoite, S. V. (2021). *Reproductive rights of women with special reference to right to safe abortion in India: Problems and perspectives* (Unpublished Ph.D. thesis). Savitribai Phule Pune University. http://hdl.handle.net/10603/470624

2. Cook, R. J., Dickens, B. M., et al. (1996). *Reproductive health and human rights: Integrating medicine, ethics and law*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199241323.001.0001
3. Government of India. (2022). *Annual report 2021–22, Department of Health & Family Welfare, Ministry of Health & Family Welfare* (pp. 107–108).
4. International Conference on Population and Development. (1994). *Programme of action* (Chap. VII, UN Doc A/CONF.171/13).
5. Kumar, A. (2010). Institution of marriage – Judicial approach. *All India Reporter*, 97(AIR 6).
6. Ministry of Health and Family Welfare, Government of India. (2019–2021). *National family health survey (NFHS-5) – Compendium* (p. 5).
7. Samyak, S. (2013). The issue of reproductive rights in India: How is it different from other societies? *Journal of Indian Law and Society (JILS)*. https://jilsblognujs.wordpress.com/2013/03/24/the-issue-of-reproductive-rights-in-india-how-is-it-different-from-other-societies/
8. Shakuntala, & Raj, O. (2022). Constitutional and criminal perspectives of women's reproductive rights. *Indian Journal of Integrated Research in Law*, 2. https://ijirl.com/wp-content/uploads/2022/09/CONSTITUTIONAL-AND-CRIMINAL-PERSPECTIVES-OF-WOMENS-REPRODUCTIVE-RIGHTS.pdf
9. Srivastava v. Chandigarh Administration, AIR 2010 SC 235.
10. United Nations. (1979, December 18). *Convention on the elimination of all forms of discrimination against women* (GA Res 34/180, UN Doc A/RES/34/180).
11. United Nations. (1994, September 5–13). *Programme of action adopted at the International Conference on Population and Development, Cairo*.
12. World Health Organization. (2013). *Global and regional estimates of violence against women*. WHO.

Figures

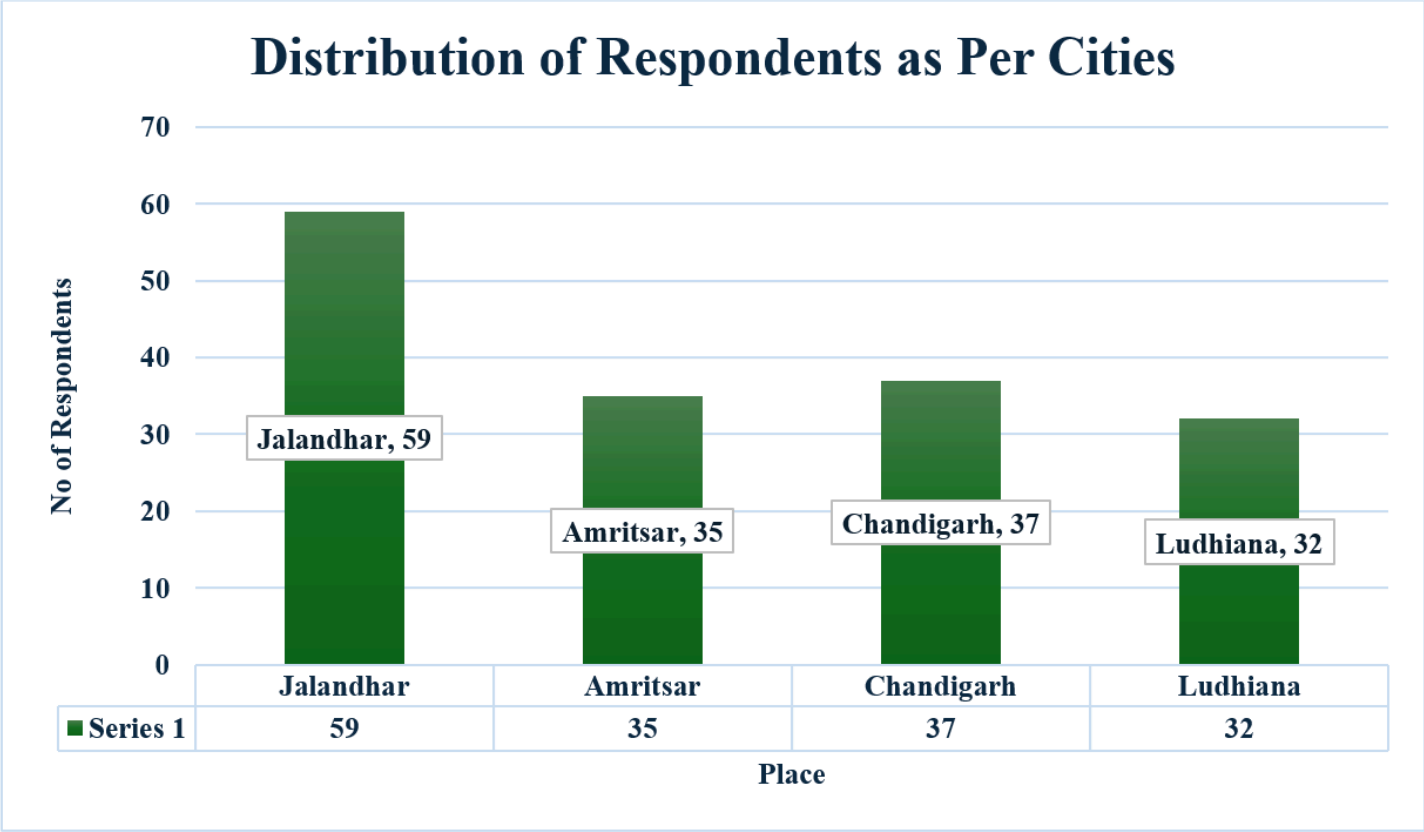


Figure 1

Distribution of Respondents as per Cities

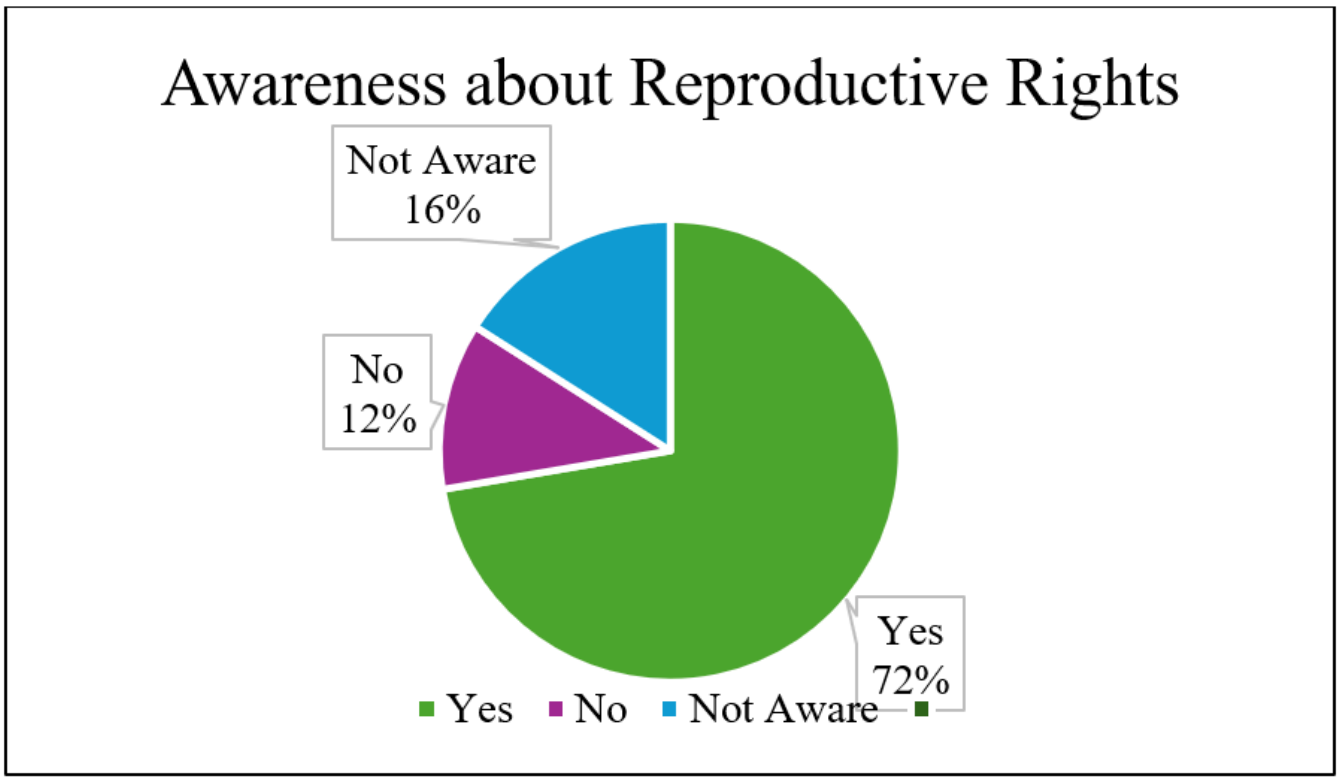


Figure 2

Awareness about Reproductive Rights