BLOCK 5
HEALTH LAW

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THE PEOPLE'S
UNIVERSITY

UNIT 17 REPRODUCTIVE HEALTH

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17.1 INTRODUCTION

Reproduction is a realm that is closely associated with biology while the law is conceptualised as an instrument to regulate the social realm. In the first instance, therefore, the concern of law with reproduction would appear to be counter intuitive. However, a deeper look into violations such as forced sterilisation of women, female genital mutilation, criminalisation of abortion and forced pregnancies would reveal that the realm of the biological has never been autonomous from the prevalent patriarchal social mores. Human Rights Law Network (2019), Claiming Dignity: Using Law to Advance Reproductive and Sexual Health Rights. Around reproductive health, therefore, have the potential not only act as a deterrent against reproductive coercions but also facilitate the growth of social awareness around matters related to reproductive health. The contemporary development agenda recognises the centrality of reproductive health to women's empowerment and gender equality. SDG 3 envisions that by 2030 interventions must be made for 'universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. Moreover, the UNDP which measures gender inequality among countries using its Gender Inequality Index (GII) looks at 'Female Reproductive Health Index' as one of the three indices for computation of the GII value. It is therefore not surprising that reproductive health would emerge as an important matter of concern for all such countries which espouse to promote gender equality. In this unit, we will try to understand the concept of reproductive health and reproductive rights. What are the debates related to reproductive healths emerges as an important issue in human rights law. What is the role of courts in ensuring access to reproductive rights, especially in the Indian context?

17.2 LEARNING OUTCOMES

After studying this Unit, you should be able to:

- Comprehend the concept of reproductive health and reproductive rights
- Understand how reproductive health emerges as an important issue in human rights law
- Assess the role of courts in ensuring access to reproductive rights, especially in the Indian context.

17.3 WHAT IS SEXUAL AND REPRODUCTIVE HEALTH (SRH)?

The growing popularity of the concept of 'sexual and reproductive health and rights' within international legal instruments is a recognition of the long-standing obligations that states have in ensuring the inviolability of women's bodies. Though debates around reproduction have been around for centuries, but it was only in 1994, during the International Conference on Population and Development (ICPD) that the term 'reproductive health' was defined and gained credence. Prior to that reproduction was primarily looked through the lens of population control rather than as an aspect of health. The 'population control' approach holds overpopulation as the dominant reason for economic underdevelopment and environmental degradation. Within this framework, women were held as the targets for lowering the fertility rates. Reproductive behaviour under these approaches were seen in isolation from the general health status of women and the socio-economic context within which women existed. Women were treated as no more than a vehicle of reproduction and state intervention in birth control was termed legitimate. In the 1960s, though a range of family planning methods such as the diaphragm, cervical caps, injectables, implants, contraceptive pills, condoms, sterilisation and intrauterine devices were available, the haste towards achieving population control led towards a preference for sterilisation and insertion of IUDs.Mostly, these sterilisation programmes were coercive wherein the consent of the women was never sought. In some cases, women did give their consent on paper, but with the dismal levels of literacy, it is understandable that this could not have been an 'informed consent'. By the 1970s, Injectable Contraceptives and Contraceptive Implants were developed by pharmaceutical companies in the West and sponsored by the population establishment to under-developed countries like Zimbabwe, Egypt, South Africa, Ghana, Peru, Mexico, Mozambique, Tanzania, Nigeria, Thailand, etc. Though the claim was that these methods widened the reproductive 'choice' available to women, evidence showed that women complained of side-effects such as dizziness, psychological disturbances, risk of low bone density, chances of cardiovascular diseases, changes in menstrual pattern and increased body weight. In the late 1980s and early 1990s, quinacrine pellet sterilisation was primarily used on poor women from the developing countries such as Bangladesh, Pakistan, Brazil, India and Indonesia as another method for female sterilisation. Even this intervention was done

without any clinical trials and therefore the efficacy of the methodand the dangers associated with it called the attention to the violations of women's reproductive health, which were supported on the grounds of 'population control'. The ICPD or the Cairo Conference, held from 5th September to 13th September, 1994 made the concepts of 'sexual and reproductive health' and 'reproductive rights' gain visibility within international human rights instruments. The percussors to the ICPD was the Tehran International Conference on Human Rights (1968) which asserted that 'parents have a basic human right to determine freely and responsibly the number and the spacing of their children' and states have an obligation to provide 'adequate education and information in this respect.' In Bucharest World Conference on Population (1974) developing countries led by Argentina and Algeria refused to accept that population growth was the reason behind slow economic development and coined the slogan 'Development is the best contraception'. Between 1974-1994, three other significant conferences took place (i) The Mexico World Conference on Women of 1975 included in its Declaration the right to reproductive autonomy as an integral part of women's right to bodily integrity. (ii) The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) adopted in 1979 included that men and women should have the same rights of reproductive choice. (iii) The Mexico World Conference on Population held in 1984 discussed significant matters like balance between population and development, protection of basic human rights, education of women and abortion as a means of population control.

The Cairo Conference defined reproductive health as "of complete physical, mental and social well-being and not merely the absence of disease or infirmity a state, in all matters relating to the reproductive system and to its functions and processes" (UN Population Fund (UNFPA), *Report of the International Conference on Population and Development*, Cairo, 5-13 September 1994, 1995, A/CONF.171/13/Rev.1, available at: https://www.unfpa.org/sites/default/files/pubpdf/programmeofactionWeb%20 ENGLISH.pdf [accessed 20 December 2021],p. 59) and this was subsequently adopted by the World Health Organisation (WHO) and all other international agencies. The Cairo Conference laid down that factors such as ignorance on matters related to sexuality, unavailability of reproductive health related information and services, social prejudice against women, and the lack of control that women have over their own bodies and reproductive decisions impeded the path of reproductive health.The ICPD Programme of Action placed women at the centre in all aspects of reproductive health and instructed states that reproductive health care programmes "must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services." (UN Population Fund (UNFPA), *Report of the International Conference on Population and Development*, Cairo, 5-13 September 1994, 1995, A/CONF.171/13/Rev.1, available at: https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf [accessed 20 December 2021],p. 59).

Considering the significance of Cairo for reproductive health, it has been heralded as "no less than a revolution." (Barbara Crossette. 2004. Has the Cairo Consensus Lost Momentum: A Journalist's View. Remarks as prepared for Population Commission. https://www.un.org › pdf › keynote › crossette).

Almost within a year from the Cairo Conference, the Fourth World Conference on Women was held in Beijing from 4th – 15thSeptember 1995. The Beijing conference not only used the language of the Cairo Conference of sexual and reproductive health but also took it forward. Women's Health was one of the twelve Critical Areas identified by the Beijing Platform for Action (PFA). In tandem with the Cairo Conference, it gave a holistic definition of reproductive health and held that "the explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment." (United Nations., & World Conference on Women. (1996). *The Beijing Declaration and the Platform for Action: Fourth World Conference on Women, Beijing, China, 4-15 September 1995*. New York: Dept. of Public Information, United Nations, p. 3.)

It held that attainment of reproductive health is impeded by factors like

- "Inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services;
- the prevalence of high-risk sexual behaviour;
- discriminatory social practices; negative attitudes towards women and girls; and
- the limited power many women and girls have over their sexual and reproductive lives." (United Nations., & World Conference on Women. (1996). *The Beijing Declaration and the Platform for Action: Fourth World Conference on Women, Beijing, China, 4-15 September 1995*. New York: Dept. of Public Information, United Nations, p. 3.)

Taking a life cycle approach towards women's health, it urged upon the states to provide accessible and affordable healthcare systems for women. The *Platform for Action* demanded that states commit towards policy changes that would promote research on women's health and dissemination of such information, earmark resources for women's health as well as monitoring and initiate preventive programmes for women's health. The PFA noted that decreased public spending under Structural Adjustment Programmes were having an adverse impact on women's health in developing and least developed countries. It recommends that governments must mainstream gender in all its policies and programmes so that the inequities in health can be addressed. The Beijing Conference moved ahead of the Cairo Conference on two major fronts: first, it emphasised on decriminalisation of abortion and second, it laid down the groundwork for a discourse on sexual rights (to emerge in the future) by emphasising on women's autonomy over their sexuality.

Check Your Progress – 1

1) What is Reproductive Health?

2) What are the impediments to Reproductive Health?

17.4 ASPECTS OF REPRODUCTIVE HEALTH

The ICPD Programme of Action (POA) identifies the following as important aspects of Reproductive Health:

- Safe Motherhood, Maternal Mortality and Morbidity
- Family Planning and information on Contraception
- Access to Safe Abortions
- Sexually Transmitted Diseases and HIV/AIDS
- Sexuality and gender relations
- Youth and Adolescents

The ICPD laid down that in order for people to able to enjoy reproductive health, they should be able to

- To have a safe and satisfying sex life;
- the ability to reproduce; and
- the right to decide if, when, and how frequently to reproduce.

The Cairo Conference is significant not only because of the centrality that it placed on gender equality and women's empowerment but also because it placed sexual health within the ambit of reproductive health, thereby de-linking sexuality from reproduction. In Cairo, a new model was created which asserted that "programs that are demographically driven, and are intended to act directly on fertility, are inherently coercive and abusive of women's right to choose the number and timing of their children." (McIntosh, A. and L. Finkle, J. 1995. The Cairo Conference on Population and Development: A New Paradigm? *Population and Development Review*, 21:2, p. 227).

The Cairo POA laid down that all states would include reproductive health into their primary health care system and this would include "family planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and treatment of infertility; abortion as specified in paragraph 8.25; treatment of reproductive tract infections, sexually transmitted diseases (STDs) and other reproductive health conditions; and information, education and counselling

on human sexuality, reproductive health and responsible parenthood" (UN Population Fund (UNFPA), *Report of the International Conference on Population and Development*, Cairo, 5-13 September 1994, 1995, A/CONF.171/13/Rev.1, available at: https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf [accessed 20 December 2021], p.61).

By comprehensively shifting the discourse on reproduction from targets to rights, the Cairo Conference served a springboard for women's reproductive health rights.

The work of Cairo was taken forward in Beijing. As far as reproductive health is concerned the Beijing Platform for Action (PFA) emphasised that:

- maternal mortality rates be halved of the 1990 levels, by 2000 and further halved by 2015
- family planning information and services be widely made available to all groups of women
- abortions be decriminalised across all countries and provisions be made for affordable and accessible abortion services
- Provide preventive services for HIV/AIDS and Sexually Transmitted Diseases and initiate the availability of non-discriminatory and gender sensitive health services to those affected
- Women have a right to control and decide freely on matters related to their sexuality, the lack of which creates particular health risks
- Elimination of harmful social practices such as female genital mutilation, son preference, early marriage, violence against women, sexual exploitation, and sexual abuse.
- Provision for health and nutrition services for adolescent girls, along with education and information, that enables them to deal with their sexuality in a positive way and also to be aware regarding sexually transmitted diseases and issues related to their reproductive and sexual health.

With such a comprehensive agenda on SRH, the PFA defined reproductive health care as "the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." (United Nations., & World Conference on Women. (1996). *The Beijing Declaration and the Platform for Action: Fourth World Conference on Women, Beijing, China, 4-15 September 1995*. New York: Dept. of Public Information, United Nations, p. 35).

The Millennium Summit, held from 6 September, to Friday, 8 September 2000 which led to the Millennium Declaration and the Millennium Development Goals (MDG) were the next significant developments in the

international arena which affected the domain SRH. The MDGs which were a set of eight broad goals, eighteen specific targets and forty-eight indicators, regrettably had only one goal- Goal 5 'to improve maternal health'- which is explicitly related to women's health. In sharp contrast to the previous international consensus wherein development and reproductive health were seen as directly linked with one another, the MDGs limited the wide scope of reproductive health to maternal health alone, which was to be measured through two indices: maternal mortality ratio and percentage of birth attended by skilled health personnel. Therefore, it failed to recognise that maternal mortality is linked to issues such as health and nutrition among adolescent girls, women's ability to make contraception related decisions (including abortion), elimination of harmful social practices etc. Though in Goal 3 of the MDGs was to 'Promote gender equality and empower women'the emphasis was on education, literacy, wage employment and political participation, it was realised that these will not empower women where lack of access to reproductive health facilities persists.

As a result of the widespread criticism for limiting the domain of reproductive health to maternal mortality alone, in 2007 the revised monitoring framework included an additional goal: Universal Access to Reproductive Health. Therefore, by 2007 targets under Goal 5 of the MDGs read as:

"Target 5.1: Maternal Mortality Ratio

Target 5.2: Proportion of births attended by skilled health personnel

Target 5.3: Contraceptive Prevalence Rates

Target 5.4: Adolescent birth rate

Target 5.5: Antenatal coverage (at least one visit and at least four visits)

Target 5.6: Unmet need for family planning" (https://www.who.int/pmnch/media/press_materials/fs/about_mdgs/en/).

Yet, the revised monitoring framework failed to include issues like abortion rights, women's right to decide on their sexuality, and education and information that allows girls to avoid STDs and deal positively with their sexuality. Though HIV/AIDS prevention was included as a part of Goal 6, there was no linkage made with the gender dimension of HIV/AIDS. Moreover, other Sexually Transmitted Diseases (STD) did not find adequate space. Moreover, though the implicit assumption in the MDGs was that Goal 2 'achieve universal primary education' and Goal 3 'empower women' was expected to have positive impact on SRH, the absence of clear and comprehensive agenda for SRH would have dangerous repercussion for women in developing countries (Basu,2005).In 2015, the Sustainable Development Goals (SDG) succeeded the MDGs as a set of 17 'actionable' goals to be achieved by all countries, by 2030, with the declared objective "to end poverty, protect the planet and improve the lives and prospects of everyone, everywhere."(https://www.undp.org/sustainable-development goals#:~:text=The%20Sustainable%20Development%20Goals%20(SDGs)%2C%20also%20known%20as%20the,people%20enjoy%20peace%20and%20prosperity).

As far as Sexual and Reproductive Health is concerned, the SGD Goal 3 that pertains to 'Good Health and Well-being' and Goal 5 related to 'Gender Equality' are central.

Indicators of Sustainable Development Goals that deal with Sexual and Reproductive Health?

Indicators under Goal 3:

3.1.1. Maternal Mortality Ratio

3.1.2 Percentage of Birth Attended by Skilled Health Personnel

3.7.1 The Proportion of Women of Reproductive Age (Aged 15-49 Years) who have their need for Family Planning Satisfied with Modern Methods

3.7.2 Adolescent Birth Rate (Aged 10-14 Years; Aged 15-19 Years) Per 1,000 Women.

Indicators under Goal 4:

4.7.2: Percentage of schools that provided life skills-based HIV and sexuality education within the previous academic year

Indicators under Goal 5:

5.6.1: Proportion of women who are able to make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

5.6.2: Countries that have legal and regulatory environment around maternity care, contraception and family planning, comprehensive sexuality education and information, HIV and HPV in accordance with the international consensus reached in Cairo and Beijing

Under Goal 3, indicators 3.1.1. and 3.1.2 continued in the line of the MDGs by talking of maternal mortality ratio and percentage of birth attended by skilled health personnel respectively. But it took the agenda forward by laying down target 3.7as "universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes"for all by 2030.Accordingly, indicator 3.7.1 is intended to measure the proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods and indicator 3.7.2 measures the adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women.

Under Goal 4 aimed at ensuring "inclusive and equitable quality education and promote lifelong learning opportunities for all" thematic indicator 4.7.2measures percentage of schools that provided life skills-based HIV and sexuality education within the previous academic year.

Additionally, target 5.6 also mandates "universal access to sexual and

reproductive health and reproductive rights as agreed in accordance with the POA of the IPCD and the Beijing PFA and the outcome documents of their review conferences." As far as target 5.6 is concerned, the Inter-Agency and Expert Group on SDG Indicators (IAEG-SDGs) which is entrusted with the work of developing a list of indicators for each goal identified the following for SRH:

- Proportion of women who are able to make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (Indicator 5.6.1), and
- Countries that have legal and regulatory environment around maternity care, contraception and family planning, comprehensive sexuality education and information, HIV and HPVin accordance with the international consensus reached in Cairo and Beijing (Indicator 5.6.2).

Despite the significant improvement that the SDGs have made over the MDGs, yet the reluctance to engage with sexual rights mas meant that issues like laws that criminalise sex workers and same sex sexual practices, the rights to choose one's partner, the right to a satisfying, safe and pleasurable sex life and to information and education regarding the same find no space (Logie,2003). This is in stark contrast to the Beijing conference where the delegates discussed (though not finally included in the PFA) non-discrimination based on sexual orientation as human rights (Miller,2000:83). Other sections of the Beijing PFA like decriminalisation of abortion and provisions for affordable and accessible abortion services, women's right to control and decide freely on matters related to sexuality are also absent from the SDGs. In brief, while substantial development in understanding sexual and reproductive rights was achieved in Cairo and Beijing, a backlash was observed in the subsequent years which has made the ambit of SRH narrow.

17.5 REPRODUCTIVE HEALTH ACROSS THE WORLD AND IN INDIA: STATUS, VIOLATIONS AND JURISPRUDENCE

Across the world, 216 maternal deaths per 1,00,000 live births or 830 deaths per day occurred from 2000-2017. As per WHO 'Trends in Maternal Mortality Report' (2019), in 2015 on an average 3,03,000 maternal deaths occurred and the highest deaths were recorded in Nigeria (58,000), India (45,000), Democratic Republic of Congo (22,000), Ethiopia (11,000) and Pakistan (9,700). In 2011, the Delhi High Court in the historic Laxmi Mandal v. Deen Dayal Harinagar Hospital &Ors. Case held that death due to denials of maternal health care is a violation of India's commitment to international treaty obligations under CEDAW and ICESCR. In 2012, the Madhya Pradesh High Court used Article 21 to support the right to maternal health care for every woman in the country while delivering its verdict in Sandesh Bansal v. Union of India. In both these cases, the state was indicted for its inability to protect the SRH rights of women. In order to meet with SDG indicator 3.1.1, the government of India launched several schemes like Janani Suraksha Yojana (JSY) in 2005, Janani Shishu Suraksha Karyakram (JSSK) in 2011

and Pradhan Mantri Matru Vandana Yojana (PMMVY) in 2016. These steps have helped in decreasing the Maternal Mortality Ratio of the country from 174 per 1,00,000 live births in 2015 to 113 in 2020. Yet the target of 70 has been elusive. Only seven out of the 37 states/UTs of India have been able to record MMR below the target of 70 (Niti Aayog, 2021).

The risk of maternal mortality increases with the lower availability of Skilled Birth Attendants (SBA). Compared to 2010, when 70.14% births worldwide were attended to by skilled health personnel, in 2018 the figure increased to 80.89%. SBAs includes midwives, doctors and nurses. In the case of India, there is only 37 SBA available per 10,000 population which makes women in India remain extremely vulnerable to maternal mortality (Niti Aayog, 2021). Of this, a large number of women are auxiliary nurse midwives (ANMs) who are faced with extremely limiting conditions of work. A study reports that there were around 2,00,000 women working as ANMs in 2020 (Karvande et al,2020)

As recent as 2021, 24 countries across the world continue to prohibit abortions under any circumstances, limiting not just a woman's right to choose whether she wants to bear a child or not but also putting her life and health in peril. Only 56 countries provide abortion services at the request of women with no justifications. WHO reports show that 97% of all unsafe abortions occur in developing countries. It is noteworthy that out of every 10 pregnancies, 3 ends in induced abortions and therefore criminalisation of such an ‘essential health service’ endangers the life of women. Worldwide, each year around 73 million abortions take place of which 45% are unsafe. Of these unsafe abortions, 30% are done by untrained persons who use invasive and dangerous methods.

According to National Health and Family Survey-4 (2015-16), 47% of abortions in India are not performed by registered medical doctor but by nurses, ANMs, dais, family members or even by the person herself. Abortions in India are regulated by the Medical Termination of Pregnancy Act, 1971 and was amended recently in 2021. The necessity of amendment was long felt as the MTP Act, 1971 did not allow for abortion after 20 weeks of pregnancy. Several court cases had to be filed wherein parents sought abortions on grounds of foetal abnormalities, which however were detected only after 24 weeks. The Hallo Bi v. State of Madhya Pradesh (2013) was a landmark case as far as abortion rights is concerned as it touched upon the thorny issue of access to abortion for rape survivors. The restrictions imposed by the MTP Act 1971 constituted violations of women’s reproductive autonomy. The amended act allows for increased flexibility with termination of pregnancy up to twenty weeks requiring the advice of one doctor, those between twenty to twenty-four weeks requiring the advice of two doctors and those beyond twenty-four weeks requiring the approval of a medical board. However, even under the amended act, women in India continue to have conditional access to abortion services. Studies have shown that women in India prefer medical (drug induced) abortions rather than surgical abortions because public health facilities lack in providing safe and affordable abortion services. However, women’s reliance on self-administered methods of

abortion through over-the-counter drugs supplied by informal vendors leaves women vulnerable to side effects and contra-indications. Such risks can be easily avoided when women have information regarding and easy access to contraception.

Till 2019, among the 107 countries reporting to UNFPA, 38% had not made comprehensive sexuality education a part of the mandatory curriculum. A similar study by UNESCO (2021) also showed that among 155 countries, 78 countries have education policies that provide comprehensive sexuality education at both primary and secondary schools while 30 reported to have policies only for the secondary level. Such data, however, do not give an idea about the curriculum content and its delivery. Moreover, another recent study showed that less than one among three persons between the ages of 15-24 of Asia-Pacific region held that their schools taught sexuality education well (UNESCO, 2021). UNESCO Institute of Statistics (UIS) data base for 2020 shows that India under indicator 4.7.2 life skills-based HIV and sexuality education is provided from secondary levels. However, as education is a state subject in India, variations are visible across the different states. While the number of women who want to use family planning has increased worldwide from 900 million in 2000 to 1.1 billion in 2020, the proportion of women availing such services has not increased substantially: as against 73.6% against in 2000, in 2020 it stood at 76.8%.(https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception).

The corresponding figures in India according to the recent NHFS-5 data is 56.5%, of which 36.9% take recourse to female sterilisation as the method for family planning. Male sterilisation stands at a dismal 0.3%. The emphasis on female sterilisation for family planning is not accidental. Even in 2014-15, 85% of the family planning budget was dedicated to sterilisation of which 71.1% was for female sterilisation. The Devika Biswas v. Union of India (2016) highlighted the brutal way target driven sterilisation programmes among marginalised groups led to the death of 13 women and injury of 65 women in Chhattisgarh. Though the National Population Policy 2000 decried target driven sterilisation, yet this case showed how violations of women's SRH continued unabated. While delivering the judgement, the Supreme Court held that reproductive rights come under the scope of Article 21 and it must include access to "a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free, and responsible decisions about their reproductive behaviour." (Human Rights Law Network,2019:119). Forced sterilization of women from the weaker economic section, women who are HIV positive, belong to ethnic minorities, bodily violations of transgender persons and women with disabilities have also tainted the human rights record of countries as diverse as Japan, Australia, Sweden, Peru, Canada, Bolivia, Kenya and France.

As against the widespread recourse to female sterilisation in India, other methods of family planning like condoms, pills, intra-uterine devices, and injectables account only for 9.5%, 5.1%, 2.1% and 0.6% respectively. These figures are indicative of how awareness regarding reversible methods of contraception is low among the population. Especially, about condoms, low

awareness is a matter of public health concern alongside a SRH concern as condoms are also useful in preventing the spread of sexually transmitted diseases (STDs) including HIV/AIDS and HPV. Despite this, factors like prevalent bias against existing methods, religious and cultural considerations against contraception, barriers for women in accessing contraceptive services due to their gender, marital status, limited resources and ignorance as well as dangers of side effects stand in the way from availing spacing non-surgical methods.

Across the world, the HIV incidence fell by 24 % in 2019 in comparison to 2009. Though 1.7 million new HIV infections were reported in 2019, yet the rate of incidence fell from 0.48 infections per 1,000 uninfected people in 2010 to 0.37 in 2019 (UN, 2021). The gendered way in which HIV/AIDS impacts women and men is visible when the fact that HIV AIDS is the fourth major cause of death amongst women reporting a value of 6.92% is considered. As against this, for men it is the fifth cause with a corresponding value of 3.62%. The dangers are compounded for women as sex workers have not been included into the framework. The AIDS Society of India (ASI) presents that of the total 2.35 million people living with HIV, there were 69,220 new HIV infections in 2019. National Aids Control Organisation (NACO) estimates for the same year show HIV prevalence among adult males as 0.24% and among adult females as 0.20%. Despite this, only 21.6 % women and 30.7% men have comprehensive knowledge about HIV/AIDS (NHFS-5).

Till 2019, among the 107 countries that reported to UNFPA, 38% had not made comprehensive sexuality education a part of the mandatory curriculum. A similar study by UNESCO (2021) also showed that among 155 countries surveyed, 78 countries have education policies that provided comprehensive sexuality education at both primary and secondary schools while 30 reported to have policies only for the secondary level. Such data, however, do not give an idea about the curriculum content and its delivery. As another recent study proved: less than one among three persons between the ages of 15-24 of Asia-Pacific region held that their schools taught sexuality education well (UNESCO, 2021). UNESCO Institute of Statistics (UIS) data base for 2020 shows that India under indicator 4.7.2 life skills-based HIV and sexuality education is provided from secondary levels. However, as education is a state subject in India, variations are visible across the different states.A worthwhile development in the field of SRH has been the decline in adolescent birth rate. As against the figures of 1994 when the adolescent birth rate was 72.4 per 1000, it has decreased to 43.6 per 1000 in 2017 across 142 countries (Santelli etal. 2017). While the largest decline has been recorded from South Asia, the least is from Middle East/North Africa with 70% and 55% respectively. In India, more than 12 million people were married prior to the age of ten (Census 2011), which directly has an impact on the adolescent birth rate. In 2003, the Supreme Court in the Forum for Fact Finding Documentation and Advocacy v. Union of India case chastised the Government for failing to stop child marriages and directed the Parliament to formulate a new legislation that replaces the Child Marriage Restraint Act of 1929. Subsequently, in 2006, the Prohibition of Child Marriage Act was enacted which criminalises

conduct of child marriages. Recent estimates of child marriage in 2016 shows that it significantly decreased from 47 percent in 2006 to27 percent.Correspondingly, the adolescent fertility rate declined from 51 in 2015-16 to 43 in 2019-21 with 6.8 % women between the age of 15-19 already pregnant while the NHFS-5 was being conducted as against 7.9 % during NHFS-4.Though these statistics may be indicative of better economic, educational, and occupational opportunities, yet the indicator has its limitations as it will not reflect pregnancy and abortion rates among adolescents, sexual activity, and contraception use.

The provisions under Medical Termination of Pregnancy Amendment Act, 2021.

The Medical Termination of Pregnancy Amendment Act 2021 allows for termination of pregnancy up to twenty weeks on the advice of one doctor, those between twenty to twenty-four weeks on the advice of two doctors and those pregnancy beyond twenty-four weeks requiring the approval of a medical board.

17.6 GAPS IN REPRODUCTIVE HEALTH

As seen from the discussion above, the arena of Sexual and Reproductive Health is a highly uneven one with visible disjuncture between the aspirations and its fulfilment. Sexual and Reproductive Health as it is understood with the current development framework is couched within a heteronormative framework wherein the health concerns of sex workers and persons who identify as Lesbian Gay Bisexual Transgender Intersex and Queer do not find adequate attention. The exclusion of the SRH concerns of these two groups of people not only emanates from the existing stigma and disempowerment that they suffer from, but it also reinforces such stigma and disempowerment. It is worthwhile to note that women in sex work need access to safe abortion, maternal and child health services, contraception, and comprehensive HIV and STD care. The lack of suchessential services, in most parts of the world, not just affects female sex workers but also transgender sex workers. With regard to HIV incidence also, it has been seen that Men who have sex with Men (MSM) are more likely to avoid HIV testing and treatment due to the discriminatory treatment by the medical establishment. Lesbian and bisexual women may suffer from greater risks in accessing SRH services in societies where the presence and permissions of male relatives is mandatory (see https://www.loc.gov/lgbt-pride-month/about/)

The WHO recognises Violence Against Women as a public health. Unintended pregnancies, induced abortions, incidence of HIV and STDs, miscarriages and stillbirths are high among women who face intimate partner violence and sexual violence. Despite the existing evidence and the inclusion of VAW as an impediment to Gender Equality in the SDGs, thirty-two countries have not made marital rape a criminal offence. Induced or forced abortions without the consent of the woman constitute one of the violations of women's bodily integrity. Though access to safe abortions have been of

considerable emphasis within the discussions of SRH, forced abortions have not found adequate space. In recent times, sex-selective abortions in countries like China and India have complicated the debate on abortion. The preference for the male child is not only seen in the pre-natal diagnosis which reveals the sex of the child, but also through the sex selection that can take place while using Assisted Reproductive Technologies (ART). In this context, engagement of with ARTs becomes extremely important. To consider the ARTs is not only important because of sex section during the stage of conception and structures of inequality that exist among the service providers and the service seekers, but also because it offers possibilities to lesbian and gay couples who intend to have biologically related children. In brief, there are several issues that have merged in the recent times, which have thrown new questions to the domain of SRH and no definitive answers are available till now.

17.7 LET US SUM UP

In this unit, we learn about the expansion of Sexual and Reproductive Health **(**SRH)from narrow focus on population control to a broader perspective of asserting women's reproductive agency has been made possible due to the feminist mobilisation of the 1970s and 1980s. Reproduction which was traditionally viewed to be an issue for the private domain was opened up for scrutiny through the women's liberation movement that discussed abortion rights, violence against women and women's sexuality as political issues. Though the progressive agenda of the women's movement is yet to be fully realised, the significance of the intervention lies in the fact that today there is an acknowledgement that Sexual and Reproductive Health rights cannot be exercised without certain enabling conditions, and that the role of the state and the civil society therefore would continue to remain crucial.

In the present context, the global pandemic of Covid-19 has compounded the existing social inequalities and its impact can be seen in the SRH issues, especially in maternal health and HIV services which have seen drastic disruptions. According to a UNICEF report, 35 per cent countries reported interruptions of maternal health services which may result in estimated 11,000 additional maternal deaths in the South Asian region. Though the global target for HIV, by 2020, was to have less than 5,00,000 new infections but the real instances were three times the target and this was due to the interruption of HIV prevention, testing and treatment services. More than ever, it is being recognised that to reduce inequalities and poverty, provision of universal health coverage is necessary which must include a range of essential services including Sexual and Reproductive Health services.

17.8 UNIT END QUESTIONS

1) 'Ensuring sexual and reproductive health is indispensable for attaining gender equality.' Do you agree? Justify.
2) Discuss how sexual and reproductive health is violated when women are considered as targets for population control.

3) Evaluate the role of courts in ensuring access to reproductive rights.

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UNIT 18 SURROGACY

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18.1 INTRODUCTION

Human beings usually have the desire to have a biological offspring for the continuance of the human species. However, due to a variety of factors many people are not able to have child/children through the biological process. Medical science has attempted to address the childlessness and offers a number of methods to have a child. Assisted Human Reproductive Technologies (ART) are advanced and innovative medical developments that help people to give birth to child/children. There are numerous types of ART such as artificial insemination, In vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), Zygote intra-fallopian transfer (ZIFT), reproductive cloning, intra-cytoplasmic sperm injection (ICSI), and Surrogacy. Surrogacy is a procedure in which a woman gives her consent to carry out a pregnancy for intended parent(s) (IP) and give away the child after birth to IP. The practice of surrogacy involves a woman who acts a surrogate mother to bear the child for another person or couple. There are various forms of surrogacy and many legal and ethical dimensions to it. The practice of surrogacy can be seen in many countries across the world

governed by their respective legislations and legal frameworks.

18.2 LEARNING OUTCOMES

After reading this Unit, you should be able to:

- Learn about the concept, types, and arrangements of surrogacy and its historical development;
- Understand an overview of worldwide legal framework on surrogacy; and
- Know the legislations relating to surrogacy in India.

18.3 DEFINITION OF SURROGACY AND TYPES OF SURROGACIES

The Oxford Dictionary of Law defines surrogacy as 'an arrangement in which a woman ("the carrying mother") agrees to bear a child and to hand over that child, on birth, to another person or persons ("the commissioning parents"). The 'carrying mother' is called as the surrogate woman and in some contexts as surrogate mother. The person/persons to whom the child will be handed over after the birth is referred as the 'commissioning parent/s' or 'intending or intended parent/s'. The term 'surrogate' originated from the Latin word '*Surrogatus*' and the meaning is substitute that refers to a person who is appointed to act in the place of someone else. Therefore, a surrogate woman/mother is someone who carries a child for another woman. She conceives either through artificial insemination of the sperm of the commissioning father or donated gametes of the intending parents. The Indian Council of Medical Research Guidelines (2005) "Surrogacy is an arrangement in which a woman agrees to carry a pregnancy that is genetically unrelated to her and her husband, with the intention to carry it to term and hand over the child to the genetic parents for whom she is acting as a surrogate". This definition is applicable to only one form of surrogacy called gestational surrogacy, which is discussed in the following section. As mentioned earlier the practice of surrogacy is considered as one of the forms of ART, however, in recent times there have been many debates nationally as well as internationally around it. Many rules and regulations have been made by a number of nations to the practice of surrogacy due to various ethical and legal dimensions have arisen in recent times. Several categorisations of surrogacy are done and let us read about it.

18.3.1 Traditional and Gestational Surrogacy

Surrogacy may be categorised into two forms based on the nature of the conception of the embryo- traditional surrogacy and gestational surrogacy. In the traditional surrogacy, the surrogate mother's egg is used for pregnancy. She can conceive either by artificial insemination with a donor's sperm or her eggs are fertilized with the donor's sperm in the laboratory to make an embryo. In both of the situation, she becomes the biological mother of the child she conceives and carries.

In gestational surrogacy, the embryo is made through the intendingparent/s's sperm and/or oocytes or donorgametesand the surrogate woman is impregnated by transferring the embryo through in vitro fertilization (IVF) and she then carries and delivers the child for the intending parent/s. There are very rare instances where an embryo is made from the egg and sperm both taken from donors and then implanted in the surrogate woman. In both the occasions, the surrogate woman does not have any biological link to the baby.

18.3.2 Altruistic and commercial surrogacy

Surrogacy can be characterised as altruistic or commercial on the basis of its arrangements. In altruistic surrogacy the surrogate woman is not given any financial or material compensation except the required medical expenses and other pregnancy related costs and these kinds of surrogacy arrangements are made between close friends, family, or relatives. In commercial surrogacy the surrogate woman is compensated monetarily in return to her energy and time put in giving birth to the baby and usually a legal contract is done between the surrogate mother and the intending parents. Though the commercial surrogacy is based on legal contract, in many occasions conflict of interests have emerged between/among the stakeholders of surrogacy arrangements (see case study 1 and 2).

18.4 WHY SURROGACY?

Human beings, as mentioned earlier, has a desire to have their children. This desire may be 'natural' or due to the socio-cultural construction of the significance of 'child/children' in one's life to continue the hereditary and family traditions, to preserve a community, to take part in the religious rituals, and so on. Therefore, having a child becomes vital to most of the people across the world. However, due to a number of factors, one might not be able to have a natural offspring and infertility is the major reason of childlessness. There are two types of infertility- medical and social. Medical infertility is a condition when a woman is not able to become pregnant after attempting to conceive naturally through regular sexual intercourse for a year or two (Inhorn and Balen, 2002). Social infertility refers to the incapability of individuals to have child/children as a result of numerous social circumstances, for example, single individuals, widowed, divorced, homosexual couples, aged people etc. (Soo:2010). There is also one group of people to whom it is physically unbearable to conceive despite being fertile due to serious health conditions, and few people might be not prepared to be pregnant but want a child. There are generally two options for these people- adoption or surrogacy. Adoption can be difficult due to many regulatory obstacles (particularly for single parent, homosexual individuals) and there may be also a preference for 'genetic link' amongst many infertile people. Therefore, surrogacy becomes a viable option to have a child for many. The present format of surrogacy, though, is a recent practice as a form of the ART; however, surrogacy has been practiced since ancient period. A practice called *'ventremlocare'* meaning abdomen rental was common in ancient Rome (Aluas,2018). In this practice a fertile wife could give to another man

temporarily whose wife gave birth to dead children or was sterile (Godwin,1999).

18.5 SURROGACY ARRANGEMENTS IN RECENT TIMES

Surrogacy arrangements may be of many forms as discussed above- traditional, gestational, altruistic, or commercial. Elizabeth Kane (pseudonymous), an American woman, became the first paid traditional surrogate mother to give birth to a baby girl for an amount of $10,000 (American dollar) in 1980 through artificial insemination of sperm of another woman's husband. Her book 'Birth Mother- The Story of America's First Legal Surrogate Mother', written in a diary form, got published in 1988.In 1983, a menopausal woman from Australia gave birth to a baby using eggs from donor. In 1985, the first successful gestational surrogacy took place when Shannon Boff gave birth to the baby (named Shira) of Sandy and Elliot, the intended parents. Sandy could not conceive due to a health condition, however, one of her eggs was fertilised with Elliot's sperm and then it was implanted in Boff's womb. Boff was paid an amount of $10,000 for acting as the gestational surrogate. A woman named Vivien Morris became the first oldest surrogate mother of the world at the age of 54 and gave birth to her grandchild since her daughter could not have own child due to health conditions. There are many such examples in last two decades when the grandmothers have given birth to the grandchild in many countries due to the inability of the intended mother to become pregnant due to various health conditions.

18.6 SURROGACY IN INDIA

The first gestational surrogacy in India took place in 1994 in Chennai as per a report published in the newspaper The Hindu (2006). After three years, as per a report of Sunday Times of India (Srinivasan,1997), the first gestational surrogacy occurred in 1997 whena woman from Chandigarh agreed to carry a child for someone else. She was given an amount of Rs. 50,000 which she needed to incur the expenses for the treatment of her paralyzed husband. A number of instances of surrogacy came into light afterwards. In 1999, a German couple became parents through a surrogate mother from a village of Gujarat (Gupta,2006).

In 2002, India allowed commercial surrogacy and the following two decades have seen a huge number of surrogacy arrangements in the country and made commercial surrogacy a 'global business' in India. Between the year 2003-2006 instances of surrogacy doubled (Ramachandran,2006) and there was an increase of more than three times in the number of gestational surrogacies between the year 2007-2009 (Malhotra,2013). India emerged as the 'surrogacy capital of the world' and opened the doors to many national and international unfertile couple both medically and socially. The transnational demand for commercial surrogate women of India started an enormous 'fertility tourism' in India. Childless intended/commissioning parents from

different countries resorted to a growing number of Indian surrogate women particularly those from economically disadvantageous background. In order to regulate commercial surrogacy, the Government of India has introduced many Guidelines and Bills which will be discussed in the next section.

18.7 LEGAL FRAMEWORKS ON SURROGACY

The socio-cultural, economic and political as well as religious context of a country impacts the approach and arrangements of surrogacy in different countries. This has resulted in country specific legislations on surrogacy. Both commercial and altruistic surrogacy is practised in certain nations, whereas in certain instances only altruistic surrogacy is legalised, and there is total ban in some countries. Legal interventions also have become significant due to the fact that many conflict of interest and breach of agreements occurred in surrogacy arrangements across countries.

18.7.1 Legal framework relating to surrogacy worldwide

Different countries have their own legal framework towards surrogacy arrangements. Surrogacy altogether is banned in many countries (e.g., France, Germany, Switzerland, Italy, Taiwan, some States of U.S., China etc.) whereas, few countries (e.g., United Kingdom, some states of U.S., Brazil etc.) impose partial ban, and in others (Greece, Belgiumetc.) there is no regulation at all. India too, until recently, had only Bills and guidelines on surrogacy arrangements. It is only on 25 January 2022 that a law came into effect in India to regulate surrogacy i.e., the Surrogacy (Regulation) Act 2021 which received the President of India's assent on 25 December 2021.

The surrogacy law in the United Statesis different from state to state. There are written legislations in some of the states and shared legal framework in others, surrogacy arrangements are facilitated in some states whereas commercial surrogacy is penalised in some other states. California, Maryland etc. are surrogacy friendly states and individuals living in non-friendly states could take help of a surrogate woman living in surrogacy friendly state. The Gestational Surrogacy Act 2004 lays down the rules and procedures of gestational surrogacy in USA to protect the parties involved and the legal status of the baby born through gestational surrogacy. California, a surrogacy friendly state, offers surrogacy agreements to individuals who are socially infertile such as people belonging to queer community (Lesbian, Gay, Bisexual, Transgender, and homosexuals etc.) under the State's Uniform Parentage Act, 2000.

In United Kingdom, surrogacy is regulated under the Surrogacy Arrangement Act 1985, and amended by the Human Fertilisation and Embryology Act 1990, however, commercial surrogacy is prohibited which means that it is illegal to advertise or commercialise surrogacy and other than a rational amount related to pregnancy expenses no money could be paid to the surrogate mother. Canada also offers a similar kind of legalisation of surrogacy arrangements where commercial surrogacy is prohibited under the Assisted Human Reproduction Act 2004.

18.7.2 Surrogacy Agreement

The surrogacy agreement is generally a contract made between the surrogate woman and the intending parents which specify the terms and condition of the surrogacy arrangement, e.g.- the compensation, rights, responsibilities, and liabilities, payment schedule and other related matters. As discussed earlier, the legislation and regulations differ from country to country, therefore, the validity of a surrogacy agreement also vary. There have been many occasions where despite having an agreement, conflict of interests and breach of the contract occurred. In USA the case of *Baby M (*see the Box 1) is a well-known where there was no such regulation regarding the legality of the surrogacy contract and led to initiation of laws related to surrogacy.

Case Study-1

The Case of *Baby M*

Baby Melissa (known as Baby M) was born on 27th March 1986 to William Stern and Elizabeth Stern by surrogate mother, Mary Beth Whitehead through a traditional surrogacy arrangement. It was outlined in their agreement that Mary Beth would be both the surrogate and the egg donor and William's sperm would be inseminated artificially inseminated and she would given a $10,000 against the parental rights of the biological mother after the birth. However, after a few days of giving birth, she demanded the baby back who was under the care of Sterns. A legal battle was fought between the two and the custody was finally given to the Sterns by considering the best interests of the child. The New Jersey court stated that Mary Beth Whitehead breached the contract by demanding back the child and refusing to relinquish her parental rights to the child as outlined in the contract. This extremely publicised case signifies many conflicting human rights and legal issues of surrogacy and the requirement of the legal framework to control and regulate the practice of surrogacy.

Source: McDonald:1991

The Baby M case has been used as a benchmark to address other disputed surrogacy cases and it changed the attitude towards surrogacy in USA and surrogacy was legalised with terms and conditions to have a child in 'modern' families including same-sex couples.

18.8 SURROGACY LAWS IN INDIA

India, as mentioned earlier, intended parents from India as well as across the world considered to take the services of an Indian surrogate women when commercial surrogacy was allowed in 2002. Surrogacy was cheaper in comparison to other countries having medical expertise along with modern technologies. As per the Report of the Law Commission of India (2009), the cost of surrogacy in India was one third of the fees in developed countries like USA. Therefore, India became a popular destination particularly amongst the transnational intended parents-both medically and social infertile

individuals. Informally the practice came to be known as 'rent a womb'. It became a 'business' having a turnover of half a billion dollars. Gujarat became a 'hub of surrogacy'having a huge number of fertility clinics in the cities like Jamnagar, Anand, and Surat. In view of these certain guidelines, bills, and legislations have been initiated by different stakeholders of Govt. of India to have some kind of regulation on surrogacy arrangements in India.

18.8.1 The validity of Surrogacy under Indian Constitution

The Constitution of India under Article 21 protects the Right to Life, Personal Liberty, and Privacy and Right to earn a living. These constitutional rights can be contextualised in terms of surrogacy where a woman has the right to earn a livelihood is surrogacy is considered as an economic labour, her right to reproductive choices and personal liberty. The High Court of Andhra Pradesh held that the reproductive rights of the citizen constitute a fundamental right and the concept of reproductive autonomy of an individual was upheld in the case of *B.K. Parthasarathi v. Government of Andhra Pradesh.* However, the commercial surrogacy without regulation has become a mere business where women from poor economic background are exploited in the clinics which are established in many parts of the country. The surrogate woman is put in a hostel who should obey the instructions for the good health of the baby and mostly given a meagre amount of compensation and is discarded after the birth of the baby. Therefore, the requirement of an active legal framework is very important to regulate the practice.

18.8.2 National Guidelines for Accreditation, Supervision and Regulation of ART Clinics

The Indian Council of Medical Research issued the National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India, also known as ICMR Guidelines, in 2005. The objective of the Guidelines was to bridge the gap in implementing the surrogacy arrangements and to regulate it. It specified that the value of the monetary compensation of the surrogate mother would be decided by her and the intended parent/s. It also mentioned that the egg of the surrogate mother could not be donated for the surrogacy and she would not have any parental rights over the baby. There are a number of drawbacks to the ICMR guidelines, the major being the obscureness regarding the minimum age of the surrogate mother, the number of children and previous pregnancies. Moreover, the nature of the guidelines is voluntary and non-binding that gives an opportunity to the ART clinics to not following the directives. Hence, it does not adequately protect the rights and interest of the all the stakeholders involved in surrogacy. The positive outcome of the guidelines is that it acted as the blueprint in drafting the Assisted Reproductive Technology (Regulation) Bill and Rules, 2008which was re-drafted in the years 2010, 2013, 2014, 2016, and 2017, 2020 respectively.

National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India, 2005 (ICMR Guidelines)

The guidelines have laid down many provisions to regulate surrogacy. The definition of surrogacy is "Surrogacy is an arrangement in which a woman agrees to carry a pregnancy that is genetically unrelated to her and her husband, with the intention to carry it to term and hand over the child to the genetic parents for whom she is acting as a surrogate (1.2.33)" and "surrogacy by assisted conception should normally be considered only for patients for whom it would be physically or medically impossible/ undesirable to carry a baby to term (3.10.2)".It also specified that "The ART clinic must not be a party to any commercial element in donor programmes or in gestational surrogacy (3.5.3)". Further the guidelines stated that "All the expenses of the surrogate mother during the period of pregnancy and post-natal care relating to pregnancy should be borne by the couple seeking surrogacy. The surrogate mother would also be entitled to a monetary compensation from the couple for agreeing to act as a surrogate; the exact value of this compensation should be decided by discussion between the couple and the proposed surrogate mother (3.5.4)". The age of the surrogate mother has also been specified that she "should not be over 45 years of age (3.10.5)". "A relative, a known person, as well as a person unknown to the couple may act as a surrogate mother for the couple. In the case of a relative acting as a surrogate, the relative should belong to the same generation as the women desiring the surrogate (3.10.6)". The specification related to the number of times a woman act as a surrogate is stated that "no woman may act as a surrogate more than thrice in her lifetime (3.10.8)". There is also mention of rules to be followed by the ART clinics that "payments to surrogate mothers should cover all genuine expenses associated with the pregnancy. Documentary evidence of the financial arrangement for surrogacy must be available. The ART centre should not be involved in this monetary aspect (3.10.3)" and "advertisements regarding surrogacy should not be made by the ART clinic. The responsibility of finding a surrogate mother, through advertisement or otherwise, should rest with the couple, or a semen bank (3.10.4)". It also clearly expressed the following regarding the surrogate (3.10.7) that -

- A prospective surrogate mother must be tested for HIV and shown to be seronegative for this virus just before embryo transfer.
- She must also provide a written certificate that (a) she has not had a drug intravenously administered into her through a shared syringe, (b) she has not undergone blood transfusion; and (c) she and her husband (to the best of her/his knowledge) has had no extramarital relationship in the last six months. (This is to ensure that the person would not come up with symptoms of HIV infection during the period of surrogacy.)
- The prospective surrogate mother must also declare that she will not use drugs intravenously, and not undergo blood transfusion excepting

of blood obtained through a certified blood bank.

A format of the Agreement for Surrogacy (4.7) has also been laid down by the guidelines.

Source: ICMR Guidelines:2005

18.9 THE REPORT OF THE LAW COMMISSION OF INDIA

The report entitles 'Need for Legislation to Regulate Assisted Reproductive Technology Clinics as well as Rights and Obligations of Parties to a Surrogacy' was submitted by the Law Commission of India in August 2009 after a comprehensive debates and discussions that came out due to conflict of interests in surrogacy arrangements in India.

The report stated that-

"The legal issues related with surrogacy are very complex and need to be addressed by a comprehensive legislation. Surrogacy involves conflict of various interests and has inscrutable impact on the primary unit of society viz. family. Non-intervention of law in this knotty issue will not be proper at a time when law is to act as ardent defender of human liberty and an instrument of distribution of positive entitlements. At the same time, prohibition on vague moral grounds without a proper assessment of social ends and purposes which surrogacy can serve would be irrational. Active legislative intervention is required to facilitate correct uses of the new technology i.e., ART and relinquish the cocooned approach to legalization of surrogacy adopted hitherto. The need of the hour is to adopt a pragmatic approach by legalizing altruistic surrogacy arrangements and prohibit commercial ones."

The Law Commission recommended the following by considering the realities (see the textbox 2 for the case study of a surrogate baby) going on at the ground level:

"[1] Surrogacy arrangement will continue to be governed by contract amongst parties, which will contain all the terms requiring consent of surrogate mother to bear child, agreement of her husband and other family members for the same, medical procedures of artificial insemination, reimbursement of all reasonable expenses for carrying child to full term, willingness to hand over the child born to the commissioning parent(s), etc. But such an arrangement should not be for commercial purposes.

[2] A surrogacy arrangement should provide for financial support for surrogate child in the event of death of the commissioning couple or individual before delivery of the child, or divorce between the intended parents and subsequent willingness of none to take delivery of the child.

[3] A surrogacy contract should necessarily take care of life insurance cover for surrogate mother.

[4] One of the intended parents should be a donor as well, because the bond of love and affection with a child primarily emanates from biological relationship. Also, the chances of various kinds of child-abuse, which have been noticed in cases of adoptions, will be reduced. In case the intended parent is single, he or she should be a donor to be able to have a surrogate child. Otherwise, adoption is the way to have a child which is resorted to if biological (natural) parents and adoptive parents are different.

[5] Legislation itself should recognize a surrogate child to be the legitimate child of the commissioning parent(s) without there being any need for adoption or even declaration of guardian.

[6] The birth certificate of the surrogate child should contain the name(s) of the commissioning parent(s) only.

[7] Right to privacy of donor as well as surrogate mother should be protected.

[8] Sex-selective surrogacy should be prohibited.

[9] Cases of abortions should be governed by the Medical Termination of Pregnancy Act 1971 only."

Source: Law Commission of India: 2009

Case Study -2

Baby Manji

In November 2007, a Japanese couple Dr. Yuki Yamada and Dr Ikufumi Yamada came to India looking for surrogates and discussed it with a fertility clinic in Anand, Gujarat which was globally famous for its commercial surrogacy services. The clinic arranged for a surrogacy contract between the intended parents and the surrogate mother. The biological father of the child was Ikufumi Yamada as he provided the sperm for embryo creation and the egg donor was an anonymous Indian woman. The method of gestational surrogacy was adopted and the embryo was implanted inside the womb of the surrogate mother (gestational carrier).

In June 2008, there were matrimonial discords between the commissioning parents and the couple got divorced. Dr Yuki (intended mother) did not want to raise the child as she was biologically or legally unrelated to it and the genetic father Dr Ikufumi Yamada wanted to take possession of the child but he had to fly back to Japan due to the expiration of his Visa.

Although the genetic father wished to keep her, he was not allowed to return to Japan with her because under Indian law he was not recognized as the child's father and – as a single man – was barred from adopting her. In addition, the authorities refused to issue a birth certificate for Manji as a result of her ambiguous parentage under Indian law. Eventually after considerable media attention (and apparently diplomatic overtures between

India and Japan), Manji's paternal grandmother was permitted to take her to Japan." (The Hindu and the Times of India, August 2008).

It was the first case in India wherein a decision linked to surrogacy was made by the Apex Court and it marked the importance of developing surrogacy regulation laws in India.

Source: Writ Petition (C) No. 369 of 2008, *Baby Manji Yamada vs Union of India & Anr,* Supreme Court of India

The *Baby Manji* case has also developed new directions in the practice of commercial surrogacy in India and its legality. The Law Commission in its' report highly recommended for strong and active legal intervention so that surrogacy can be practiced as a form of ART in the correct way and the rights of the child, surrogate mother and the intending parents are protected.

18.10 THE ART (REGULATION) BILLS AND RULES ON SURROGACY IN INDIA

The Govt. of India drafted the Assisted Reproductive Technologies (Regulation) Bill' in 2008 to regulate surrogacy which was amended later a number of times in 2010, 2012, 2013, 2014 and 2015. There was a similarity of ART Bill 2008 to the ICMR Guidelines. According to the Bill ART was available to all irrespective of marital status and it put restricted on egg donation. In case of intending parents from abroad, the provision for appointment of a local guardian was incorporated and that a 75% of the remuneration be paid to the surrogate at the time of embryo transfer. This ART Bill 2008 was followed by ART Bill 2010 by the Ministry of Health and Welfare and a new meaning was given to the term 'couple' referring to two persons living in India who have a legal sexual relationship in India. It specified, in the context of foreign intending parents, that there should be proof of permission for surrogate babies in their respective countries and in case of failure to take the baby the local guardian should take the responsibility of the baby. It held surrogacy as legal in India, and upheld the practice of gestation commercial surrogacy as per the ICMR guidelines and Surrogacy was open to all irrespective of nationality, gender, sexuality and marital status andalso infertility status. This version of the Bill is considered to be the most liberal in nature. An amended version of the Bill in 2012 banned surrogacy for foreign gay couple and single individuals and allowed married couple of at least two years.

The ART Billn 2013 put restrictions on number of surrogacies to three live births that includes the child/children of the surrogate woman. The 2014 version of the Bill put bar on foreign people to hire surrogates in India but did not prohibit overseas citizens of India (OCIs), people of Indian origin (PIOs), non-resident Indians (NRIs)and even to foreigners married toan Indian citizen. It, however, did not permit the homosexuals and people in live-in relationships to take the services of surrogacy.

In 2016, a new Bill the 'Surrogacy (Regulation) Bill' (2016) was proposed

and approved by the cabinet in which the ART Bill was split—one Bill dealt with ART and the other with surrogacy. Commercial surrogacy was completely prohibited under the 2016 'Surrogacy Bill' permitting only Indian couple married for at least 5 years having fertility related issues at least by one of them. Only altruistic surrogacy was allowed wherein a close relative of the commissioning couple would be permitted reimbursing only related medical and insurance costs. It also bans unmarried people, live-in couples and homosexuals, foreigners, and Indian from overseas also cannot commission surrogacy. However, due to the absence of a definite law, commercial surrogacy was still practiced by intended parents of Indian origins. In 2019, the 'Surrogacy (Regulation) Bill' (2016) was introduced in Rajya Sabha which permitted only altruistic surrogacy and put a total prohibition on commercial surrogacy. The Bill was then again introduced in 2020 which now included 'willing' women to be surrogate instead of a 'close relative'. It then became an Act and the Surrogacy (Regulation) Act, 2021 was adopted on 25th December, 2021 and it came into effect on 25 January 2022.

The Surrogacy (Regulation) Act, 2021 strictly prohibits commercial surrogacy and permits altruistic surrogacy for legally married Indian man (aged between 26-55) and woman (aged between 25-50) who do not have any previous biological, adopted or surrogate child. It has specified the age of the surrogate mother to be between the age of 35-45 years who can not be a surrogate more than once in her lifetime. It also called for establishment of National Assisted Reproductive Technology and Surrogacy Registry for the purpose of registration of surrogacy clinics under the Act and such bodies at the level of State and Union Territories. It has criminalised commercial surrogacy as an imprisonment up to 5 years and fine up to Rs 50,000 for first offence; and for subsequent offence, imprisonment shall be up to 10 years and fine up to Rs 1,00,000. There shall be imprisonment of 10 years and a fine up to 10 lakhs if any person, organisation or clinic found to be involved in exploitation of surrogate mothers or children born through surrogacy.

The SRB and SRA, 2021 have come under many criticisms. The total prohibition of commercial surrogacy under the SRB and SRA, 2021 reinforces women's socio-cultural norm that women's work in the private sphere does not have economic value. It also reemphasizes and validates only heterosexual legal marriage as the basis of parenthood excluding the rights of queer people along with single individuals. It completely denies the right to have reproductive choices of socially infertile couple. Further, altruistic surrogacy limits the option of intending parents to select a surrogate mother as it has to be a 'willing' woman which is very vaguely mentioned in the Act.

18.11 LET US SUM UP

In this unit, we learn that legal provisions and regulation on surrogacy as a form of ART have undergone many changes across the world and in India too. There are new kind of restrictions on surrogacy particularly on commercial surrogacy in most of the countries across the world. Many feminists argue that rather than total prohibition on commercial surrogacy,

active regulation would enable to exercise the right to reproductive choices by many individuals who otherwise can not become parent/s.

18.12 UNIT END QUESTIONS

1) What is surrogacy? Discuss the historical development and relevance of surrogacy.
2) Examine the legal frameworks on surrogacy with the help of suitable examples.
3) Critically discuss the surrogacy laws in India and how the recent laws have put restrictions on commercial surrogacy.

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UNIT 19 MENTAL HEALTH LAW

Structure

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19.1 INTRODUCTION

Mental health is undeniably one of our most precious possessions to be nurtured, fully promoted and preserved. According to the World Health Organisation, health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (WHO, 2002). In this unit, we will study about the meaning and factors that are determinants

of mental health. How the interrelationship between mental health states such as mental distress, mental health problem, and mental disorder occurs and also understand the signs and symptoms of common mental disorders. It will inform us the status of mental health in India.

19.2 LEARING OUTCOMES

After studying this Unit, you should be able to:

- Learn the meaning and determinants of mental health
- Know the interrelationship between mental health states – mental distress, mental health problem, and mental disorder
- Understand the signs and symptoms of common mental disorders, and
- Inform us the status of mental health in India.

19.3 BACKGROUND

The World Health Organisation defines "health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (WHO, 2002). An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities. Expanding and building on this definition, one can infer that mental health is the state of mind in which the individual can experience sustained joy of life while working productively, interacting with others meaningfully, and facing adversity without losing capacity to function physically, psychologically, and socially. Mental health or psychological well-being makes up an integral part of an individual's capacity to lead a fulfilling life, including the ability to form and maintain relationships, to study, work or pursue leisure interests, and to make day-to-day decisions about educational, employment, housing or other choices (Abdullah, 2017). Disturbances to an individual's mental well-being can adversely compromise these capacities and choices, leading not only to diminished functioning at the individual level but also broader welfare losses at the household and societal level. Therefore, it is a vital resource for a nation's development and its absence represents a great burden to the economic, political, and social functioning of any nation. There are physical and psychological changes, Social and economic factors that can make women more vulnerable and at greater risk of poor mental health than men. These changes can include things like poverty, sexual abuse, stress, intimate partner violence, and so on.

"Around one in five women have a common mental health problem, such as depression and anxiety----Life events and hormonal changes can affect women's mental health".(Women and mental health | Mental Health Foundation). According to a study done by the US Armed Forces Health Surveillance Branch. There was a 1.4 times higher incidence of anxiety among women service members than there was among their male counterparts, and there was also 1.9 times higher incidence of depression among women service members than there was among their male counterparts (Mental Health in Women | Mental Health Space).

19.4 FACTORS THAT DETERMINANTS OF MENTAL HEALTH

Mental health or well-being is influenced not only by individual characteristics or attributes, but also by the socioeconomic circumstances in which we find ourselves and the broader environment in which we live (Figure-1).

19.4.1 Individual Characteristics and Behaviours

These relate to a person's innate as well as learned ability to deal with thoughts and feelings and to manage him/herself in daily life (emotional intelligence), as well as the capacity to deal with the social world around by partaking in social activities, taking responsibilities or respecting the views of others (social intelligence). An individual's mental health state can also be influenced by genetic and biological factors; that is, determinants that persons are born or endowed with, including chromosomal abnormalities (e.g. Down's syndrome) and intellectual disability caused by prenatal exposure to alcohol or oxygen deprivation at birth (WHO, 2012).

19.4.2 Social and Economic Circumstances

The capacity for an individual to develop and flourish is deeply influenced by their immediate social surroundings – including their opportunity to engage positively with family members, friends or colleagues, and earn a living for themselves and their families - and also by the socio-economic circumstances in which they find themselves. Restricted or lost opportunities to gain an education and income are especially pertinent socio-economic factors (WHO, 2012).

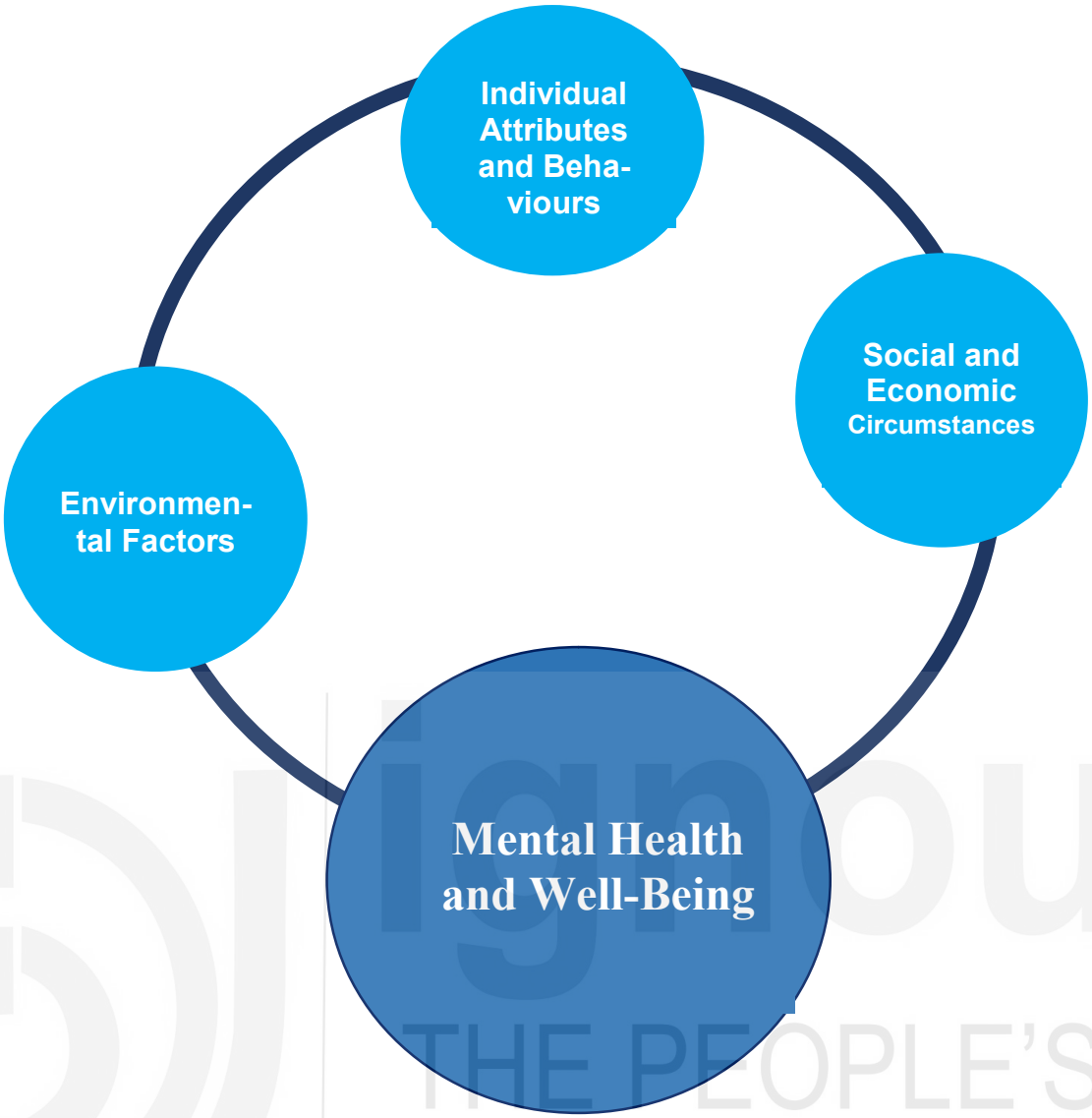

Figure-1: Determinants of Mental Health and Well-Being

19.4.3 Environmental Factors

The wider sociocultural and geopolitical environment in which people live can also affect an individual's, household's or community's mental health status, including levels of access to basic commodities and services (water, essential health services, the rule of law), exposure to predominating cultural beliefs, attitudes or practices, as well as by social and economic policies formed at the national level; for example, the on-going global financial crisis is expected to have significant mental health consequences, including increased rates of suicide and harmful alcohol use. Discrimination, social or gender inequality and conflict are examples of adverse structural determinants of mental well-being (*ibid*).

It is important to note that these different determinants interact with each other in a dynamic way, and that they can work for or against an individual's mental health state. An illustrative set of factors that may threaten or protect mental health is described in Table-1. For example, an individual's level of self-worth could be enhanced or diminished depending on social support or economic security at the household level, which in turn might be influenced

by the extent of political stability, social justice or economic growth in a country.

Table-1: Determinants of Mental Health

Level	Adverse Factors	Protective Factors
Individual attributes	**Low self-esteem** **Cognitive/emotional immaturity** **Difficulties in communicating** **Medical illness, substance use**	**Self-esteem, confidence** **Ability to solve problems and manage stress or adversity** **Communication skills** **Physical health, fitness**
Social circumstances	**Loneliness, bereavement** **Neglect, family conflict** **Exposure to violence/abuse** **Low income and poverty** **Difficulties or failure at school** **Work stress, unemployment**	**Social support of family & friends** **Good parenting/ family interaction** **Physical security and safety** **Economic security** **Scholastic achievement** **Satisfaction and success at work**
Environmental factors	**Poor access to basic services.** **Injustice and discrimination** **Social and gender inequalities** **Exposure to disaster or conflict/war**	**Equality of access to basic services** **Social justice, tolerance, inclusion** **Social and gender equality** **Physical security and safety**

19.5 MENTAL HEALTH STATES

We, as human beings, possess multiple and complex mental health states (e.g., no distress problem or illness; mental distress; mental health problem, and mental disorder or illness) and experience various emotions and cognitions and exhibit various behaviours at different points of our life. These emotions, cognitions and behaviours are influenced by the complex interactions that are continuously occurring between our brain and the environment. The environment (everything that exists outside the brain) influences how the brain functions and the brain influence and changes its environment (TMH, 2019). Figure-2 describes the interrelationship of mental

health states using a pyramid.

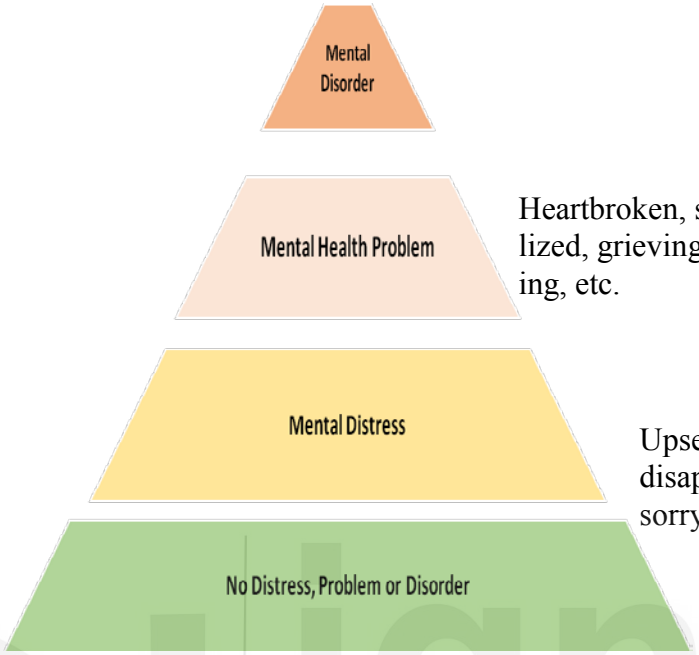

Figure-2: Interrelationship of Mental Health States

It is important to note that these states are not mutually exclusive. Any person can experience some or all these mental health states within a short period of time (such as an hour), or over a longer period (weeks, months or even years). Mental health states are also not a continuum. People do not progress from mental distress to developing a mental illness. Otherwise, everyone will end up with a mental illness. People can experience one or more states at the same time and different mental health states should be addressed differently. Every person will experience at least three of these mental health states (no distress problem or illness; mental distress; mental health problem) over the period of their lifetime. These three states are all part of usual life and together constitute mental health. They will also experience each of the other three states. A person can have mental health and mental illness concurrently.

19.6 MENTAL DISTRESS

Mental distress is the common, expected and normal response to the stresses of everyday life. For example, writing an exam, going to a job interview, giving a presentation in front of the class, asking a person to go out on a date, etc. It is a signal to us, from our brain, telling us that we need to adapt to the environment, and it is the basis for adaptation and resilience. This is called a 'stress signal' or 'stress response'. A stress response has different components to it - emotions/feelings (such as worrying, unhappiness, feeling energized, annoyance), cognitions/thinking (negative thoughts such as 'I am not good at anything', 'I wish I did not have to do this', or positive thoughts such as 'this is something I need to solve', 'it may be difficult but I can do

this', 'I should ask my friend for their advice'), physical symptoms (such as stomach aches and headaches, the stomach 'butterflies') and behaviours (such as avoidance of the situation, engagement of the challenge, positive energy, withdrawal from others, yelling at someone or helping someone). As we can see, the stress response can have both negative and positive components. We need to make sure we don't always focus on the negative ones

Everybody experiences mental distress (often called 'stress') every day. It is a part of good mental health. It is a signal that tells us to try something new to solve the challenge we are facing. As the person who feels distress tries to develop solutions or strategies to solve the challenges (often called 'stressors') they figure out what works and what does not work well. Successfully dealing with the stressor (also called solving the problem) leads to learning what strategy worked and use of that strategy in similar situations in the future. The distress goes away once the person has successfully overcome the challenge. But the learning and skill sets remain and are ready to be used another time. This process is called adaptation or resilience building.

Mental distress should not be addressed using professional intervention. On the contrary, people can adapt by themselves naturally, or with usual support and advice from the family or community. For example, a student is distressed because they are going to be late for school. Then they may get up earlier the next day for school. Learning the skills needed to be able to deal with life's challenges is an important component of prevention. These skills can be used to learn how to cope with and decrease the impact of future life challenges.

Check your progress-1

1) Give some facts about women's mental health.

2) Review any popular book on mental health.

19.7 MENTAL HEALTH PROBLEMS

Mental health problems are indicators of adaptation being challenged by the magnitude of the stressor. They are characterized by negative emotions, challenging cognitions and various difficulties with behaviour that can be severe at times and of either short or long durations (for example: death of a loved one, loss of a job, etc.) When faced with these large stressors, everyone experiences strong negative emotions (such as: sadness, grief, anger, demoralization, etc.). These emotions are also accompanied by substantial difficulties in other domains, such as, cognitive/thinking (for example, 'nothing will ever be the same', 'I don't know if I can go on in my life', etc.), physical (for example, sleep problems, loss of energy, numerous aches and

pains), and behavioural (for example, social withdrawal, avoidance of usual activities, angry outbursts, etc.). Almost everyone will experience these states many times during their life. Sometimes people experiencing a mental health problem will exhibit noticeable difficulties in everyday functioning - at school, college, office and outside of school, college, office, etc. People with mental health problems, such as grief, may need extra professional help, such as counselling, in addition to family and community support. Medical treatment (medication or psychotherapy) is usually not necessary. The presence of a supportive adult is a key component that can help people deal with a mental health problem.

19.8 MENTAL DISORDER OR ILLNESS

A mental disorder is very different from mental distress and from a mental health problem. It arises from a complex interplay between a person's genetic makeup and the environment in which they live or have been exposed to at different times in their lives. A mental disorder (also called a mental illness) is a medical condition diagnosed by trained health professionals (such as doctors, mental health clinicians, psychiatric nurses and psychologists) using internationally established diagnostic criteria. According to the American Psychiatric Association, mental illness refers collectively to all diagnosable mental disorders - health conditions involving significant changes in thinking, emotion and/or behaviour. These are associated with distress and/or problems functioning in social, work or family activities (APA, n.d.). There are many different mental disorders, with different presentations. They are generally characterized by a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others (WHO, 2019).A person with a mental disorder will experience significant, substantial and persistent challenges with emotions/feelings (for example, depression, panic attacks, overwhelming anxiety, etc.), cognition/thinking (delusions, disordered thoughts, hopelessness, suicidal thoughts, etc.), physical (for example: fatigue, lethargy, excessive movement, etc.), and behaviour (for example, withdrawal from family and friends, suicide attempt, poor self-care, etc.). The presence of a mental disorder signifies that the individual needs best evidence-based interventions that may be of many different types (such as medications, psychotherapies, social interventions, etc.), provided by appropriately trained health care providers. While interventions that can help distress and mental health problems can also be used to help a person who has a mental illness, and general health enhancing activities are always useful, a person with a mental disorder requires a degree of care above and beyond that usually provided for a mental health problem. Mental disorders require treatment using best evidence-based care by trained health professionals (such as, mental health professionals/ doctors, psychiatric nurses, psychologists, etc.).

19.8.1 Common Mental Disorders

Mental disorders are medical illnesses signifying disturbances of usual brain function. The brain has six key functions - thinking, perception, emotion, signalling, physical movements and behaviour. A mental disorder occurs

when one or more of these brain functions fail to work as they should. A variety of different influences on the brain can lead to a mental disorder. Basically, there are two major causes that can be independent or can interact - genetics (the effect of genes on brain development and brain function) and environment (the effect of things outside the brain on the brain, such as, infection, malnutrition, severe trauma, etc.) Both genetic and environmental factors exert their impact by affecting how brain cells and circuit's function.

By understanding the signs and symptoms of the mental disorder, and the underlying mechanisms that are not functioning properly, one can identify treatment/ interventions (clinical, academic and social) to best help people experiencing a mental disorder. Treatments can improve symptoms and functioning, they may prevent the illness from recurring as well as preventing the negative impact of the illness on life success (e.g., early effective treatment of depression may prevent relation breakdown or job loss).

19.8.2 Depression

Depression is a common mental disorder and one of the main causes of disability worldwide. Globally, an estimated 264 million people are affected by depression (GBD, 2017 as cited in WHO, 2019). More women are affected than men. It is characterised by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, tiredness, and poor concentration. People with depression may also have multiple physical complaints with no apparent physical cause. Depression can be long-lasting or recurrent, substantially impairing people's ability to function at work or school and to cope with daily life. At its most severe, depression can lead to suicide. Prevention programmes have been shown to reduce depression, both for children (e.g. through protection and psychological support following physical and sexual abuse) and adults (e.g. through psychosocial assistance after disasters and conflicts). There are also effective treatments. Mild to moderate depression can be effectively treated with talking therapies, such as cognitive behaviour therapy or psychotherapy. Antidepressants can be an effective form of treatment for moderate to severe depression but are not the first line of treatment for cases of mild depression. They should not be used for treating depression in children and are not the first line of treatment in adolescents, among whom they should be used with caution. Management of depression should include psychosocial aspects, including identifying stress factors, such as financial problems, difficulties at work or physical or mental abuse, and sources of support, such as family members and friends. The maintenance or reactivation of social networks and social activities is important (WHO, 2019).

19.8.3 Bipolar Disorder

This disorder affects about 45 million people worldwide (GBD, 2017 as cited in WHO, 2019). It is typically characterized by cycles (episodes) of depression and mania, i.e., consisting of both manic and depressive episodes separated by periods of normal mood. Cycles can be frequent (daily) or

infrequent (many years apart). During depressive or manic episodes, the person may become psychotic (TMHO, 2016). Manic episodes involve elevated or irritable mood, over-activity, rapid speech, inflated self-esteem, self-destructive or self-harmful behaviours, including spending sprees, violence towards others, sexual indiscretions, and a decreased need for sleep. Psychotic symptoms include hallucinations and delusions. People who have manic attacks but do not experience depressive episodes are also classified as having bipolar disorder. A person with possible bipolar disorder requires immediate referral to a highly qualified mental health services provider TMHO, 2016). Effective treatments are available for the treatment of the acute phase of bipolar disorder and the prevention of relapse. These are medicines that stabilize mood. Psychosocial support is an important component of treatment.

19.8.4 Schizophrenia and Other Psychoses

Schizophrenia is a severe mental disorder, affecting 20 million people worldwide (GBD, 2017 as cited in WHO, 2019). Psychoses, including schizophrenia, are characterized by distortions in thinking, perception, emotions, language, sense of self and behaviour. Common psychotic experiences include hallucinations and delusions The disorder can make it difficult for people affected to work or study normally. A person with schizophrenia will also demonstrate a variety of cognitive problems ranging from difficulties with concentration to 'higher order' difficulties such as with abstract reasoning and problem-solving (TMHO, 2016). Delusions are fixed erroneous beliefs that are held with conviction and may involve misinterpretation of experiences. One common type of delusion is persecutory (also commonly called paranoid) in which the person thinks they are being harmed in some way by another person, force or entity (such as God, the police, spirits, etc.). On the other hand, hallucinations are perceptions (such as hearing sounds or voices, smelling scents, etc.) that may occur in any sensory modality in the absence of an actual sensory stimulus. In schizophrenia, hallucinations are experienced as real perceptions. Stigma and discrimination can result in a lack of access to health and social services. Furthermore, people with psychosis, including schizophrenia are at high risk of exposure to human rights violations, such as long-term confinement in institutions. Schizophrenia typically begins in late adolescence or early adulthood. Treatment with medicines and psychosocial support is effective. With appropriate treatment and social support, affected people can lead a productive life and be integrated in society. Facilitation of assisted living, supported housing and supported employment can act as a base from which people with severe mental disorders, including schizophrenia, can achieve numerous recovery goals as they often face difficulty in obtaining or retaining a place to live and normal employment (WHO, 2019).

19.8.5 Dementia

Worldwide, approximately 50 million people have dementia. Dementia is usually of a chronic or progressive nature in which there is deterioration in cognitive function (i.e., the ability to process thought) beyond what might be

expected from normal ageing. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. The impairment in cognitive function is commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation. Dementia is caused by a variety of diseases and injuries that affect the brain, such as Alzheimer's disease or stroke. Though there is no treatment currently available to cure dementia or to alter its progressive course, many treatments are in various stages of clinical trials. Much can be done, however, to support and improve the lives of people with dementia and their carers and families (WHO, 2019).

19.8.6 Developmental Disorders, including Autism

Developmental disorder is an umbrella term covering intellectual disability and pervasive developmental disorders (PDDs) including autism. Developmental disorders usually have a childhood onset but tend to persist into adulthood, causing impairment or delay in functions related to the central nervous system maturation. They generally follow a steady course rather than the periods of remissions and relapses that characterize many mental disorders (WHO, 2019). Intellectual disability is characterized by impairment of skills across multiple developmental areas such as cognitive functioning and adaptive behaviour. Lower intelligence diminishes the ability to adapt to the daily demands of life. Symptoms of pervasive developmental disorders, such as autism, include impaired social behaviour, communication and language, and a narrow range of interests and activities that are both unique to the individual and are carried out repetitively. Developmental disorders often originate in infancy or early childhood. People with these disorders occasionally display some degree of intellectual disability. Family involvement in care of people with developmental disorders is very important. Knowing what causes affected people both distress and well-being is an important element of care, as is finding out what environments are most conducive to better learning. Structure to daily routines helps prevent unnecessary stress, with regular times for eating, playing, learning, being with others, and sleeping. Regular follow up by health services of both children and adults with developmental disorders, and their careers, needs to be in place (WHO, 2019).

There are different effects on men and women with mental illnesses. Depression is more common in women than in men. There are certain illnesses that only affect women and not men. Some women may experience problems during hormonal transition, such as prenatal depression, premenstrual dysphoric disorder, and perimenopause-related sadness. There are no significant differences between males and females' occurrence rates of other mental disorders, such as schizophrenia and bipolar disorder. There are some illnesses that are more common in women than in men, and this might have an impact on how they develop. (NIMH » Women and Mental Health (nih.gov).

19.9 MENTAL HEALTH IN INDIA

India was one of the first countries to develop a National Mental Health Programme (NMHP) in the early eighties with a focus on accessible and equitable mental health care. However, NMHP underwent major strategic revisions over its course (Starting from setting a district as the unit for program planning and implementation under the District Mental Health Program (DMHP) to incorporating it with the National Rural Health Mission (NRHM) for effectively scaling up the program) and its impact was limited by financial and human resource constraints, lack of community participation and a robust monitoring and evaluation system. The fact of the matter is – mental health problems are still a matter of great concern in the country and the myths and taboos attached to this subject are prevalent to this date.

Today, the country is known as the world's suicide capital with over 2.6 lakh cases of suicide in a year. WHO estimates that roughly 20 per cent of Indians suffer from some sort of mental disorder (Bhatia, 2020). According to another estimate, common mental disorders (CMDs), including depression, anxiety disorders and substance use disorders are a huge burden affecting nearly 10.0% of the population (NMHS, 2015-16). WHO also estimates the economic loss due to mental health conditions in India, between 2012-2030, at USD 1.03 trillion (WHO, n.d.).

19.10 LAW AND POLICY RELATED TO MENTAL HEALTH IN INDIA

National Mental Health Programme-*The Mental Health Care Act 2017* was passed on 7 April 2017 and came into force from 7th July 2018.The law was described in its opening paragraph as "An Act to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto. "This Act superseded the previously existing the **Mental Health Act, 1987** that was passed on 22 May 1987.

The Government of India launched the **National Mental Health Programme (NMHP) in 1982**, keeping in view the heavy burden of mental illness in the community, and the absolute inadequacy of mental health care infrastructure in the country to deal with it. The district Mental Health Program was added to the Program in 1996. The Program was re-strategized in 2003 to include two schemes, viz. Modernization of State Mental Hospitals and Up-gradation of Psychiatric Wings of Medical Colleges/General Hospitals. The Manpower development scheme (Scheme-A & B) became part of the Program in 2009.

3 main components of NMHP -

- Treatment of Mentally ill
- Rehabilitation

- Prevention and promotion of positive mental health.

Objectives -

- To ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future;
- To encourage the application of mental health knowledge in general healthcare and in social development;
- To promote community participation in the mental health service development; and
- To enhance human resource in mental health sub-specialties.
- Strategies -
- Integration mental health with primary health care through the NMHP
- Provision of tertiary care institutions for treatment of mental disorders
- Eradicating stigmatization of mentally ill patients and protecting their rights through regulatory institutions like the Central Mental Health Authority, and State Mental health Authority.

District Mental Health Program:

Envisages provision of basic mental health care services at the community level.

Objective: -

- To provide sustainable basic mental health services to the community and to integrate these services with other health services
- Early detection and treatment of patients within the community itself
- To reduce the stigma of mental illness through public awareness.
- To treat and rehabilitate mental patients within the community.

Source : https://www.nhp.gov.in/national-mental-health-programme_pg

19.11 KEY GAPS

Some of the key dimensions of India's mental health crisis are –

a) Shortage of mental health professionals,
b) Inadequate infrastructure,
c) Poor service delivery,
d) Low awareness,
e) Dearth of evidence and research,
f) Inadequate policy provisions, and
g) Poor financing

19.11.1 Shortage of mental health professionals

The entire mental health workforce, comprising clinical psychiatrists, psychologists, psychiatric social workers, and psychiatric nurses, stands at 7,000, while the actual requirement is around 55,000 (TNN, 2018). Thus, there is huge gap between demand and supply. On the other hand, mental health agenda is largely driven by psychiatrists who specialize in clinical management and don't have any formal public health training. This is a significant barrier to the sector adopting a holistic approach (DASRA, 2017).

19.11.2 Inadequate infrastructure

At least 3.5 million Indians need hospitalization on account of mental illnesses. The country has 40 institutions with a total of 26,000 beds equipped for mental health patients. Of these 40, only nine are equipped to treat children's Rural areas are even worse equipped About 70% of India's population lives in rural areas, but only 25% of hospitals, clinics and mental health professionals are in rural areas (DASRA, 2017).

19.11.3 Poor service delivery

There is disproportionate emphasis on the biomedical approach in the country. Psychiatrists are trained to prescribe medication as the only cure. This neglects the role of social factors in mental health, and the benefits of alternative forms of therapy. It also disregards the role of counsellors, social workers and other professionals who facilitate access to legal aid, employment, housing, etc. There is also inadequate focus on community-based care. Most mental healthcare in India is currently delivered through institutions. However, more than 90% of patients with chronic mental illness live with their families. Research has shown that caring for a relative with mental illness is associated with high distress for the family caregiver. Yet few programs exist to support them (DASRA, 2017).

19.11.4 Low awareness level

There is lack of mental health literacy. A study of rural, urban and tribal communities across five states in India found that a large proportion of respondents did not know what constitutes mental illness, where mental healthcare is available, and even that medical treatment for mental health exists and can be effective. Most people believed that mental illness is the result of evil spirits, black magic, or sins from a past life, and that a traditional healer could improve their condition (Gaiha, 2014). There is also widespread stigma surrounding mental illness. It causes delays in seeking care, impedes timely diagnosis and treatment, hinders recovery and rehabilitation, and ultimately reduces the opportunity for fuller participation in life.

19.11.5 Dearth of serious evidence and research

Rich qualitative data from local, lived experiences is rarely used as evidence to build programmes. Therefore, international trends and successes from one-

off trials often influence development of local models, losing the nuance and granularity needed to develop effective responses and sustainably scale interventions. Investment in research and evaluation of innovative pilot programs, to understand their effectiveness and potential to scale in the Indian context is also lacking (DASRA, 2017).

19.11.6 Inadequate provisions

Although India has various legal measures to protect the human rights of the mentally ill, the proper implementation of these Acts is an issue, Especially Women's mental health has not given adequate attention in India, many government institutions still retain prison-like environments and structures, with patients sleeping on the floor, urinating, and defecating in the cell due to lack of toilets, and archaic practices such as uniforms and shaved heads. There is no comprehensive regulatory mechanism to maintain minimum standards at private and public residential mental health facilities either. Self-proclaimed and unqualified psychologists, life coaches, social workers and counsellors, as well as practitioners of alternative medicine and traditional faith healers are adversely affecting the standard of mental health services in India, and too often result in a breach of ethical practice, and harm done to the patient.

19.11.7 Poor financing

There is limited government funding on mental health programmes. As against 10.8% and 6.2% spending on mental health as a percentage of health budgets in England and United States, respectively, the corresponding figure is a meagre 0.06% only for India. While health at large is one of the leading sectors that philanthropists in India give to, mental health is still a highly underfunded cause within private and corporate philanthropy, largely due to the difficulty of measuring impact in the sector (DASRA, 2017).

Therefore, the need of the hour is to sensitise and educate individuals about the signs and symptoms of mental illness, while normalising the idea of seeking support for themselves and their loved ones. There needs to be more open discussion and dialogue with the general public (and not just with experts) on this subject. Therefore, to create a better mental health landscape in the country, a multi-pronged approach will be required – from improving mental health infrastructure and service delivery to increasing awareness/reducing stigma, generating high quality data & evidence, and enhanced government & private funding to mental health programmes.

19.12 LET US SUM UP

Thus, in this Unit we studied that the maxim, 'there is no health without mental health' underlines the fact that mental health is an integral and essential component of health. Article 21 of the Constitution of India provides for the right to life that includes the right to health. However Mental health, hitherto neglected, is now recognised as a critical requirement, and is engaging the attention of policymakers, professionals, and communities in

India and across the globe. In the Indian context, a systems approach to mental health becomes critical not only to advance mental health, but also because of its impact on the nation's commitment to implement Mental Health Action plans and to achieve Sustainable Development Goals (SDGs) in the coming years. Unfortunately, in most parts of the world, mental health and mental disorders are not accorded anywhere near the same degree of importance as physical health. Rather, they have been largely ignored or neglected. The relationship between the burden of mental disorders and spending is clearly inappropriate. Urgent action is needed also to close the treatment gap and to overcome barriers which prevent people from receiving appropriate care. The funding for mental health programmes needs to be streamlined with good planning, increased allocation, performance based timely disbursal, guaranteed complete utilisation and robust mechanisms for oversight and accountability. Legal, social, and economic protection for persons with mental illness should be ensured through existing legislative provisions and state specific legislations to guarantee mental health care to citizens should be strictly implemented. It is essential that mentally ill persons should receive good quality mental healthcare and living conditions in their homes and society.

19.13 UNIT END QUESTIONS

1) What do you understand by mental health?

2) Explain the key dimensions of India's mental health crisis.

3) Describes the interrelationship of mental health states.

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UNIT 20 OCCUPATIONAL HEALTH

Structure

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20.8 Critique of the Labour Code

20.9 Let Us Sum Up

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20.11 Refences

20.12 Suggested Readings

20.1 INTRODUCTION

In this unit, we will study about occupational health laws in India. The Constitution of India provides a detailed framework to protect the civil and political rights of the individuals and citizens under Chapter 3 titled as `Fundamental Rights' while the provisions for ensuring the social and economic rights are being made in the Chapter 4 titled as `Directive Principles of State Policy. These Directive Principles provides for securing health of workers, both men and women. It is also stated that it is the duty of the state to ensure that children of tender age are not abused or exploited or be engaged in any hazardous employment (Article 24) and that the citizens are not forced by the economic necessity to enter into vocations which are not suited to their age or strength (Article 39). Also, it is stated that it is the duty of the state to ensure just and humane working conditions and also to ensure that maternity reliefs are provided at the work place. (Article 42) The government shall take steps to secure the participation of workers in the management. (Article 43A). Occupational health and safety (OSH) is an important endeavor and to achieve this goal, the government has enacted several laws to ensure that every worker, man or a woman, is safe. Some of these are: Factories Act, 1948, the Mines Act, 1952, the Workmen Compensation Act, 1923, the Maternity Benefits, 1961 Act among many others. This is to preserve human resources, ensure wellbeing of the workers and to ensure healthy working conditions at every workplace because without ensuring safe and healthy working environment, neither social justice can be done nor economic growth could be achieved. However, in 2020, the government enacted four Codes while replacing 29 legislations in order to modernize labor regulations. In this unit, we will discuss the Occupational

Safety and health issues. We will also understand inadequacy of the laws relating to OSH laws and also provisions related to safety of women.

20.2 LEARNING OUTCOMES

After studying this Unit, you should be able to:

- Learn the legislation available in India relating to occupational health and safety (OSH)
- Understand inadequacy of the laws relating to OSH laws
- Engaged with Specific Provisions relating to Safety of Women; and
- Know about case studies

20.3 OCCUPATIONAL HEALTH AND EMPLOYMENT

Health is an important human right and needs extra protection by specific policies and legislations. Occupational health is defined as the highest degree of physical, mental and social wellbeing of the workers and deals with health and safety at workplace. At the basic level, it also deals with prevention of hazards.

At the workplace, workers may face different forms of problems. Occupational disorders may include not only physical harm or injuries but these may also be psychological harm and may also be caused by biological and chemical actions. Major occupational injuries include – injuries due to accidents, pneumoconiosis (lung damage due to dust inhalation, such as silicosis), chronic obstructive lungs diseases, muscoskeletal problems, stress, skin problems, allergies, cancer, and other diseases.

It has been estimated by the ILO that 2.78 million people die every year as the result of occupational incidents or work-related diseases. Additionally, there are some 374 million non-fatal injuries that take place every year resulting in more than 4 days absence from work. In fact, the work-related health problems result in loss of 4 – 6 % GDP for most of the developed countries and 10 percent for the developing countries. Much expenditure is incurred in financial burden due to compensation, providing health care, rehabilitation and loss of life. Research studies have demonstrated that workplace health initiatives can help reduce sick leave absenteeism by 27% and health care cost for companies by 26% (WHO Fact Sheets, 2017).

The World Health Organization has developed several guidelines that are applicable to work settings and relate to protecting health in workplaces. (WHO, 2017) The Occupational Safety and Health Convention No. 155 of the International Labour Organization also provides for adoption of coherent national safety and health policy and lays out actions to be taken by the governments and within enterprises to promote occupational safety and health to improve working conditions. In the next section, we will study about occupational health and employment Indian perspective.

Check Your Progress-1

1) What is meant by the term occupational health?

2) What are the international law provisions regarding occupational health?

20.4 OCCUPATIONAL HEALTH AND EMPLOYMENT INDIAN PERSPECTIVE

The Indian Constitution requires State to ensure health and wellbeing of the citizens. Workers, either employed in public or in private sectors or are self-employed, majorly contribute to the social and economic development of the country. Safety and health of workers has a positive impact on productivity and economic development and should be seen as an important part of the business.

In India, the 6th Economic census conducted in 2013-14 reported that there are 5.9 crores establishments in India that employ 13.1 crores people (out of which 72% were self-employed and 28% hired at least one worker). A total of 79% workers were in an establishment with less than 10 workers. Another Annual Survey of Industries (2017-2018) of registered factories indicate that 47% factories employ less than 20 workers, and provided 5% employment and 4% output. Further, a vast number are working in agriculture and other informal sectors.

So, broadly, the workers can be categorized as those working in the organized sector and those working in the unorganized sector and protecting the rights of workers in all the sectors is essential. However, the major labour laws relating to occupational health and safety are applicable in the organized or formal sector, whereas the vast majority of workers are employed in the unorganized sector that frequently remains out of the purview of the law. Therefore, for workers in the unorganized sectors, no provisions exist to take care of their occupational health.

The situation today is that the incidents of industrial accidents are rising. During the lockdown imposed due to COVID-19 alone, 30 industrial accidents occurred in India killing at least 75 workers and injuring hundreds. Even earlier, the Bhopal Gas Tragedy that took place in December 1984 exposed more than 500,000 people to the deadly Methyl Isocyanate gas that leaked through a pesticide plant in Bhopal, Madhya Pradesh. The immediate official death toll was 2,259. Another report estimated that more than 8000 people died while thousands suffered temporary or permanent disabilities. The industrial accidents are under reported but are a major concern as little protection has been granted to workers or people affected by the industrial accidents. The lackadaisical policies have caused much destruction in terms of health and loss of life. With the underdeveloped health care system and lack of proper implementation of labor laws, occupational disorders are

increasing resulting in huge losses in terms of lives, capital and time.

The concern therefore is to create an enabling environment that facilitates output, job creation, and growth, yet at the same time, the need is to protect the rights of the workers, assure them their minimum wages, social security, reduction of job insecurity, maintaining health and safety standards, policies for protecting health rights of workers, stringent regulation of factories dealing in hazardous material, resolution of effective management of industrial disputes and a mechanism to ensure collective bargaining and enforcement of basic rights of workers.

20.5 OVERVIEW OF THE EXISTING LEGISLATION RELATING TO OCCUPATIONAL HEALTH AND SAFETY (OSH)

The basic aim of the labour laws is to ensure safe standards, to protect basic needs and rights of the workers and take care of their welfare. There are almost over 100 state laws and 40 central laws regulating various aspects of labor including those relating to resolution of industrial disputes, working conditions, social security and wages. Broadly these laws may be categorized as

1) Laws regulate working hours, condition of services and employment such as the Factories Act, 1948, the Plantation Labour Act, 1951, the Mines Act 1952, the Motor Transport Workers Act, 1961, the Beedi and Cigar Workers (Condition of Employment Act, 1966, the Contract Labor (Regulation and Abolition) Act, 1970, and many other such laws

2) Laws relating to social security such as the Workmen Compensation Act, 1923, the Employee State Insurance Act, 1948, the Employee Provident Fund and Miscellaneous Provisions Act, 1952 and the Payment of Gratuity Act, 1972.

3) Laws relating to labor welfare such as the Mica Mines Labor Welfare Fund Act 1946, the Beedi Workers Welfare Fund Act, 1976, the Cine Workers Welfare Fund Act 1981, the Employment of Manual Scavengers and Construction of Dry Latrines (Prohibition) Act, 1993

4) Laws relating to employment training such as the Employment Exchange (Compulsory Notification of Vacancy) Act 1959 and the Apprentice Act, 1961

5) Laws relating to equality and empowerment of women such as the Maternity Benefit Act, 1961, the Equal Remuneration Act, 1976, and the Sexual Harassment of Women at Workplace (Prevention, Prohibition, and Redressal) Act, 2013

6) Laws against exploitation such as the Bonded Labor System (Abolition) Act 1976 and the Child Labor (Prohibition and Regulation) Act 1986

7) Laws relating to resolution of industrial disputes such as Industrial Dispute Act, 1947

8) Other miscellaneous legislation such as the Fatal Accident Act, 1855, the Weekly Holiday Act, 1942, and the Public Liability Insurance Act, 1991

Besides the legal framework, the Ministry of Labour and Employment, Government of India has approved a national policy on safety, health and environment at workplace in 2009. It provides guidelines for developing and maintaining safety cultures at workplaces. It includes eight specific areas for actions – enforcement, development of national standards, ensuring compliance, increasing awareness, promoting research and development, occupational safety, health skill development and data collection. The main objectives of OSH legislation and policies are:

- To provide a statutory framework to control the economic exploitation of workers and design suitable mechanism for compliance.
- To ensure a system of incentives to employers and employees so as to achieve high standards of health and safety
- Reducing the risk of workplace injuries, fatalities and diseases
- Reducing the cost relating to workplace injuries
- Increase community awareness regarding OSH measures
- Provide administrative and technical support services

Besides, the WHO and the International Labour Organization (ILO) has adopted numerous international standards conventions and recommendations concerning occupational health and safety and for implementation of labour laws. India has ratified some of these conventions, however, much more needs to be done to protect the rights of the workers. In the next section, we will read about specific provisions relating to safety of women.

Check Your Progress-2

1) Why do you think we require special laws to ensure occupational health and safety of workers?

2) What are the objectives of OSH laws?

20.6 SPECIFIC PROVISIONS RELATING TO SAFETY OF WOMEN

As per census 2011, the total number of women workers is 149.8 million of which 121.8 million workers are in rural areas and 28 million are in urban areas.

- Many women face harassment at the workplace. The Sexual Harassment of Women at Workplace (Prevention, Prohibition, and Redressal) Act, 2013 is enacted to ensure safe working environment to women.

- Under several laws such as the Factories Act, 1948, the Plantation Labor Act, 1951, the Mines Act, 1952, the Contract Labour (Regulation and Abolition) Act, 1970, the provisions have been specifically made for separate toilets and washing facilities for women workers besides provisions have been made that employers should provide creche facilities.

- To ensure safety to women working in night shifts, earlier the Section 66 (1) of the Factories Act, 1948 states that no woman shall be required or allowed to work in any factory except between the hours of 6 am and 7 pm. However, later, changes have been made and certain state governments extend these timings to 5 am and 10 pm. Some of the High Courts such as those in Madras and Gujarat considers this provision of not allowing women to work in night shifts as discriminatory. The Madras High Court in Vasantha R v Union of India (Case No. WPC 4604 of 1999) laid down certain conditions for providing protection to women in case they are required to work beyond 10 pm, which include separate transportation facilities, separate canteen facilities, restrooms, women to work in groups and so on.

- Similarly, under the Shop and Establishment Act, female employees are allowed to work during the daytime and it is held that it is the duty of the commercial establishment to provide adequate security and proper transport facility to women workers during the night shift.

- The state governments of Haryana, Maharashtra and Tamil Nadu have also laid down certain specific regulations for employing women during the night shifts. For the IT (Information Technology) Companies, the state governments in Delhi, Maharashtra, Karnataka and Haryana have enacted specific IT policies where the employers are mandated to take specific measures to ensure safety of women employees.

Case Study -1

A female air hostess challenged the Air India Employee Service Rules claiming that these were discriminatory against female employees in terms of multitudes of grounds such as promotional avenues, different retirement age for male and female employees, different conditions pertaining to termination of services of Air hostesses in case of marriage and pregnancy (retirement age for females at that point was 35 years or on marriage or on first pregnancy for female employees as compared to that of male employees which was 58 years), and also discriminatory powers being given to the Managing Director under Rule 47 to increase the age of retirement at his own behest. The Supreme Court held that such provisions are discriminatory under Article 14 of the Indian Constitution (Right to Equality before law), Article 15 (Non-Discrimination) and Article 16 (Equality of opportunity in the matter of public employment) The Supreme Court held that the Rules regarding discrimination in retirement and termination are unconstitutional. **(For details see Air India versus Nargeesh Mirza)**

Let us read labour laws and reforms in the next section.

20.7 LABOUR LAWS, REFORMS

Many of the critiques have stated that the labour laws relating to occupational health are inadequate and complex. It has also been stated that India has spates of laws to protect the rights of workers, yet most of these are not properly implemented. The number of industrial accidents remain high. The health infrastructure is worrisome and the schemes such as Employees State Insurance Scheme focus only on curative treatment rather than on prevention, diagnosis or treatment of occupational diseases. (Mavlankar D 2019) Lack of occupational health expertise and facilities to diagnose occupational diseases remains abysmal.

The laws provide for appointment of health or safety inspectors. Yet, there numbers remain inadequate and due to scarcity of staff, regular inspection could not be carried out. Training of the staff is yet another issue as they are not adequately equipped to respond to the complaints or accidents. Laws could not keep pace with the technical or the scientific developments. Also, a large part employed in the unorganized sector remained out of the purview of the benefits of laws. The Second National Commission on Labor in 2002 found that the existing legislation is archaic, complex and inconsistent.

To improve ease of compliance and to ensure uniformity in the legislation this Commission suggested to consolidate the labor laws and in 2019, the Ministry of Labor and Employment introduced four Bills on Labor Code to consolidate 29 central laws. These Codes regulate: 1) Wages; 2) Industrial Relations, 3) Social Security and 4) Occupational Safety, Health and Working Conditions. The Code on Wages has been passed by the Indian Parliament in 2019.

The Occupational Safety, Health and Working Conditions Code 2019 (OSHWC) was presented before the Parliament on 23 July 2019 and has been passed in September 2020 along with the other two Codes. The OSHWC Code `intends to simplify, rationalize and amalgamate' the provisions in 13 labour laws concerning the factories, mines, dock workers, building and other construction workers, plantation labour, contract labour, interstate migrant workmen, working journalists and newspaper employees, beedi and cigar workers, cine workers and cinema theatre workers.

The OSHWC is applicable to the factories employing 20 or more workers and, in the process, where manufacturing is involved with machines 40 or more workers. The Code made it mandatory for the employer to appoint a welfare officer when 250 workers are employed. The workers are to be provided double the wages for overtime and the Code laid down the responsibilities of the employers to provide facilities such as provision of drinking water, proper lightening, creche for 50 female workers, and washrooms. The workplace should be free from hazards and for conducting compulsory annual health checkups, camps to be organized by the employers. The Codes passed in 2020 empowered the Central government to register the unorganized workers and to create a social security fund for the workers in

the unorganized sector. It provides for creation of Boards for the purpose of administering Schemes for unorganized workers. The Code provides that women will be entitled to be employed in all types of establishments for all type of work and in case they are required to work in hazardous conditions, the government may require the employers to provide adequate safeguards prior to their employment.

Check Your Progress-3

1) Do you agree with the critiques?

2) Why do you think we need to reform the labour laws?

20.8 CRITIQUES OF THE LABOUR CODE

The critiques of the labour law reform alleged that the Code relating to OSH is made narrowly applicable and passed without consultation with the representatives of the workers or from the state governments. (Working People's Charter, 2020) It is also stated that the Code has limited coverage and leaves out majority of establishments including those in unorganized sector, those which employ less than 10 workers. Also, it does not offer any form of social protection to vast majority of informal sector workers including migrant workers, agriculture sector that employs more than 50% of total working population, self-employed workers, home-based workers and other vulnerable groups including those working in hotel and eating places, brick kilns, fire-work, carpet manufacturing, machinery repairs among others. It is being said that the Codes facilitate ease of doing business rather than promoting welfare of workers. It does not put any safeguard for women's safety though it permits women to work in all kinds of work (Rajalakshmi,2020)

Some of the critiques noted that the Code is poorly and carelessly drafted and suffers from operational deficiencies while confusing between `employees' and `workers' that may have significant impact on the rights and responsibilities of covered workers/employees. (Shyam Sundar, 2020) It is also said that the Code defined `hazardous process' and include the list containing 29 industries but has omitted to empower the state governments to add to or delete the industries involving hazardous processes. This list has not been updated since 1987. The Code has also demolished the statutory requirement as provided in the Factories Act of 1948, regarding constitution of bipartite committees consisting of representatives of workers and management in every factory where hazardous process is employed. Hence the rights of workers are diluted. Code has also failed to fix the responsibilities of employers in respect to safety and health. The safety committees in establishments employing 250 or more workers will exclude more than 90 percent of units. Therefore, it is said that the Code has failed to comprehensively address the issues surrounding the Occupational Health and Safety.

Case Study-2

X was working in a company and it was alleged that on 12.8.88, the Chairman of the company tried to molest her. X was not competent or trained to take dictations. But the Chairman insisted her to do so and while she was taking dictation, he tried to sit close to her and touch her despite her objections. Miss X told him that he should stop doing so or `she would leave the place if he continues to behave like that'. He did not stop. Though he went out for a while but came back and repeated the same behavior. He also tried to molest her physically in the lift and she has to press the emergency button to rescue herself. The case finally went to the court and the Supreme Court says that this behavior constitutes creating the hostile work environment and is a form of sexual harassment and upheld the removal of his services. **(For details see, Apparel Export Promotion Council v AK Chopra)**

20. 9 LET US SUM UP

In the current context, the need of the hour is to focus on occupational health of the workers. The process of merely enacting laws is not sufficient, the need is of proactive policy initiatives, training and capacity building of the human resources, access to health facilities, investing in research, taking steps to take care of workers in the unorganized sector, universal health coverage, data collection, ratifying and implementing the ILO Conventions on Decent Work, Health and Safety, developing expertise in occupational health in India with the focus on the preventive aspects of health. The aim is to create safe work spaces for workers while also protecting their rights. In this chapter, we have discussed the laws relating to occupational health and safety of workers. Though India has adopted the policy of industrialization, the occupational health and safety of its growing workforce remains a challenge. We have also discussed the lacunae in the laws and discussed that the laws require reform but more so, important is proper implementation of the laws to ensure that occupational health and safety is given prime importance.

20.10 UNIT END QUESTIONS

1) What is occupational health and employment? Discuss.
2) Evaluate Indian perspectives on occupational health and employment.
3) Discuss the legislation related to occupational health and safety (OSH)

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