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Reproductive health of women in India: A sociological and legal overview

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Abstract---Women's health, including sexual and reproductive health, is integral to that of the whole person. The freedom to choose and decide on one's own life's path, including whether or not to have a family and when to start a family, hinges on this. Access to correct information, effective and inexpensive methods of contraception, and timely services and support in response to unexpected pregnancies are all components of reproductive health that go beyond just physical well-being. However, there is still a lack of familiarity with reproductive health services among policymakers, programme managers, and the general public in India, despite the fact that the Indian government has reaffirmed its commitment to the values of the 1994 International Conference on Population and Development. The present paper's major goal is to examine the current social and legal impediments in India that are affecting women's health and well-being as well as to provide strategies for overcoming those barriers.

Keywords---abortion, family planning, human rights, reproductive health, surrogacy.

Introduction

Human health, economic growth, and global prosperity all depend on individuals having access to reproductive health care and the protection of their Sexual and Reproductive Health Rights (SRHR). As a result of international agreements, governments have pledged to spend money on SRHR. An absence of a democratic

will, inadequate resources, persistent prejudice towards women and girls, as well as reluctance to discuss sexuality problems openly and comprehensively have all hampered development. Sexually transmitted illnesses like HIV, gender-based violence, and other issues connected to the reproductive organs and sexual behavior disproportionately impact poor women, particularly those living in developing nations. The incorporation of SRHR into Sustainability Development Goals (SDGs) and international policy tools mandates the acknowledgement of reproductive health in the context of human rights and compels nations to guarantee its fulfilment. As the home for one-sixth of the world's population and a signatory to the 2030 Agenda for Sustainable Development, India has a responsibility to protect the rights to sexual and reproductive health. There is a lot of room for improvement in this area with the current laws and regulations in India that pertain to SRHR. Particularly women from underprivileged groups have been subjected to severe breaches of their right to bodily autonomy and their access to sexual and reproductive health care.

The technique of delivering reproductive rights has long been controversial, despite widespread agreement on the importance of such rights to a person's right to life. Abortion and menstruation leaves are only two examples of how contemporary society, to some extent, has acknowledged women's rights but has failed to consider the basic human rights of other marginalised groups. This, however, may not always accord with local laws as a current definition of feminism states, "equity between all genders and sexualities". Although the concept of a non-binary society is gaining popularity, it is important to incorporate this understanding into our legal system. The goal of this article is to not just limit the discussion around reproductive rights of women but also include members of other underrepresented groups, such as those who identify as transgender or who are not of the heterosexual orientation.

Materials and Methods

Keeping in view the nature of the problem, an analytical method shall be adopted. In accordance with the said method, attempts shall be made to use facts and information already available and analyze them to make a critical evaluation of the problem. While analyzing specific controversial issues, which often arise, conceptual methodology shall be adopted, which is generally used to develop new norms or to re-interpret existing ones.

Based on the findings of this analysis, it is clear that there is a pressing need to increase community-based education devoted to the particular concerns related to women's reproductive health as well as the wider issues related to women's entitlement to high-quality health care services. Raising knowledge about the risks of unsafe abortion and the provision of safe abortion services would benefit household decision-makers, including men and women. Community-based education programmes should prioritize reaching young women and rural poor who have fewer options when it comes to reproductive health services. The researcher has relied upon various newspaper articles, academic journals and various data collected by the Ministry of Health and Family Welfare, Govt. of India to conduct this study.

Result and Discussion

Need for Sexual and Reproductive Health Rights (SRHR) in India

Numerous public demonstrations, requests for stronger legislation, and appeals for speedier enforcement of laws have sprung up in response to recent horrifying incidents of rape throughout India, suggesting a shift away from politically careful debates and neglect of sexual assault on national forums. To better the reproductive health of the people of India, several issues related to reproductive health must be addressed. “78% of the 15 million abortions in India take place outside medical facilities” (Thomas, 2017). Studies show that almost 30,000,000 married women of childbearing age do not have access to modern methods of contraception (Thomas, 2017).

As per a fact sheet, just 52% of pregnant teenagers in India go to the minimum of four prenatal care visits suggested by experts, and 78% of abortions on teenagers are unsafe, increasing the risk of complications. Also, 190,000 teenagers do not get the care they need after having an unsafe abortion. (Rashtriya Kishor Swasthya Karyakram, 2015) Historically, the Indian state's strategy towards reproductive rights has prioritized population control above encouraging individual autonomy and reducing structural barriers to reproductive health care, as shown by a national case study. This has shifted attention from ensuring everyone has access to reproductive health care generally, including abortion and contraception, to achieving centralized goals of population management (Santhya & Jejeebhoy, 2013).

Despite international regulations and well-established health consequences, Gender Based Violence has continued to remain a vital issue within India's public health system, where it is largely viewed as a law-and-order issue, according to a country evaluation on reproductive health and well-being conducted on behalf of the National Human Rights Commission (Jain & Tronic, 2019). Due to high rates of both unplanned fertility and maternal mortality, there is a significant need in India for access to safe abortion services. Unsafe abortions are the third largest cause of maternal mortality, killing an average of 13 women per day (National Programme for Family Planning, 2018).

Implementation of reproductive rights and choices in India: Social Context

There is a considerable presence of grassroot NGOs in India that are working to ensure women's rights and freedom of choice. On the contrary, many women continue to experience societal and family barriers that make it difficult for them to make and implement choices about their reproductive health. In particular, evidence points to a persistent preference for sons. 85% of females desire to have at least one boy, and 33% would prefer to have more sons than girls. It is important to keep in mind that although reproductive autonomy is a very personal issue, in Indian culture, the choice is made as a family unit. Careful consideration is required before extrapolating such rights to the social context of India.

Consent of Spouse for abortion and sterilization

Articles 12 & 16 of the Convention on the Elimination of all Forms of Discrimination Against Women provide women with the right to make autonomous and voluntary choices regarding their health care and medical treatment, including those regarding their fertility and sexuality (1978). Fundamental ethical considerations in delivering reproductive health treatments include respect for the individual's autonomy, the right to informed consent, and the maintenance of patient confidentiality. In addition, if a mentally capable adult were to seek medical care without the involvement of a third party, this would be considered a kind of autonomy.

Even the word "consent" has been narrowed down to apply solely to the individual directly affected by the study; when both spouses are engaged, it is mandatory to have "partner agreement" status, following contemporary ethical standards in reproductive health research. In this regard, Supreme Court's decision on Ghosh vs. Ghosh case, ruled on March 26, 2007, stated that *"If a husband submits himself for an operation of sterilization without medical reasons and without the consent or knowledge of his wife and similarly if the wife undergoes vasectomy (read tubectomy) or abortion without medical reason or without the consent or knowledge of her husband, such an act of the spouse may lead to mental cruelty."* (Samar Ghosh v. Jaya Ghosh, Appeal (civil) 151 of 2004. Supreme Court of India)

Refusing to have intimate intercourse with one's spouse and making the choice to forgo having children on one's own were both deemed to be acts of mental cruelty by the court. The court decided to grant the divorce because of the unique circumstances. Because it requires spouse permission for induced abortion and sterilisation, the verdict might have far-reaching effects on reproductive health care in India. The decision runs counter to the standards now in place for medical care, and it is sure to cause confusion among both patients and medical professionals. It suggests that a husband might use a wife's decision to have an abortion or be sterilised without his knowledge or permission as grounds for divorce on the basis of mental cruelty. This ruling goes to the heart of reproductive rights, which include the freedom to make a choice and get care without facing threats of violence or coercion. As a result, many service providers are likely to be on high alert to avoid any potential legal trouble. This decision might be used by many medical facilities to institute a policy of requiring both partners' permission. In order to prevent legal issues, suppliers in the public sector may also need a spouse's signature. When it comes to protecting and advancing human rights, particularly those of women, the nation's top court needs to show more compassion and dedication (Rajlaxmi, 2007).

Reproductive Rights in Mentally Retarded Women

A girl-child with a disability in India is often treated with disdain and disdainfully ignored. Women who have impairments have historically been denied basic civil liberties. A mentally disabled orphan girl, aged 19, was raped on the grounds of the government-run shelter for homeless women at Nari Niketan, Chandigarh, in March 2009. In May 2009, a positive pregnancy test was finally received (Mahabal, 2009). A total of 4 doctors forming a Multi-Disciplinary Medical Board

along with a psychiatrist suggested that the woman “has the adequate physical capacity to bear and raise the child but that her mental health can be further affected by the stress of bearing and raising her child” (Mahabal, 2009). With these findings in mind, the Punjab and Haryana High Court ruled to mandate abortions be terminated medically (MTP). The Supreme Court (SC) of India allowed a 19-year-old mentally disabled orphan girl to continue with a pregnancy that resulted from a sexual assault, in a historic ruling that followed an NGO’s appeal of a High court’s verdict. As a result, this case brought up some very important questions about the nature of consent and the kind of assistance that should be provided while evaluating it. The present study’s issue is not about abortion in itself, but rather whether or not the law in this nation recognises and protects a woman’s agency to make choices about her life and body, including all of its subtleties whether the woman seems to be an individual with mental retardation (MR) or any other impairment. (Clarke, 2009)

The Medical Termination of Pregnancy Act (MTP) incorrectly differentiates between women with mental retardation and women with mental illness, taking the former completely out of the equation. Additionally, the Act fails to recognise that both of these types of women are more likely than not to be poor, making guardianship a complex issue. Since the Supreme Court of India has decided to allow the pregnancy to continue but hasn’t addressed the responsibility of the state to provide her with “comprehensive and reliable support systems” within a rights framework, as required by Article 12 of the United Nations Convention on the Rights of Persons with Disabilities, the state has breached its duty to her (Dierde & Singh, 1995). This case makes it abundantly clear that India’s legal system has to be significantly upgraded in order to bring it into compliance with international law. It also begs the issue of whether or not our government structures are secure enough to safeguard women and, much more so, individuals with disabilities (Clarke, 2009).

Evaluation of reproductive rights and choices in India: Legal Context

The purpose of law in any legal system is to protect citizens from oppression and injury, as well as to discourage and punish illegal activities. In India, national courts and legislators have played a crucial role in overturning discriminatory criminal laws, such as those that might have adverse impacts on a person’s health (Dierde & Singh, 1995).

Section 312 of the Indian Penal Code

Despite the fact that the IPC 1860 has been the subject of several publications on abortion, its provisions were never meant to give guidance as to how abortions must be carried. Due to a lack of legislation, many abortions were performed illegally during this time, endangering the well-being of the women who sought them (Panchauri & Subramanyam, 1999). This provision is still in effect and was most recently referenced on August 7, 2014, in Smt. Sumita Mukherjee vs. The State of Madhya Pradesh, where the defendant appealed to the High Court. The High Court ruled that lower courts should have considered the possibility that the prosecutrix’s miscarriage had been induced in good faith to preserve her health.

Therefore, the petitioner could not be prosecuted under Section 312 of the IPC (Panchauri & Subramanyam, 1999).

Despite the importance of this provision, no corresponding laws have been enacted. This demonstrates a lack of data on the actual state of affairs. Women are generally unable to tell authorities about the abuse they suffer, typically at the hands of their own or their in-laws' families, hence forced miscarriages carried out by hunger, torture, or other cruel tactics often go unacknowledged (Paulson, 1998).

Provisions on Medical Termination of Pregnancy

To some extent, the Medical Termination of Pregnancy (MTP) Act of 1971 in India can be regarded as the country's first abortion law. It established criteria for who is eligible for abortion and detailed where that procedure may be carried out lawfully. Within twelve weeks of the Act's enactment, the woman was required to obtain the written permission of a single licenced physician. If the duration of the pregnancy is more than twelve weeks, two doctors will be needed. The "sine qua non" of this law was the "good faith" requirement, which meant that even if a woman planned to abort her own pregnancy, a danger to her physical health was among the key considerations in deciding whether the abortion would be approved. Other cases in which abortion may be granted were:

- When pregnancy is caused by rape,
- If a married woman and her husband's attempt to reduce their family size via the use of a contraceptive device or technique fails, they may be held legally responsible for any resulting pregnancy (Paulson 1998).

The law specified that no one under the age of 18 or legally classified as insane may have their pregnancy terminated without permission from their legal guardian and that abortions could only take place in government-run hospitals or other facilities specifically designated by the government. The statute required that a woman's right to confidentiality be upheld. Nonetheless, it was subsequently determined that the criteria for the same were unclear (Stanley & Susheela, 1999).

This Act was a beacon of hope in a seemingly endless tunnel, but it ultimately fell short of its intended purpose of eliminating illegal abortions. It ignored the full extent of executive failure by relying on vague "guidelines" rather than giving women complete control over their bodies. Because of this, the law is unable to grant the necessary relief in situations when the cause for the pregnancy does not fit within the provided subgroups, such as when a married woman does not want to have children. This revealed the sexist attitudes prevalent in Indian society, where women are only allowed to terminate a pregnancy if they have "enough children". (Paulson 1998)

The MTP Act, 2003, clarified and updated the preceding Act. This law was enacted with the intention of reducing the risk of an unintended pregnancy termination by limiting access to advise on the issue from unlicensed medical professionals. However, terminations may still be performed with the advice and authorization of

a licenced medical professional. To achieve this goal, the procedures for cancelling or reviewing an approved certificate were outlined, along with the training & experience requirements for such doctors, the criteria for approving facilities at which the procedure could be performed, and the means by which such facilities could be inspected. There was an improvement in women's security which was really appreciated. However, the Act failed to recognise transgender women. The Act is only available to transgender women due to the blatantly sexist language used in Indian law. The law is silent on men who identify as transgender but have opted out of surgery or hormone therapy. Therefore, they may be biologically capable of fatherhood but have decided against having an abortion. People who identify as intersex get likewise excluded from these laws. Because of this, not only was abortion illegal in many areas, but reproductive healthcare was also unavailable.

The MTP Act of 2021, like its predecessors, is limited in its application because of its reliance on the term "women", which means that transgender persons and members of other gender minorities are not eligible to receive its protections; keeping in mind that trans people in India are subject to extreme levels of violence, including rape and sexual assault. If a transgender or intersex person conceives in such a situation, they would be left with fewer options than a cisgender woman would. Cases like *Suchita Srivastava v. Chandigarh Administration* as well as *ABC v. Union of India* (2017) have examined the importance of bodily autonomy in relation to this Act at length. For certain categories of women, the Act establishes an additional maximum gestational age cap of 20 to 24 weeks, as detailed in the MTP Regulations. Those who benefit from the adjustments are not limited to women who have experienced violence (such as those who have been the victims of rape or incest) or those who are otherwise at risk (such as women with disabilities or children). One medical professional's opinion is sufficient up to the 20th week of pregnancy. Although not perfect, this is an improvement over the prior acts. And now, unmarried women may have abortions for "failure of contraception", which is a huge step in the right direction.

Laws on Surrogacy

It is important to remember that although commercial surrogacy is illegal in India, altruistic surrogacy is tolerated. This is done to prevent surrogacy as a means of human trafficking. The legislation specifies the requirements for the "intending pair" in which surrogacy may be used. Again, the use of binary words in this law has the effect of excluding the queer community; for example, a non-binary person does not qualify as an "intended parent", even if they are physiologically capable of carrying a kid and hence cannot use a surrogate to have a child. Although both sexes lie inside the binary of the gender spectrum, the Bill discriminates against gay couples in the same way as adoption laws do.

'Rights' v. 'Health': Convergences and Divergences

Recently, the international 'rights and health' discourses have begun to merge. For example, violence against women is now recognised as a public health and women's rights concern. Women's rights are at stake because gender-based violence undermines their fundamental right to be treated as equals in all aspects

of society. Women's physical and mental health is negatively impacted by violence as well. Mental health issues, drug misuse, physical harm, STDs, homicide, and suicide are all exacerbated by violence against women. Furthermore, women's authority over their bodies is diminished as a result of violence.

Key players in India, including campaigners and legislators, continue to perceive violence as just an issue of women's rights rather than a health problem. According to the data presented, rape and domestic abuse are responsible for the premature death of about one out of every five reproductive-aged women (15-44 years). Unwanted pregnancies decreased access to contraception, increased risk of sexually transmitted diseases, including HIV, and a decrease in women's sexual autonomy both within and outside of marriage are all associated with violence against women. It is fascinating that women aren't given the option to say no to conjugal sex, but men are seen as having a "right" to unlimited sexual access to their spouses after they are married. Similar to how forced sex inside a marriage is not considered rape as per legal interpretations.

Many aspects of maternal care policies and programmes are impacted by the current way in which health and rights are seen as being separate, unrelated realms. As a starting point, we may say that women's health professionals do not often address topics like gender-based violence. Until violence is recognised as a health concern, the health sector will not be able to play the crucial role it can in resolving the problem.

Rights and health are typically seen as opposites rather than complementary, even in the sphere of sexual and reproductive health. In December 1998, a physician sued a reputable private hospital for damages after telling his fiancée's family that he was HIV positive. Because of this, his wedding plans were scrapped. The Supreme Court of India found that the hospital had not broken any confidentiality or privacy rules by disclosing his medical history to his wife. Furthermore, the court found that those living with HIV will not have an absolute right to be married. Although this is an important point, it is not central to the debate over whether or not an HIV-positive person's right to privacy should take precedence over the right of others to know about a potential threat to their health. The problem is that the court improperly weighed rights against health considerations (Stars, 1998).

Another example is the government's efforts to prevent the spread of HIV among sex workers. This is done not because of any belief in the inherent dignity of sex workers to excellent health, but rather so that the customers of those employees may also enjoy that health. Therefore, despite the state's provision of health facilities for sex workers, it also often arrests them for soliciting, thus violating their freedom to make a livelihood. Therefore, extensive ongoing campaigning is required to raise politicians' awareness of the interconnectedness of health and rights. Otherwise, we will have a system of backward health policies that habitually violate human rights, all in the name of improving public health. In the most general sense, India's development during the previous half-century has seen a shift from a "needs" perspective to one focused on economic expansion. The idea of rights has always been lacking from this image. While the government claims to care about its people and work to address their concerns, the issue of

citizens' rights is seldom discussed. This leads to an inaccurate image in which 'too many people' are blamed for poverty rather than the inequitable allocation or distribution of resources (Thomas, 2007).

Steps towards empowering women's rights to reproductive health

Unwanted pregnancies, unsafe abortions, and maternal mortality and morbidity that might have been prevented are all consequences of insufficient reproductive health care for women. Violence against women, especially damaging cultural practices like female genocide, takes a high toll on women's health, well-being and social engagement. In addition to contributing to the perpetuation of inequality, the violence of any kind may act as a barrier to a woman achieving her reproductive potential. When it comes to reproductive health, men have their own set of concerns and requirements, and men's participation is crucial to ensuring the safety of women's reproductive rights. Women are better equipped to manage their lives and have children without risk when they have access to reproductive health care. Moreover, it safeguards their health and makes it easier for them to join the society and find gainful jobs.

Reproductive health is not only a women's concern; it is a family's and a community's concern as well. A gender viewpoint suggests also that organisations and communities embrace more equal and inclusive practices. Women, as the major recipients of reproductive health care services, must have a voice in shaping and implementing policies and programmes. Policymakers need to evaluate the consequences of their policies on men and women as well as how gender roles promote or obstruct projects and development towards gender equality (Stanley & Susheela, 1999). Reproductive health care must include the following aspects:

- Strong government backing for family planning and service providers that are knowledgeable, culturally aware, attentive, and courteous are all essential elements. Cost-effective services and several options for birth control are provided—discreet counselling to provide informed consent in contraception choice; clean, pleasant facilities; timely service.
- Treatment for complications like bleeding, infection, high blood pressure, and obstructed labour should be readily available as part of any safe motherhood initiative. Interventions that might save lives, such as suggesting people to visit hospitals; a network of local organisations working together to get patients to hospitals quickly; counselling on breastfeeding, new-born care, cleanliness, vaccines, family planning, and maintaining excellent health, as well as identifying and treating postpartum disorders.
- Abortion and Post-abortion Care - Abortion is a major problem in the field of public health. Abortions are avoided, and the number of unplanned pregnancies is reduced because of family planning programmes. Safe abortion procedures and good post-abortion care would drastically cut down on maternal death rates in countries where abortion is legal.
- Prevention and treatment of STDs and HIV/AIDS: Women are more likely to get sexually transmitted diseases than males due to biological and cultural reasons. Through the distribution of female and male condoms, the diagnosis and treatment of STDs, and the creation of contact tracing and

prevention plans, the combination of family planning and STD/HIV/AIDS services among reproductive health services might reduce the rates of STDs, including HIV/AIDS (Stanley & Susheela, 1999).

- Involvement of men in Reproductive Health Programme: Increasing male participation in reproductive health choices will increase rather than decrease women's agency. All family members' happiness is a shared priority. Men may help promote gender equality and strengthen their families by doing things like looking after their spouses' health and standing by them when they make life decisions. Examples include thinking about using male-preferred methods of contraception, talking openly about reproductive health issues, and working together to find answers. Women will benefit from understanding how to address potential threats to their reproductive health, such as - sexually transmitted infections, infertility, erectile dysfunction, aggressive or abusive behaviour, refusing to engage in any kind of violence towards women, being a good parent; health and education will benefit from efforts to achieve gender parity.

Conclusion

Change in society is challenging in general, but it is especially problematic when it affects fundamental gender roles at home and in society. There is a rising awareness that the rules controlling men's and women's access to resources, social standing, and actions may make or break the possibility of rapid progress and equity. Providing a better life for women and men in the age of globalisation and urbanisation requires local solutions that are compatible with local customs and situations and are based on a shared vision of justice including gender equality.

Reproductive health and access to reproductive health care is a social and health concern for all members of society, not just women. The welfare of the family and the individual is the ultimate goal of the right to reproduction. Governments have an obligation to provide citizens with high-quality reproductive health services, as well as to safeguard citizens' freedom to choose their reproductive outcomes while also taking into account regional and cultural norms and preferences. Safeguarding the reproductive rights of persons with disabilities, particularly those with mental retardation or mental illness, requires a heightened sensitivity on the part of the court and political systems. There is also a growing need for the legal system to be educated about the abortion consent procedure. Active community engagement and involvement of males are necessary to guarantee optimal reproductive health care.

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