A) Women’s Right to Health:

Down the ages, women have been going through a hell like situation in a male-dominated society. It is true not only in the Indian context but elsewhere in the world. The ancient Indian scriptures mention that where women are worshipped God resides at that place. But do the males realize this fact? On the contrary, they have stored this idea or belief in their mind that God created women for men and so he uses women as a mere toy or an object to play with for the fulfillment of his needs.

The vedic period can best be termed as the period of feminine glory and also of masculine sagacity and liberalism. In the later Aryan period after 300 B.C., domination by the Brahmins (the priestly growth of the caste system and other factors) led to social decline. Wives were expected to worship their husbands, barren women were thrown out of homes and widows were not permitted to remarry. The Bhakti cult tried to restore women status and some of the forms of oppression. In the Medieval period, the position of women was further degraded and they came to be treated as chattles. Women were put behind veil. Social evils like Sati, Child Marriage, female infanticide arose. Women suffered great disabilities. The evil of dowry, child marriage, sati had become deep rooted,

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2 Id at 21.
4 Id at 21.
especially in Rajasthan\textsuperscript{6} and even after 62 years of independence, such evils continue to exist in various parts of the country.

(i) Gender Discrimination and Women Health

The gender bias is prevalent not only at the societal level but it has embodied its deep roots into the basic unit of the society i.e. the family. The story starts from the moment it is known that the conceived baby is a girl and runs throughout her childhood, adolescence, married life, old age and ends only with her death. In other words the discrimination starts from the womb and ends up in the tomb.\textsuperscript{7}

Obsession for a son is deeply enriched in our society, and infact, is by and large an Asian phenomenon. A number of cultural, social and economic factors influence the, relative benefits of sons and daughters, and ultimately parent’s gender preference. The factors that underlie ‘son preference are mainly socio-culture. In the context of India’s patrilineal & patriarchal society, having a son is imperative for continuation of family lineage. There is a mindset that sons are important as only they can perform many religious functions. According to Hindu traditions, sons are needed to perform last rites and also sons are expected to provide economic support to the family especially during old age of the parents.

Desire for sons often results in repeated, closely spaced pregnancies, birth of unwanted girls, and premature female death. The desire for a male child manifests itself so blatantly that parents have no fears about terminating the girl child even before she is born. The practice of female infanticide has existed in different parts of India for generations, whereas female foeticide relatively new

practice which is widely practiced today. The birth of a girl child is taken as a curse as she is perceived to be an economic and social liability. The discrimination is reflected in all aspects including nutrition, education and health care. There is a well documented practice of preferential treatment of boys and gross neglect of female children in intra-household and outside allocation of resources. After birth, girl has to learn quite early that she is a second class citizen in her mother’s home.

Women are subjected to violence and discrimination right from birth till death in all spheres including health. The ‘Right to Health’ is central not only to all human rights but also to long term development of individual and society at large. In this context, one has to specifically address female health as it is of the utmost importance, for she is the one who carries the future progeny. It is a woman who looks after the entire family and nurtures the future progeny. In case of the denial of health right to a woman, it will not only have adverse consequences for her own self but the entire family will be affected.

Further, women, constituting around half of the population, play a distinct role in development of our nation. As a housewife, she maintains the productivity of the human capital within her household through proper home management. The average maternal mortality rate in India is between four and five of 1000 live births, and, is one of the highest in the world. Women are under-nourished and at times malnourished. Frequent pregnancies, coupled with a

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8 Female infanticide occurs when the child is killed after birth, while female foeticides occurs when the foetus is killed while it is still in the womb of the mother after determining that it is female.


10 supra note 7.
poor diet, result in anemia and women fall ill more frequently. All these result in a reduced life span of women. Illiteracy among women, in particular amongst rural women, has added to the problem, as most of the rural women are subjected to the various traditional beliefs and health practices. The basic nature of health problems is attributed also to lack of health literature and health consciousness, poor maternal and child health services and occupational hazards. The social status of women and girl child also leads to the negligence of their health in the society. The consequences of inadequate body reserves, deficient dietary intakes, and the resultant low pregnancy weight gains, results in the nutritional stress. However, less attention has been accorded to these nutritional problems in the context of rural women’s general well being and their participation in economic and social development.

The caste system is an unfortunate and evil reality of the Indian Hindu society. While there is discrimination against women in all castes, the status of Indian dalit women is, undoubtedly, worst in the world. She is the one, who is paraded naked in village, gang raped, hanged and chopped into pieces if she marries a man of another caste, and the health picture of dalit women is not very good. The tragic reality is that too often maternal deaths are not visible. They don’t leave any trace behind and their deaths are not accounted for.

New data suggests that among the women dying during pregnancy, delivery or post partum complication, a large proportion about 50% are from the Scheduled Castes and Scheduled Tribes. According to data collected by Unicef, on Maternal and Perinatal

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11 B.V. Sandhyavani, "Health Problems of Rural women", Kurukshetra, at 28 (October 2008).
12 Ibid
Death Inquiry and Response (MAPEDIR), cases of 1600 women were analysed and was found that in some states MMR was higher than the national average. It was found to be 301-358 in Orissa, 371 in Bihar, and 379 in M.P. Since many deaths occurred in the anonymity of women’s homes or on the way to seek medical help they often go unrecorded.\textsuperscript{14}

Further, fertility rates are found to be higher for women among Scheduled Castes (2.8) and Scheduled Tribes (2.9), when compared to other women because women in these groups are less likely to use family planning methods. Mothers from these caste groups are more likely to take their children to the anganwadi centres than other groups. Only 4\% of expectant women from SCs & STs had an ultrasound tests. Under nutrition anaemia is particularly seriously high in rural areas among scheduled tribes and scheduled castes, and among those with no education.\textsuperscript{15}

Women and girls are the most affected by hunger and poverty. Girls are breast fed less frequently and for shorter durations in infancy. Adult women consume approximately 1,000 calories fewer per day than men according to one estimates from Punjab.\textsuperscript{16}

A primary way that parents discriminate against their girl children is through neglect during illness. Sick little girls are not taken to the doctor as frequently as are their brothers. A study in Punjab shows that medical expenditures for boys are 2.3 times higher than girls. Similarly, adult women get less health care than men.\textsuperscript{17}

\textsuperscript{14}‘Unicef: SCs/STs Account for 50\% Pregnancy Deaths’, The Times of India, October 11 2008.
\textsuperscript{16}Divya Shukla, “Rural Women and their Nutritional Health”, Kurukshetra, at 32 (October 2009)
\textsuperscript{17}Id, at 33. In India, a girl is 1.5 times less likely to be hospitalized than a boy, and upto 50\% more likely to die between her first and fifth birthday.
Moreover, according to available data of NFHS III (2005-06), 55% of women are anaemic. Women who are breast feeding or pregnant are also more likely to have anaemia. Early marriage leads to another set of health hazards according to the National Family Health Survey. Most women die because they are too young to take care of their children, repeated pregnancies for the sake of a son also cost them their lives. Hence, millions of mothers and children are dying every year in pregnancy, childbirth and early childhood.

The major reasons for both maternal and infant mortality are poverty, early marriage, malnutrition and lack of awareness about health care during pregnancy. For instance, although diarrhoea is the second largest killer of babies, only 43% mothers know about ORS and only 26 percent report ever having used it. Most of children are fed complementary foods between the ages of six and nine. The second National Family Health Survey says that uneducated mothers tend to lose the most infants. The Third National Family Health Survey (2005-06) Report says that among mothers who gives birth, 50% receives antenatal care from a health professional, and 24% from other health personnel. Young women were more likely than older women to receive antenatal care. Two-thirds of women in Bihar did not receive any antenatal care. Survey say three out of every five births in India takes place at home only, whereas two in five births

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18 A Recent survey conducted by national rural health mission (NRHM) reveals that iron deficiency is highly prevalent among young women in Punjab. Blood Examination of 33, 685 pregnant women and 16, 595 children in 299 health camps organized by the Punjab health department revealed that the haemoglobin level over 65% women was below 8 g/dl. See for details '65% women in Pb anaemic: Study'. The Times of India August 28, 2009.

19 supra note 15. Girls below 18 years get married and have the first baby by 19. In rural India 60 percent girls are married before they are 18 and also become mothers. Also visit http://www.infochangeindia.org/womenibp.jsp (accessed on December 4, 2006).

20 'Young Mothers' The Tribune, April 7, 2005.

take place in health centre. Most women receive no post natal care at all.22

Social restrictions on women’s mobility also contribute to lesser health care for them and their children. For example, 90 percent of married women in Uttar Pradesh and Jammu Kashmir and about 80 percent in Bihar, Madhya Pradesh, Rajasthan and Haryana, West Bengal and Assam need permission to visit even friends and relatives. As per reports communicable diseases are more of a threat to pregnancy. Tuberculosis and not pregnancy is the leading cause of death of women in reproductive age group, followed by burns and suicides. In India, the risk of dying between ages one and five years is 30-50 percent higher for females than for males. As compared to boys, female children are often brought to health facilities in more advanced stages of illness, are taken to less qualified doctors when they are ill, and medical expenditure for boys are 2.3 times higher than for girls.23 In the International Conference On Population and Development (ICPD) held in Cairo in 1994, ‘Reproductive rights’ were defined as:24

“right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have information and means to do so, and the right to attain the highest standard of sexual and reproductive health”

The conference used the internationally recognized definition of reproductive health, as:

“a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.”25

India offers both contraception and limited abortion services to women. There are, number of laws relating to children and women

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22 supra note 15.
23 supra note 13 at 60.
25 Ibid.
in India. Though there has been an articulation for the general right to health and for specific aspects of reproductive health within constitutional law, yet the Indian government, it appears, has not explicitly created a legally enforceable reproductive rights regime in practice.

It is submitted that a comprehensive law on reproductive rights, one which is grounded in a theory of right to gender equality, would be a positive step in such a direction. A reproductive rights regime however, needs to be complemented by a women empowerment regime, otherwise, in a patriarchal society like India, reproductive decisions may turn out to be disadvantageous for a girl child.

The fertility revolution has impacted lives of women in many significant ways. Contraception has given a lot of sexual freedom to woman as well as control over their bodies. 'Fertility by choice, not by chance, is a basic requirement of women's health, well-being and quality of life. A woman who does not have the means or the power to regulate and control her fertility cannot be considered in a "state of complete physical, mental and social well being". She cannot have the joy of pregnancy that is wanted, avoid the distress of a pregnancy that is unwanted, plan her life, pursue her education, undertake a productive career, or plan her births to take place at optimal times for child bearing, ensuring greater safety for herself and better chances for her child's healthy development.'

It is equally important to recognize that women have more stakes in fertility control and are responsible for approximately ¾ of

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contraceptive use in comparison with men’s.\textsuperscript{28} Now women have a wide choice of methods that are highly effective as well as reversible. They have more reliable methods of birth control than ever before, but they have paid its price also. As with any drug, an increase in the effectiveness of contraceptive is often accompanied by a decrease in the margin of safety.

Many of the methods that are available for use of women are associated with potential health hazards like menstruation disturbances, headache, or weight gain. These may not threaten life, but may be of extreme concern and often significantly affect a woman’s quality of life. The consequence of bearing a child too impact them much more than men, emotionally as well as physically. Not only do women have the prime responsibility of being the carer for babies but also many pay a high price indicated by the high rate of maternal mortality. The rate of maternal mortality in rural areas in India is highest in the world.

Fertility control has been promoted in India as in many developing countries, as a measure of population control. The primary aim of government policy regarding fertility control is achieving demographic targets though the health and welfare of clients is not completely lost sight of.\textsuperscript{29} The declaration made at the end of the two day colloquium on Population Policy-Development and Human Rights jointly organized by the Department of Family Welfare, Ministry of Health and Family Welfare, the National Human Rights Commission and the United National Population Fund

\textsuperscript{28} 56% married women use contraceptives most men (78%) in India reject the idea of using contraception and think that it is women’s business and a they should not have to worry about it. (NFHS III 2005-06)

\textsuperscript{29} The National Family Health Survey (2005-06) report says fertility level decreased by 0.5 children between NFHS-1 and NFHS-2. Fertility rates are highest in Bihar and Uttar Pradesh where at current fertility levels, a woman would have about four children during her life time. Seventy one percent of adults either want no more children are already sterilized or have a spouse who is sterilized. See \textit{supra} note 15.
UNFPA recognized that family planning measures have been coercive and impacted the life of women negatively specially due to the son-preference practice. It affirmed that giving priority to health, education and livelihood of women is necessary for empowerment of women as also for reduction in fertility rates and stabilization of Population.

(ii) Abortion And Medical Termination of Pregnancy Act 1971

Abortion is the expulsion or extraction from expectant mother of an embryo or foetus weighing 500 gm or less when it is not capable of independent survival (WHO). This 500 gm of fetal development is attained approximately at 22 weeks of gestation. The expelled embryo or fetus is called 'abortus'. Abortion is the termination of pregnancy by any method (spontaneous or induced) before the foetus is sufficiently developed to survive independently (foetus less than 20 weeks of pregnancy). Performing an abortion in violation of the conditions mentioned in the Medical Termination of Pregnancy (MTP) Act, 1971 is a criminal offence under the Indian Penal code 1860. Sec. 312 of the Indian Penal Code makes the voluntarily causing of miscarriage of an expectant woman and not in good faith an offence. Similarly, section 313 punishes any one who causes miscarriage of a pregnant woman without her consent.

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30 Supra note 27 at 104.
31 Government is involved in the manufacture and distribution of contraceptives. The key central statute applicable is the Drugs and Cosmetics Act 1940 which is relevant primarily for the approval of contraceptives as drugs.
33 Sec. 312 of the I.P.C. reads as "whoever voluntarily causes a woman with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the women be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine."
34 Section 313 of the IPC reads as "whoever commits the offence defined in the last preceding section without the consent of the woman whether the woman is quick with child or not, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine."
India pioneered in legalising induced abortion under the MTP Act, 1971 that specifies the reasons for which an abortion can legally be performed. The Act also clearly specifies who can legally perform the abortions and the kind of facilities in which they can be carried out. The stipulated conditions are such that abortions performed by trained doctors who are not registered in facilities not specifically approved for abortion services are termed illegal in India. Illegal abortions may be 8 to 11 times as high as legal abortions. While the intention is to provide women with safe, legal, timely abortion services, given the stringent nature of the said Act of 1971, many safe abortions may be classified as not legal. Sometimes, many abortions not only take place outside the ambit of the Act but are often performed in unsafe conditions leading not only to post-abortion complications, but also result in death.

The MTP Act 1971 has been enacted with the objective of safeguarding the rights of women as well as registered doctors who perform abortions.

In recent years, when health services have expanded and hospitals are availed to the fullest extent by all classes of society, doctors have often been confronted with gravely ill or dying pregnant women whose pregnant uterus have been tempered with a view to causing an abortion, and consequently suffered very severely. There is, thus, avoidable wastage of the mother's health, strength and sometimes life. Furthermore, most of these mothers are married women, and are under no particular necessity to conceal their pregnancy.

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37 Ibid.
38 Ibid, at 89.
39 Ibid.
The proposed measure which seeks to liberalize certain existing provisions relating to termination of pregnancy has been conceived (1) as health measure—when there is danger to the life risk to physical or mental health of the woman; (2) on humanitarian grounds—such as when pregnancy arises from a sex crime like rape or intercourse with lunatic woman etc; (3) eugenic grounds—where there is substantial risk that the child if born would suffer deformities and diseases.40

The MTP Act 1971 provides for termination of pregnancy by a registered medical practitioner41 where the pregnancy does not exceed 12 weeks, and by two medical practitioners in case the pregnancy exceeds 12 weeks but does not exceed 20 weeks, if he is or they are of opinion, formed in good faith, that42

2. the continuance of the pregnancy would involve a risk to life of the pregnant woman or of grave injury to her physical or mental health; or

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40 Ibid. In Chandigarh Adm v. Nemo CWP No. 8760/2009 (Nari Niketan Rape case) In a landmark judgement, the Supreme Court while reversing Punjab and Haryana High Court directions in SLP, allowed a mentally challenged rape victim to have her baby. However, the controversial issue was that, that who will take care of the baby. A bench headed by Chief justice of India Balakrishnan along with Justice Sathasivam and Justice B.S. Chauhan underlined the fact that human rights for a disabled woman in State custody should be strengthened not weakened. The court further said that the rights of disabled men and women to parenthood is provided under several international and Indian laws. Also visit http://www.ndtv.com/news/india/mentally-challenged-rape-victim-can-have-baby-php. http://law and other things.blog.spot.com/ 2009/07/Chandigarh-admin-v-nemo-should-mentally.html. (accessed on August 23, 2009). also see Times of India, July 27, 2009

41 As per sec.2(d) MTP Act 1971 “Registered Medical practitioner” means a medical practitioner who possesses any recognized medical qualification as defined in sec.2(h) of the Indian Medical Council Act 1956, whose name has been entered in a state medical Register who has such experience or training in gynecology and obstetrics as may be prescribed by rules made under this Act.

42 Id Sec 3 (2) MTP Act 1971. As per sec 3 (3), in determining whether the continuance of a pregnancy would involve such risk of injury to health, account may be taken to the pregnant woman's actual or reasonable and foreseeable environment.
3. there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

In certain cases, the anguish caused by a pregnancy constitutes a grave injury to the ‘mental health’ of a pregnant woman.

1. Where pregnancy is alleged to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to her mental health.43

2. Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to her mental health.44

In certain emergency cases, the pregnancy could be terminated beyond the period of 20 weeks. In a case where registered medical practitioner is of the opinion, formed in good faith, that the termination of pregnancy is immediately necessary to save the life of the pregnant woman, the length of the pregnancy as well as the opinion of at least two medical practitioners if the pregnancy is more than 12 weeks but less than 20 weeks, will not be necessary.45

The MTP Act specifically provides that the pregnancy of a woman who has not attained the age of 18 years cannot be terminated except with written consent of her guardian. Similarly, if a woman is above 18 years and mentally ill, the written consent of her guardian is essential.46 In all other cases, consent of the

43 Id Explanation 1, Section 3 (2).
44 Id, Explanation 2.
45 Id Sec.5. For the purposes of this section, the registered allopathic medical practitioner causing abortion need not possess experience or training in gynecology and obstetrics. Also, the facility may not have prior certification. However, the provider is required to report an abortion done to save a woman’s life within one working day.
46 Id Sec. 3(4) (a).
pregnant woman (married or unmarried) has been made essential under the Act.\textsuperscript{47}

In theory, the law recognizes the women's right, as the medical practitioner has to consider only the woman's environment under the law, even the consent of the husband is not necessary. In reality, however, a woman's right to abortion is very restricted, and in most instances, it is invariably the family's decision. The courts have chosen to restrict the absolute right given under the statute, and tend to view abortion from a patriarchal perspective. Various decisions of judiciary have held that aborting a foetus, without the husband's consent would amount to 'cruelty' under Sec. 13(1) (ii a) of the Hindu Marriage Act, 1955, and hence a ground for divorce.\textsuperscript{48}

In \textit{Satya v. Siri Ram},\textsuperscript{49} the Punjab and Haryana High Court observed that in such type of cases, the court has to attach due weight to the general principle underlying the Hindu law of marriage and sonship, and the importance attached by Hindus to the principle of spiritual benefit of having a son who can offer a funeral cake and libation of water to the manes of his ancestors.

In another case \textit{Sushil Kumar v. Usha},\textsuperscript{50} the Delhi High Court opined that whether or not an abortion would amount to

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\item \textsuperscript{47} Id, Sec. 3(4) (b). the legally protected decision to abort is made by health professionals, instead of the pregnant woman.
\item \textsuperscript{48} Supra note 24 at 95.
\item \textsuperscript{49} AIR 1983 P&H 252 (para 3) at 253, Justice I.S. Tiwana delivered this judgement. The appellant's marriage with respondent stands dissolved by the impugned decree of divorce granted under section 13 of the Hindu Marriage Act, 1955. on the ground, which has been accepted by the lower court, that the appellant has been cruel to the respondent husband in as much as she refused to bear a child in spite of his persuasion. After marriage, the respondent impregnated her twice but both the times she got herself aborted. The court observed that "if a wife deliberately and consistently refuses to satisfy her husband's natural and legitimate craving to have children, and the deprivation reduces him to despair and affects his mental health, the wife is guilty of cruelty."
\item \textsuperscript{50} AIR 1987 Delhi 86. Justice Mahinder Narain, delivered this judgement. In this case the husband filed appeal against the order of Additional District Judge whereby the husband's petition for a decree of divorce under sec. 13 (1) (ia) of Hindu Marriage Act was refused. The parties were married according to the Hindu rites at Delhi. The wife was stated to have left the appellant. At the time of departure of the
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cruelty would also depend upon whether one of the parties desired child and did not consent to it. The court further held that aborting the foetus in the very first pregnancy by a deliberate act without the husband’s consent would amount to cruelty.\textsuperscript{51}

The opinion expressed in an English case\textsuperscript{52} may also be noted here. The opinion goes well with the reproductive autonomy of a woman, and it does not ignore a man altogether. Such opinion are, however, few and far between. The judiciary has implicitly recognized the father’s right.

The MTP Act protects action taken in good faith.\textsuperscript{53} In the exercise of the powers conferred by Sec. 6 of the MTP Act, 1971, the Central Government made the Medical Termination of Pregnancy Rules, 1975, that provide for the experience or training of a registered medical practitioner.\textsuperscript{54} Rules also provide for approval of a place for the purposes of termination of pregnancy,\textsuperscript{55} inspection of such place,\textsuperscript{56} cancellation or suspension of certificate of approval,\textsuperscript{57} and review.\textsuperscript{58}

If the Chief Medical Officer has reason to believe that there has been death of, or injury to, a pregnant woman at the place or that

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\textsuperscript{51} Fowler v. Fowler (1952) 2 TLR 143. See Kusum, Family law lecture, at 50(2003). "If a man takes contraceptive measures against the will of his wife so as to prevent her having children without reasonable excuse for so doing, then it is easy to infer that he does it with intent to inflict misery on her, but when a wife herself takes contraceptive measures, or asks her husband to take them, her conduct can often be attributed to fear for the consequences to herself, without any intention of injuring him. She fears the pains and risk of childbirth. This is very unnatural and unfortunate, but it is not cruelty unless she has also an intention to inflict misery on her husband.

\textsuperscript{52} Sec. 8 MTP Act 1971. If any registered medical practitioner causes any damage by anything which is in good faith done or intended to be done under the Act, no suit or other legal proceedings can be instituted against them.

\textsuperscript{53} Rule 3; MTP Rules, 1975.

\textsuperscript{54} Id, Rule 4.

\textsuperscript{55} Id, Rule 5.

\textsuperscript{56} Id, Rule 6.

\textsuperscript{57} Id, Rule 7.
termination of pregnancies is not being done under safe and hygienic conditions, he may call for any information or may seize any article, medicine, ampoule, admission register or other document\(^59\) on finding lack of safe and hygienic conditions and proper facilities, he shall make a report of the fact to the government giving the detail of the deficiencies or defects found at the place.\(^60\)

The government health facilities providing for abortion services continue to be low despite the existence of the MTP Act and Rules framed thereunder. In 2003, the MTP Rules were amended so that women's accessibility to legal and safe abortions, is enhanced.\(^61\) The amended rules permit a registered medical practitioner to induce medical abortion in his/her clinic using mifepristone up to seven weeks gestation, provided that the doctor has either on-site capability or access to a facility capable of performing surgical abortion in the event of a failed or incomplete medical abortion. However, the Drug Controller of India has licensed mifepristone for

\(^{59}\) *Id*, Rule 5. The provisions of the Code of Cr. Procedure 1973 relating to seizure shall, so far as may be apply to such seizures.

\(^{60}\) *Id* Rule 6.

\(^{61}\) The Amended MTP Rules 2003 provide for:

(i) Simplification of the registration process for private clinics by decentralization of the process as well as evolving of separate registration procedures for facilities providing abortion services up to 12 weeks and those providing services for 12-20 weeks gestation.

(ii) The Chief Medical Officers in a district will now have the decentralized power to grant recognition to private clinics with the help of local committees (comprising of representatives from Government and NGO, empowered to approve abortion facilities and ensure provision of safe abortion care).

(iii) The amended rules mandates the district level committee to inspect the abortion facility within two months of receiving an application for registration and in the absence of or after rectification of any noted deficiency in the abortion facility, for the approval to be processed within a couple of months. However the rules do not specify measures or redress mechanisms if certification procedures are not completed in the stipulated time frame.

(iv) The rules also clearly recognized the distinction between first and second trimester abortions. While the physical standards for a facility to perform second trimester abortion remains as before, the physical standards appropriate to perform first trimester abortion have been relaxed. The rules also allow for approval of abortion facilities without the necessity of on site capability of managing emergency complications.
use up to seven weeks gestation only on the prescription of a gynecologist, restricting access to urban areas.\textsuperscript{62}

The MTP Act does not permit abortion for the purpose of sex-selection. The Act only aims at giving protection to the physical and mental health of a pregnant woman and also to the child in the womb (viz. if there is substantial risk of foetus being deformed/suffering from serious abnormalities, it could be aborted). The problem is more of female foeticide, and abortion in an illegal manner, where the pregnancy is alleged to have been caused by rape or as a result of failure of a contraceptive used by a married woman or her husband, it would be presumed to constitute grave injury to the mental health of pregnant woman.\textsuperscript{63}

But there is no method to check that the reasons specified by doctors for the termination of a pregnancy under the Act are true. Need is to maintain a register giving reasons for termination of pregnancy and the period thereof. But it is rarely done. The certificates forwarded to the government are hardly taken note of by the latter. A meager monetary punishment is provided for the violation. This is so when sex-selective abortion is totally illegal, unconstitutional and a criminal act on the part of the doctor. It may also be noted that under the MTP Act, records maintained are secret and confidential documents, not open to public inspection.

In practice, in majority of the cases, the issue is not of the reproductive rights of the women or her choice, but of the sex of the unborn child.\textsuperscript{64}

\textsuperscript{62} supra note 24 at 104.
\textsuperscript{63} supra note 3 at 165.
\textsuperscript{64} Nearly 95\% of abortion conducted in the period between 12 to 20 weeks of pregnancy have been found to be selective. It is recommended by the Delhi Medical Association that gynecologists should not abort fetuses. It has suggested that an abortion in this period can be carried out only if the doctor advises it and not because the parents want it. It has also suggested that the government should come out with a policy that abortions after 12 weeks be checked by a nodal agency. Asha Bajpai, "Child Rights in India – Law, Policy and Practice," at 395-396 (2004).
The issue of abortion is complex and influenced by religion, morals, the socio-political context and sexual politics. The issue has been further compounded by sex-selective abortion in India. As abortion before 20 weeks of pregnancy were legal, female foeticide could not be banned per se. Hence, the requirement of a new law was felt, to prevent the misuse of the MTP Act for sex selection abortions. The government of India enacted the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse Act) (PNDT Act), 1994 to deal with the latter situation. It came into force on 1st January 1996. The PNDT Act, 1994 (as amended by 2002 Amendment) provide for the prohibition of sex selection, before or after conception, and for regulation of pre-natal diagnostic techniques for the purposes of detecting genetic abnormalities or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex-linked disorders and for the prevention of their misuse for sex determination leading to female foeticide.

The Act has three aspects viz prohibitory, regulatory and preventive. It prohibits sex selection completely either before or after conception. It regulates the use of prenatal diagnostic techniques for legal or medical purposes and prevents misuse for illegal purposes. In order to look into various policy and implementation matters, the Act provides for the setting up of various bodies along with their composition, powers and functions. Under the Act, registration is mandatory for every genetic clinic.

On and from the commencement of this Act (i.e. PNDT Act), no Genetic Counselling Centre, Genetic clinic or Genetic laboratory, Section 2(c) of the PNDT Act 1994] “Genetic Counselling Centre” means an institute, hospital, nursing home or any place which provides for genetic counseling to patients.
unless registered under the Act, can conduct or associate with or help in, conducting activities relating to pre-natal diagnostic techniques. They cannot employ or cause to be employed or take services of any person whether on honorary basis or on payment who does not possess the prescribed qualifications. Such techniques have also been prohibited to be conducted by a medical geneticist, gynecologist, pediatrician, registered medical practitioner or any other person at a place other than a registered place.67

The Act allows pre-natal diagnostic techniques to be conducted only for the purposes of detection of any of the following abnormalities namely; Chromosomal abnormalities, genetic metabolic diseases, haemoglobinopathies, sex-linked genetic diseases, congenital anomalies, or any other abnormalities or diseases specified by Central Supervisory Board.68

Pre-natal diagnostic techniques can be conducted for the above said purposes only if any of the following conditions is fulfilled.69

(i) the pregnant woman is above 35 years;
(ii) she has undergone two or more spontaneous abortions or foetal loss;
(iii) she has been exposed to potentially teratogenic agents such as drugs, radiation, infection or chemicals;
(iv) the pregnant woman or her spouse has a family history of mental retardation or physical deformities such as, spasticity or any other genetic disease;

66 *Id.* Explanation to sec. 2(d) "Genetic clinic" means a clinic, institute hospital, nursing home or any place which is used for conducting pre-natal diagnostic procedure Sec. 2(d) PNDT, 1994. It includes a vehicle, where ultrasound machine or imaging machine or scanner or other equipment capable of determining sex of the foetus or a portable equipment which has the potential for detection of sex during pregnancy or selection of sex before conception, is used.
67 *Id* Sec. 3.
68 *Id* Sec. 4(2).
69 *Id* Sec. 4(3).
(v) any other condition as may be specified by the Central Supervisory Board;\(^70\)

Because the purposes have been specified, no relative or husband of the pregnant women can seek, or encourage the conduct of any pre-natal diagnostic techniques.\(^71\)

Strict records have to be maintained of the pregnancy related techniques performed, and failure to maintain such records, particularly those related to the conduct of ultrasound tests will attract strict penalties under the Act. Any deficiency or inaccuracy in the maintenance of records of ultrasonography shall amount to contravention of the provisions of Sec. 5 or Sec. 6, of the PNDT Act, 1994\(^72\) it will then be presumed that sex of the foetus has been disclosed. No person can cause or allow to be caused selection of sex before or after conception.\(^73\) Thus sections 5 and 6 prohibits the determination of the sex of the foetus. While sex selection techniques are strictly prohibited as they are considered to have no medical indication, pre-natal diagnostic techniques can be used only for the purposes of this Act.

\(^{70}\) The Central Supervisory Board has added substantially to the list of indications for the purpose of conducting ultrasound tests. These 23 indications are to be found in Form F of PNDT Rules 1996.

\(^{71}\) \textit{Id}, Sec. 4 (4)

\(^{72}\) \textit{Id} Sec. 5 reads as (1) No person referred to in clause (2) of sec. 3 shall conduct the prenatal diagnostic procedures unless –

(a) he has explained all known side and after effects of such procedures to the pregnant women concerned;
(b) he has obtained in the prescribed form her written consent to undergo such procedures in the language which she understands; and
(c) a copy of her written consent obtained under clause (b) is given to the pregnant women.

(2) No person including the person conducting pre-natal diagnostic procedures shall communicate to the pregnant woman concerned or her relatives or any other person the sex of the foetus by words, signs, or in any other manner.

Sec.6 says that (a) no Genetic Counselling Centre, Genetic laboratory or Genetic clinic shall conduct or cause to be conducted in its centre laboratory or clinic, prenatal diagnostic techniques including ultrasonography, for the purpose of determining the sex of a foetus. (b) no person shall conduct or cause to be conducted any prenatal diagnostic techniques including ultrasonography for the purpose of determining the sex of a foetus.

\(^{73}\) \textit{Id}, Sec. 6.
With the Amendment 2002 to the Act/Rules, units are now required to submit two undertakings at the time of application.

Violation of the prohibitions contained in the Act entails punishment as prescribed under the Act. For breach of any of the provisions of the Act/Rules by any of the service providers (unit owners, medical professionals, employees of units who renders professional/technical services), the prescribed punishment is imprisonment for a term which may extend to 3 years and a fine which may extend to Rs. 10,000. For subsequent offences, imprisonment may extend to 5 years and fine up to Rs. 50,000.

The name of the registered medical practitioner shall be reported by the Appropriate authority to the State Medical Council for taking the necessary action including – (a) suspension of registration if charges are framed by the court and till the case is disposed of, and (b) on conviction, for removal of his name from the register of the council for a period of 5 years for the first offence and permanently for the subsequent offence.

Any person seeking sex determination tests or sex selection may be punishable with imprisonment for a period extending up to 3 years and with a fine extending to Rs. 50,000. For any subsequent offence, the imprisonment may extend to 5 years and fine up to Rs. 1 lakh.

Despite the introduction of the PNDT Act the situation of foeticide continues to worsen. The rate of conviction under the Act in Punjab is abysmally low. Though non-implementation of the Act

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74 Rule 4(1) PNDT Rules 1996. (i) That the unit will not conduct any tests for sex selection and will not disclose the sex of the foetus to any person.
   (ii) That the unit will display in a prominent place the statutory notice stating that no sex determination tests are conducted within their premises.
75 Sec. 23 (1) PNDT Act 1994.
76 Id Sec. 23(2)
77 The figures makes it clear that despite hue and cry over female foeticide, a lot remain to be done, till September 30, 2007 out of these 97 cases, 78 were pending while two had been dropped due to death of accused. Only 13 cases had either
could not said to be the root cause of the problem, the growing misuse of reproductive technologies have widened the gap in the already skewed sex ratio. The clearest indicator of discrimination against Indian women is the skewed sex ratio-only 927 females per 1000 males in India whereas the world average was 990 women per 1000 males according to 1991 census. Provisional figures for census 2001 indicate that has been arrested sex ratio at 933 females per 1000 males. Yet cause for concern remains. The sex ratio of the 0-6 age group has declined in 1991 to 927 in 2001.

According to a relevant report by the United Nations Children Fund (UNICEF), upto 50 million girls and women are missing from India's population as a result of systematic gender discrimination in India. Unicef's state of the world's children 2007 report found that India's already abysmal sex ratio is getting worse, with 80% of its districts recording declining child sex ratios (more male births than female) since 1991. Kerala, Pondicherry and the Lakshadweep islands were notable exceptions. Medical and scientific procedures are becoming more efficient it has consequently becoming easier to get rid of a female child. Declining of child sex ratio is not a problem which is limited to metropolitan regions but has spread to even smaller towns. The infamously skewed sex ratio in the country has been discharged or dismissed. In foeticide, 7 court cases (no conviction 6 pending one discharge. In case of sex selection 17 court case (no conviction), 14 pending, six discharged unregistered centres, 15 court cases, 2 convicted, 1 discharged, 12 pending. 'Punjab Miscarries PNDT Act', The Times of India, 30th December 2007. The culprits getting acquitted due to government's failure to notify the enactment which is mandatory for Act to come into force and empower authorities to take action against guilty. In the case of Haryana State, the publishing of notification that had to be done in 1997, was carried out on March 4, 2009. The Punjab and Haryana High Court had demanded information on the status of notification for PNDT Act in the state. PNDT blunder: Haryana ready for legal battle. The Times of India, June 24, 2009. See also ‘Hry to issue ordinance on PNDT Act’, The Times of India, July 8, 2009.

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79 'Son rise but deficit of girls'. The Times of India, March 7, 2008.
is quite horrific. It is unfortunate that law which aims at preventing such practice is not implemented effectively since it has come into force in January 1996. Therefore, one non-governmental organization (NGO) approached the apex court for fresh guidelines on this issue and filed a writ petition under Article 32 of the Constitution of India.80 In the Centre for Enquiry into Health and Allied Themes (CEHAT), case The NGO highlighted that developed medical science is misused to get rid of a girl child before birth, knowing full well that it is immoral and unethical as well as it may amount to an offence. Foetus of a girl child is being aborted skewing overall sex ratio in various states where female infanticide is prevailing without hindrance. It was also pointed out that neither the state governments nor the central government has taken appropriate actions for the implementation of the PNDT Act.

Consequently, the Supreme Court issued a series of following directions to appropriate governments:81

1. The court feeling the need for intervention issued a set of guiding directives, so as to get the PNDT Act executed by the (i) Central government Central supervisory Board (ii) State Governments Union Territories Administrations and (iv) Other Appropriate Authorities. At the core of direction, the concern has been for creation and awareness in the society against the practice of pre-natal determination of sex and female foeticide through appropriate release programme in the electronic media.

2. This shall be done by Central supervisory Board as provided under Section 16(iii) of the PNDT Act.

3. Meetings of the CSB will be held at least once in six months.

4. Under Sec. 7 the constitution of the CSB is given which empowers the Central government to appoint ten members which will include eminent medical practitioners including

80 (CEHAT) & Ors vs. Union of India and Ors. (2001) 5SCC 577. (Para 3) Justice M.B. Shah and Justice S.N. Variava were the judges who delivered this judgement. CEHAT which is a research Center of Anusandhan Trust based in Pune. Mahila Sarvangeen Utkarsh Mandal (Masum) and Dr. Sabu M. George raised this before the court.

81 Id at para 3
eminent social scientists and representatives of women welfare organization.

(5) The CSB shall review and monitor the implementation of the Act Sec-16(ii).

(6) The CSB shall lay down a code of conduct under Section 16(1)(c) of the Act to be observed by persons working in bodies specified therein and to ensure its publication so that public at large can know about it.

(7) All state Governments/UT Administrations are directed to ensure that all State/UT Appropriate Authorities furnish quarterly returns to the CSB giving a report on the implementation and working of the Act. It would contain information about (i) survey of bodies specified in Sec. 3 of the Act. (ii) registration of bodies specified in section 3 of the Act (iii) Action taking against non-registered bodies (iv) Number and nature of awareness campaigns conduct and results following therefrom.

In August 2008, a situation came up for consideration of the Bombay High Court in Dr. Nikhil D. Dattar case,\(^82\) where petitioners sought declaration that Section 583 of the Medical Termination of Pregnancy Act, 1971 should be declared ultravires to the extent that it does not include the eventualities specified under Section 3(2)(b)(ii)\(^84\) of the said Act, and pleaded that it should be modified so that to be read down to include the words “when there is a substantial risk that if child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped” and hence, direction should be issued to the respondents to allow the petitioner (wife) to terminate the pregnancy.

\(^82\) Dr. Nikhil D. Dattar, Mr X, Mrs. Y v. U.O.I., Writ Petition (L) No. 1816 of 2008.

\(^83\) Section 5 of the MTP Act 1971 reads as: sections 3 and 4 when not apply where sub sec. 2 of section 3 as relate to length of the pregnancy and the opinion of not less than two registered medical practitioner shall not apply to the termination of a pregnancy by rmp in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of pregnant women.

\(^84\) Id Sec. 3(2)(b)(ii) speaks of right to terminate pregnancy where there is substantial risk in allowing the child to take birth as it would suffer from physical or mental abnormalities as to be seriously handicapped but such right is restricted to maximum period of 20 weeks pregnancy.
The petitioner was 26th week of pregnancy at that time. She having undergone the necessary medical test learnt that the foetus in her womb was diagnosed to have congenital complete heart block. The Bombay High court dismissed the petition by saying that the court could not go to correct or make up the deficiency. Courts shall decide what the law is and not what it should be. The court dismissed the petition by observing that medical experts did not express any categorical opinion that if the child is born it would suffer from serious handicaps. When the case went to the Supreme Court for consideration the Division Bench comprising Chief Justice K.G. Balakrishnan and Justice J.P. Sathasivam issued notice on abortion law to centre government. The apex court which was initially reluctant to issue any direction, later agreed to seek reply from the government for continuing with provision of 20 weeks even if there is a fatal risk to mother and foetus.85

The Central Government came forward by assuring the Supreme Court, with concrete steps in the direction of implementation; and suggested that it is setting up a National Inspection and Monitoring Committee for the implementation of the Act.

If we analyze present legislation and program against female foeticide, it is found that progress is not consistent, comprehensive in all concern sectors. The National Population Policy 2000 has also emphasized strict enforcement of this Act. It does not really matter that the law prohibits doctors from telling their parents anything more than the health status of the unborn child, but they do it anyway. It is done in a manner where they cannot be booked or taken to court.

Moreover, the poorer illiterate people who are unable to afford MTPs, go to quacks, often with fatal results. Such quacks includes dai in the village. A lot of workers act as middlemen and get a commission of 25% (of the ultrasound fee), per case from the doctors who carry out these procedures. The workers and doctors help the people by recommending some ‘good’ ultra sound clinics. There were instances of doctors at the primary health centres conducting ultrasounds and MTPs. In case the wrong practices of doctors are reported, the doctors are known to have used their approach to waive off the punishment.86 In this background, the problem of female foeticide becomes more pronounced by the fact that the enforcing authorities are also headed by doctors and, by and large, it is noted that there doctors try to protect someone from their own fraternity, resulting in low and prolonged investigations.87

Further, to worsen the situation the modified/amended Act has become a tool in the hands of corrupt officials to extort money from private clinics and hospitals. Under the amended Act, the Chief District Medical Officers (CDMO) have been given blanket powers to conduct searches, etc. and register FIRs against clinics conducting ultrasound, etc. to determine gender. It is the only competent authority appointed by the government to have cases registered under the Act and also it grants protection to CDMO against legal action while discharging of their duties.88 The revised law also makes it necessary for these clinics to maintain detailed records of every medical investigation carried out on pregnant women and send all

86 supra note 36 at 226.
87 Karnataka is the only state that has authorized non-medical officers such as officials in the State Women’s Commission to take action for non-registration of diagnostic machines and maintenance of records of all medically terminated pregnancies. In fact, the State Women’s Commission has jointly worked with vimochana (a forum for women’s rights fighting the menace of female foeticide in Banglore and Mandya districts) to conduct several raids on clinics and nursing homes suspected of conducting sex determination tests and sex selective abortions in Banglore and Mandya districts. See supra note 24 at 150.
88 ibid.
such reports to the concerned CDMO.\textsuperscript{89} Under the Act, only
diagnostic techniques are regulated and not abortion service.\textsuperscript{90}

(iii)(a) Two Child Norm, Abortion Law and Declining Sex Ratio

Pressure to comply with the two child norm has an effect on
the dire problem of sex determination and sex-selective abortions
Several States have enacted laws to promote the two child norms and
disqualify candidates with more than two children from public office.

In \textit{Javed and others v. State of Haryana}\textsuperscript{91} the Supreme
court took up this issue, of two child norm as a condition prescribed
for contesting election under the Haryana Panchayati Raj Act. The
court upheld the legislation and ruled that it did not violate any
fundamental rights. The court stated:

“population control assumes a central importance for providing
social and economic justice to the people of India. Family
planning is essentially a scheme referable to health, family
welfare, women and child development and social welfare.
Panchayat as a potent instrument of family welfare and social
welfare schemes coming true for the betterment of people’s
health, especially women’s health and family welfare coupled
with social welfare”.\textsuperscript{92}

The gender discrimination dimensions of these societal
problems was earlier revealed in the case of \textit{State of Haryana v.
Santra}.\textsuperscript{93} In this case, a women sterilized under a government
program, nonetheless, conceived after the operation and underwent
delivery since abortion posed a risk to her life. She gave birth to a
daughter who was also her eighth child. The Supreme Court awarded
the mother damages that covered the child’s expenses until the age

\textsuperscript{89} \textit{id}, at 151.
\textsuperscript{90} \textit{id}, at 152.
\textsuperscript{91} (2003) 8 SCC 369. The Bench comprised of Justice R.C. Lahoti, Justice Ashok
Bhan and Justice Arun Kumar.
\textsuperscript{92} \textit{id} (Para 38).
\textsuperscript{93} (2000) 5 SCC 182. Justice S. Saghir Ahmad and Justice D.P. Wadhwa delivered
this judgement. In this case the doctor who performed the operation acted in a most
negligent manner as the possibility of conception by Smt. Santra was not
completely ruled out as her left fallopian tube was not touched.
of puberty. Its decision acknowledged the extra burden that an unwanted girl child posed, particularly in a country where population growth is a huge problem and are of government priority. The court further observed that:

“The family planning is a national programme. It is being implemented through the agency of various government hospitals and health centres and at some places through the agency of the Red Cross. In order that the national programme may be successfully completed and the purpose sought may bear fruit, everybody involved in the implementation of the programme has to perform this duty in all earnestness and dedication. The Government at the centre as also at the state level is aware that India is the second most populous country in the world and in order that it enters into an era of prosperity, progress and complete self-dependence, it is necessary that the population is arrested. .......... The people of the country who cooperate by offering themselves voluntarily for sterilisation reasonably except that after undergoing the operation they would be able to avoid further pregnancy and consequent birth of an additional child.”

According to a report from Delhi ten percent each of male and female patients knew about sex detection clinics in their area. Similarly 20% of the female patients accepted that someone in their area had got sex detected. Only 40% of the male and 30% of female patients were aware of that there is a ban on sex detection. However, majority says that it is good to ban sex detection. Awareness campaign in this direction is failing to have an impact on general public even in urban areas. Seeing the low awareness about the Act and girls rights, in Chehat case, the Supreme Court of India has directed the central and state governments to launch an awareness campaign using electronic and traditional media.

The apex court in responding to the various petitions, has in particular, laid emphasis on the constitution of authorized agencies at the district and sub district levels in order to monitor the

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94 Id at 191 (para 19).  
95 Supra note 13 at 102.
proliferation of unregistered clinics and misuse of medical technology.96

As seen earlier in this chapter, female infanticide is the murder of an infant girl child, often occurring as a deliberate murder of a girl infant child or as the result of neglect. It is found that out of 8000 abortions carried out in clinics, 7997 were having female fetuses. Because of rampant female killing, 35 to 40 million girls and women are missing from the Indian population alone.97 The net result is that clinics are working in full swing. In many of those clinics, particularly in rural area, or slums in urban areas, doctors who do not have requisite qualifications are still performing these procedures.98

In the Economic Survey 2001, it is stated that the worrying problem is missing women from the country. These missing millions of females were either never born or died of chronic malnutrition or because of lack of medical attention. The United Nations has expressed serious concern over elimination of girls by abortion and infanticide in India. The data showed that the girls-to-boy ratio had dropped to fewer than 800 girls per 1000 boys in some parts of the country. The most affected states are Punjab, Haryana, Himachal Pradesh and Gujrat, where the ratio has drastically declined.99

The provisional census results of 2001 reveal that there is continued decline in sex ratio (the number of females per 1000 males). This ratio has consistently shown a drop through last century starting from 1901 with marginal improvement in last census (from 927/1000 in 1991 to 933/1000 in 2001). For this little

96 Ibid.
97 Id., at 1.
98 In a recent incident in the vicinity of a private hospital in Patiala district, a 30 feet deep well yielded 50 dead foetuses all females. The owners of the Sahib hospital in Patran were arrested, http://www.indiatogether.org/2006/sep/ksh.babies.htm (accessed on October 10, 2006).
99 Supra note 13 at 11. It is also prevalent in UP, MP, Chhattisgarh and Bihar.
reversal, the Indian Government celebrated and announced a great success in the field of women empowerment. However, this improvement is not real as far as girl child is concerned, because the discovery of 24 foetuses in Narnaul (Haryana) also falsifies all claims of efforts being made to stop female foeticides.

Sex ratio female per 1000 males, India 1991-2001 in various states of India is given below:

<table>
<thead>
<tr>
<th>State</th>
<th>1991</th>
<th>2001</th>
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<tr>
<td>Punjab</td>
<td>875</td>
<td>793</td>
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<tr>
<td>Haryana</td>
<td>879</td>
<td>820</td>
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<tr>
<td>Chandigarh</td>
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<td>845</td>
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<tr>
<td>Gujarat</td>
<td>928</td>
<td>878</td>
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<td>Jammu &amp; Kashmir</td>
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<td>937</td>
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<td>Delhi</td>
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<td>Assam</td>
<td>975</td>
<td>964</td>
</tr>
</tbody>
</table>

Ibid
'Parents gloat over sons while Girls long for love' The Times of India, July 31, 2007.
Ibid.

100 Ibid.
101 Ibid.
102 Ibid.
The WHO has stated “Son preference affects all aspects of a woman’s life, including child care, health, education and employment because she is discriminated against, the moment she is born and sometimes even before it, sex-selection procedures are available."103

A worrying trend is that sex determination is far more common in urban areas than in rural areas and among literate than illiterate women. The states worst with the sex ratio are economically stronger. Punjab, for instance, has topped in economic growth as compared to other states. Similarly certain districts such as south-west and North-west Delhi where some of the richest and most educated Indians reside, have decline of girl children as high as 59 points since 1991 census. These districts are adjacent to Haryana and Punjab. This explodes the myth that with increasing levels of affluence and education, gender bias gets eroded gradually.

On several occasions, our judiciary has also put emphasis in favour of the ban on prenatal sex determination tests in India. In one case, decided by Bombay High Court, the couple, who had two daughters and wanted a son to create a ‘balance’ in their families, wanted to be able to conduct the prenatal test so that they could choose a male child. The Bombay High Court held that MTP law was meant for certain cases where a mother’s life and health, both mental and physical, might be endangered or where a child may be born with abnormalities, it is no way dealt with sex selection as a basis for a legal abortion.104

The trends of adverse sex-ratio are alarming for India and could be more disastrous if economic boom associated with son

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103 Supra note 13 at 11.
104 The Bombay High Court threw out a petition pleading that couples with same sex children be allowed to conduct such tests to “balance their families.” Saying that “sex selection is not only against the spirit of the Indian Constitution, it also insults and humiliates womanhood. It violates a woman’s right to life. The judgement came from a Division Bench comprising Chief Justice Swatanter Kumar and Justice Ranjana Desai but was written by the latter who is among the few women judges in the high court, ‘No Exception to Sex Test Ban’, The Times of India, September 7, 2007.
preference led to infanticides, female foeticides. As the states undergo the demographic transition to smaller families, they will continue to want more boys than girls. Hence, to meet this goal, people are taking recourse to expansive gender selection technologies in a situation where even basic health care is missing. Abortion pills like MT Pill and Misprost are easily available over the counter on chemist shops without doctors prescription. The injectable contraceptive is being promoted as a temporary method for spacing i.e. to increase the number of years between two successive births. The changes in her body could mean that the woman may not be able to conceive after she discontinues the injectables.

For all reasons, the testing of the injectable contraceptives and the plan to introduce them in the National Family Planning Programme was considered to be in violation of several rights of woman and her present and future progeny.

The WHO Report 2005, examines the problem of young mothers and stresses the societal need to take care of both the mother and child so that the world’s future becomes healthier. It has rightly selected the logo that “Make every mother and child count”.

It is estimated that for every 100,000 live births in India, 407 mothers die. Almost all these deaths can be prevented. Women in India have been dying during child birth and from child bearing related causes for centuries. It is this numbness towards the issue that need to be pierced, punctured or violently jabbed so that the centuries of pain, suffering and indignation of faceless women is addressed. The system has to be cleansed of callous disregard towards the loss of a woman’s life. It should be a matter of great

106 It is violative of her fundamental rights of Articles 14, 21, 19(1)(a), 32 and Directive Principles of State Policy given under Articles 39(b), (e), (f), 46, 47.
107 ‘Young Mothers’, The Tribune April 7, 2005. According to World Health Report 2005, 10.6 million children and 5,29,000 mothers are still dying each year, mostly from avoidable causes.
concern that nations that are in economic terms less vibrant than India are doing far better in taking care of women during child birth period.108

However, in an extensive survey conducted by the Registrar General of India, nearly 78,000 maternal deaths were reported in 2004. The survey report has estimated that the projected MMR would be in the range of 195 to 231 by 2012.109 We should remember that India is committed to the United Nations Millennium Development Goals, one of which calls for reducing maternal mortality by 2015.110 Hence, to reduce maternal mortality rates and check the growing population, couples opting for sterilization will now be given Rs. 800 each, while expectant mothers opting for institutional delivery will get Rs. 2000 as part of the government measures. In addition to this it is submitted that stringent steps should be taken to stop completely, female foeticide which is a social, medical, moral and religious evil, and is threatening the very survival of human race.111

(iv) Menopause and Women Health

Women of all ages need due attention right from conception to old age rather than only in reproductive ages. Not much effort has been made to study the needs of women in the late reproductive

108 Delivered to Death, The Tribune, April 11, 2005. The Maternal Mortality Rate (MMR) in Bangladesh is 230 per 100,000 live births, in Bhutan it is 255, the Maldives 160, Myanmar 255, and Sri Lanka 59.6. In Malaysia maternal mortality is as low as 39 per 100,000 live births. The West European and Canadian societies have almost forgotten what a maternal death is. http://www.tribuneindia.com/2005/20050411/edit.htm#6 (accessed on August 24, 2009)


110 The Times of India, November 1, 2006.

111 To solve the ever worsening problem of uneven sex ratio Punjab, Haryana, H.P. Uttarakhand and U.T. Chandigarh have decided to form a cooperative committee to combat the menace of female foeticide. “States Join Hands To Fight Foeticide” The Tribune July, 26, 2009.
years who are nearing menopausal age or have moved into the post menopausal stage although there has been growing attention on ageing, which mainly focuses on women aged 60 and above. WHO explained in 1996 that menopause is a stage when the menstrual cycle stops for over 12 months and there is a drop in the levels of the two most important hormones in the body of women, namely estrogen and progesterone. The drop in the estrogen and progesterone levels produces two types of effects: short term and long term. The short term effects includes hot flushes, irritability depression, and mood swings, and the long term effects include alzheimer's disease, lower-back ache, cardiovascular problems, joint pain, brittle bones and gynaecological cancer. This demographic phenomenon will pose a real challenge for health services in the near future, especially in country like India.

The study shows that around 18% of the women in the age group 30-49 are already in menopause and this percentage varies from 11% for Kerala to 31% for Andhra Pradesh. As India is still characterized by a large number of illiterate women with low age at marriage and early child bearing and with poor nutritional levels, the problem of premature menopause may continue to be a burden in the future too. The recent health policy adopted by India also does not emphasise the issues of older women especially during their menopausal period. Moreover, health education should also be an integral part of the health care of women in their mid life years. Because women as a group tend to live longer than men in nearly all countries as long life expectancy of female is partly biological.

(v) HIV, STDs and Women Health

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113 Id, at 4929.
Adolescent women are at even greater risk than adult women so far as sexually transmitted diseases are concerned because the vagina and cervix of young women are less mature and are less resistant to HIV and other sexual transmitted diseases, such as Chlamydia and gonorrhea. The younger the age, the higher the risk of STDs. Women usually become infected 5-10 years earlier than men. Changes in the reproductive tract during puberty make the tissue more susceptible to penetration by HIV. Most HIV infected women report only one sexual partner whereas most infected men report multiple partners. \textsuperscript{114} Karnataka – a diverse State in the Southwest in India has a population around 53 million. In Karnataka the average HIV prevalence at antenatal clinics has exceeded 1% in all recent years. \textsuperscript{115}

There is disagreement over how many people are currently living with HIV in India. The National AIDS Control Organization (NACO) 2008 report estimated 2.31 million people living with HIV/AIDS in India. The result of a national household survey conducted in 2005-2006, shows around 2.3 million people are living with HIV, of these estimated 39\% are females and 3.5\% are children. Today, in 2009, an estimated 50 million women in Asia are deemed to be at risk of becoming inflected with HIV/AIDS from their intimate

\textsuperscript{114} Id, at 62.

\textsuperscript{115} In Northern Karnataka is Devadasi belt Devadasi women are group of women who have historically been dedicated to the service of gods. These days, this has evolved into sanctioned prostitution, and as a result many women from this part of the country are supplied to the sex trade in big cities such as Mumbai. The average HIV prevalence among sex workers in Karnataka was 18\% in 2005. When surveillance systems in the southern Indian state of Tamilnadu, home to some 62 million people, showed that HIV infection rates among pregnant women were rising. Mumbai is the capital city of Maharashta state and is the most populous city in India, with around 20 million inhabitants. The HIV prevalence at antenatal clinics in Maharashta has exceeded 1\% in all recent years, and surveys of female sex workers have, found rates of infection above 20\%.

partners.116 These figures are not completely accurate reflections of the actual situation though, as large numbers of AIDS cases go unreported.

According to NACO, every year, an estimated 54,000 infected babies are born and an estimated 2,00,000 children are presently living with AIDS. The total outlay provided to National Aids Control Programme this year (2009) is Rs. 993 crore. Despite this, health workers exposed to HIV patients are facing acute shortage of preventive medicine.117

(vi) Violence and Women Health

Violence against women is so common throughout the world and there is no immediate remedy observed by women groups. The UN defines violence against women as any act of gender based violence that result in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. This includes Physical, sexual and psychological violence such as wife beating, burning and acid throwing, sexual abuse including rape and incest by family members, female genital mutilation, female foeticide and infanticide, and emotional abuse such as coercion and abusive language. Abduction of women and girls for prostitution and forced marriages are additional examples of gender based violence.118 Infact, rape and domestic violence together account for 5% of total disease burden among women of reproductive age group in developing nations.119

116 http://www.avert.org/indiaaids.htm
118 Supra note 13 at 65.
119 WHO, Regional Health Report, 1998,
Violence against women is often less reported, as in a number of cases neither the women nor her family report violence to the police or take legal action against violence. Because of their gender, women are often reluctant to report such cases due to religious or cultural norms and social stigma. Ignorance of their legal rights, fear of police inaction, or threats on the part of the offenders, or skepticism about court proceeding are other reasons.

According to recorded data in relation to crimes against women, the reported incidence of violence reveals “soaring crimes against women registering an increase of 56.2% or and annual growth of 7.7%. This is only the tip of iceberg as the majority of cases go unreported.120

Spousal violence or physical abuse from their male partners continues to scare Indian women. The National Family Health Survey – III, carried out in 29 states during 2005-06, has found that a substantial proportion of married women have been physically or sexually abused by their husbands at sometime in their lives. With 37% women reported abuse in India, the survey found Bihar to be the most violent, with the abuse rate against married women being as high as 59%. Strangely, 63% of these incidents were reported from urban families rather than the state’s most backward villages121.

The Survey was conducted by 18 research organizations, including five population research centres.122 It revealed that women with no education were much more likely (at 47%) than other women to have suffered spousal violence. However, spousal abuse extended

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120 Id, at 66. Studies indicate that between 16% and 52% of women worldwide are physically assaulted by an intimate partner at least once in their lives. 20 to 50% of married women worldwide undergo same degree of domestic violence.

121 ‘37% Married women abused in India’, The Times of India March 11, 2007. It was followed by Madhya Pradesh (45.8%), Rajasthan (46.3%), Manipur (43.9%), Uttar Pradesh (42.4%), Tamil Nadu (41.9%) and West Bengal (40.3%).

122 Ibid. The survey was designed to collect and provide vital information on population, family planning, maternal and child, child survival, nutrition of children and status of women. According to Amnesty International 40% of married Indian women are reported being treated with cruelty by their husbands and relatives.
to women who have secondary or higher education was reported to be with 16% while 63% of the women who faced spousal violence were illiterate in Bihar. The number stood at 54.2% in Assam, 53% in Tamil Nadu, 51% in Madhya Pradesh and 50.4% in Rajasthan. A huge number of women in rural India don’t report violence because they feel it is their destiny. They also worried about losing their shelter.

The survey also reported large variations with some states reporting low incidents of violence against married women. While Himachal Pradesh reported the least number of cases of such violence that was 6%, the incidents stood at 12.6% in Jammu and Kashmir, 16.3% in Delhi, 16.4% in Kerala, 16.5% in Sikkim and 16.8% in Goa.

India’s reputation as an unsafe country for women has taken another hit. Official statistics show that rape is the fastest growing crime in India compared to murder, robbery, kidnapping. According to National Crime Records Bureau in every 60 minutes, two women are raped in the country. The Delhi Police Annual Report of 2007 says that in 64% cases, crime against women were committed in homes and 5% had occurred in the slum areas.

The health consequences of violence include non-fatal outcomes such as minor cuts, headaches, pain and bruises and more. NFHS III (2005-06) report says one in three ever married women report having been slapped by their husband, between 12 and 15% report having their arms twisted, being pushed, shaken kicked, dragged or beaten up or having something thrown at them. The

123 Ibid.
124 Data gathered by the Punjab Police on crime against women shockingly reveal that at least one rape is reported from the state daily and a woman is murdered every second day. The Tribune September 21, 2009.
125 http://towardsfreedom.com/home/content/view/1490/61/ (accessed on August 24, 2009)
126 Supra note 15.
report also says 40% of Indian women face domestic violence. Consequently women suffer from various types of health disorders as shown in the table below:

**Table : The Health Consequences of Gender-Based Violence.**

<table>
<thead>
<tr>
<th>Health Risk</th>
<th>Health Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Violence</td>
<td>Poor nutrition, exacerbation of chronic illness, substance abuse, brain trauma, organ damage, partial or permanent disability, chronic pain, unprotected sex, pelvic inflammatory disease, gynecological problems, low birth weight, miscarriage, maternal mortality, depression, suicide and attempt of suicide and death.</td>
</tr>
<tr>
<td>Rape</td>
<td>Unwanted pregnancy, abortion pelvic inflammatory disease, infertility, STDS, partial or permanent disability, HIV, suicide, loss of 4.7 million years of productive life, death.</td>
</tr>
</tbody>
</table>

Long term health outcomes include organ damage, chronic disabilities, mental disorders, depression and adverse pregnancy outcomes. Fatal consequences such as suicide and murders are common. For a majority of women, the persistent insults, abuse, confinement, harassment and deprivation of financial and physical resources, may prove more harmful than physical attacks and result in women living in a permanent state of fear and substandard mental and physical health.

Thus, spousal violence affects not only mental health but physical health of the woman. To further strengthen the regime for violence against woman, it was observed that there is need for special formulations that would assert, protect and promote women’s

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127 Supra note 13 at 70.
rights. For this, India enacted its first law aimed at tackling domestic violence, known as The Protection Of Women From Domestic Violence Act, 2005 (DVA). It came into force on 26.10.2006.

The said Act represents a landmark achievement of gender equality for Indian women. First it rubbishes the myth that the Indian family is safe haven for all its members. A case can be filed against any male adult person as well as other relatives of the husband or male partner. For committing violence against woman in the family, the Act defines ‘domestic violence’ as any act, omission or commission or conduct of the respondent in case it:

128 Domestic violence has been acknowledged as a human right issue both in the Vienna Accord 1994 and Beijing Platform of action 1995.
129 This fact is evidenced by the broad range of harms covered under the new law, including abuse of the elderly, child sexual abuse, and violence against divorced or single, widowed women in the family. DVA provides civil law relief for domestic violence which is recognized as occurring for all sorts of reasons, across every class, religion and caste, in rural areas and urban centres. The law has some fairly revolutionary features. For the first time, marital rape is legally recognized as a form of domestic violence. While criminal law has still not been amended to enable a woman to file a rape case against her husband or domestic sexual partner.
130 The domestic relationship covered under the Act includes not only wives, widows, daughters, mothers, sisters but also woman who may not have a valid marriage as well as ex-wives. The Act even gives protection to women in live-in relationships. See section 2(f) of the Act No. 43 of 2005.
131 Id. section 3. Explanation 1- for the purposes of this section –
(i) “Physical abuse” means any act or conduct which is of such a nature as to cause bodily pain, harm, or danger to life, limb or health or impair the health or development of the aggrieved person and includes assault, criminal intimidation and criminal force;
(ii) “Sexual abuse” includes any conduct of a sexual nature that abuses, humiliates, degrades or otherwise violates the dignity of woman;
(iii) "Verbal and emotional abuse" includes-
(a) Insults ridicule, humiliation, name calling and insults or ridicule specially with regard to not having a child or male child, and
(b) Repeated threats to cause physical pain to any person in whom the aggrieved person is interested
(iv) “Economic abuse” includes-
(a) deprivation of all or any economic or financial resources to which the aggrieved person is entitled under any law or custom whether payable under an order of a court or otherwise or which the aggrieved person requires out of necessity including but not limited to, household necessities for the aggrieved person and her children, if any, stridhan, property jointly or separately owned by the aggrieved person payment of rental related to the shared household and maintenance.
(b) disposal of household effects, any alienation of assets whether movable or immovable, valuable shares, securities bonds and the like or other property in which the
(a) harms or injures or endangers the health, safety, life, limb or well being, whether mental or physical, of the aggrieved person or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse and economic abuse; or

(b) harass, harms, injures or endangers the aggrieved person with a view to coerce her or any other person related to her to meet any unlawful demands for any dowry or other property or valuable security; or

(c) has the effect of threatening the aggrieved person or any person related to her by any conduct mentioned in clause (a) or clause (b); or

(d) otherwise injures or causes harm, whether physical or mental, to the aggrieved person.

The definition is very comprehensive and provides clear legislative guidelines for judges to decide whether or not an act of domestic violence has been committed. Women are not considered victims, but also can be perpetrators of violence against other members of the household. In this way the said statute, covers acts that are violative of a woman’s dignity or any other unwelcome conduct of a sexual nature. The Act provides for the right of a woman to reside in her matrimonial home or shared household irrespective of the fact whether or not she has any title or rights on such home or household. The Act also provides for appointment of protection officers and registration of NGOs as service providers for providing assistance to the aggrieved person with respect to her medical examination, legal aid safe shelter, and also provides for monetary relief to the victims of domestic violence in various situations which include payment of compensation or damages or both for the injuries aggrieved person or her children or her stridhan or any other property jointly or separately held by the aggrieved person.

(c) Prohibition or restriction to continued access to resources or facilities which the aggrieved person is entitled to use or enjoy by virtue of the domestic relationship including access to the shared household.

Explanation II – for the purposes of determining whether any act, omission, commission or conduct constitutes domestic violence under this section overall facts and circumstances of the case shall be taken into consideration.


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including for the mental torture and emotional distress etc. The breach of protection order or interim protection order by the respondent is treated an offence which is punishable with imprisonment upto one year or fine upto Rs. 20,000 or with both. Moreover the offence is treated as cognizable and non-bailable.133

The above said legislation is, indeed, a respite for the oppressed women in India society. Being a noble piece of legislation, need is to implement in a right spirit in order to instill confidence in women that they are not always at the receiving end in a male dominated society.

(vii) Sexual Harassment and Women Health

Sexual harassment includes such unwelcome sexually determined behaviour as physical contacts and advances, sexually coloured remarks, showing pornography and sexual demands, whether by words or actions. Such conduct can be humiliating and may constitute a health and safety problem; it is discriminatory when the woman has reasonable grounds to believe that her objection would disadvantage her in connection with her employment, including recruiting or promotion or when it creates a hostile working environment.

Sexual harassment has been an invisible barrier impending women’s equal opportunities, participation and promotion in the workplace. In India so far only legal avenue for redress is in the Indian penal code, which contains provisions of rape (section 375), use of force to outrage the modesty of a woman (Section 354) or use of word or gesture to insult the modesty of a woman under section 509. But these legal provisions are hardly utilized, in practice, due to social compulsion in male dominated society. Repeated sexual harassment of women makes her physically and mentally vulnerable. She looses faith in social security system and in order to protect her

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133 Sections 19, 8, 10, 20, 22, 31 of Domestic Violence Act, 2005.
future daughter from all such harassments. She prefers to kill her even before birth.

Against the growing menace of sexual harassment of women at the work place, a three judges Bench of the apex court, by a rather innovative judicial law making process, issued certain guidelines in the historic case of *Vishaka v. State of Rajasthan*\(^{134}\) after taking note of the fact that the present civil and penal laws in the country do not adequately provide for specific protection to women from sexual harassment at places of work. Defining sexual harassment at work place, the court said that it includes such unwelcome sexually determined behaviour (whether directly or by implication) as:

a) physical contact and advances;
b) a demand or request for sexual favours;
c) sexually-coloured remarks;
d) showing pornography

e) any other unwelcome physical, verbal or non-verbal conduct of sexual nature.

Where any of these acts is committed in circumstances where under the victim of such conduct has a reasonable apprehension that in relation to the victim’s employment or work whether she is drawing salary, or honorarium or voluntary, whether in government, public or private enterprise, such conduct can be humiliating and may constitute a health and safety problem, it shall be treated as violative of dignity of such woman under the constitution.\(^{135}\) In the wake of this judgement, the protection of women against sexual harassment at work place Bill, 2007 was prepared by the UPA government.\(^{136}\) But so far, nothing concrete has emerged out of this bill.


\(^{135}\) *Ibid.*

\(^{136}\) Comments and suggestion are invited on this draft Bill by the government. PTO
Insecurity outside the household is today one of the greatest obstacles in the path of women. In India, every 26 minutes a woman is molested. It is a telling comment on a country’s law and order situation.\textsuperscript{137}

In addition to this, as seen earlier rape is said to be the fastest growing crime in the country today, and as many as 18 women are assaulted in some form or the other every hour across India. In fact over the last few days, cases of rape and assault have made it to the headlines with alarming frequency.\textsuperscript{138}

Unfortunately, this situation prevails despite the fact that India is a signatory to CEDAW and ratified it in June 1993.\textsuperscript{139} Knowledge the fact that sexual harassment both of working and non-working females, adolescent, teenaged girls causes considerable harm to victim's mental and physical health, it is submitted that law to this effect must be enacted on priority basis.

**(viii) Prostitution and Health**

Prostitution involves one gender’s taking advantage of its superior social status and manipulating the other gender. Because members of this less powerful group are compelled or forced, physically or psychologically to engage in a sexual act, gender

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The provisions of this new Bill includes in the definition of sexual harassment that no woman employees at a work place shall be subjected to sexual harassment including unwelcome sexually determined behaviour, sexual demand request for sexual favours or any other unwelcome conduct of sexual nature whether verbal, textual, physical graphic or electronic or by any other actions which may include:

(i) implied or overt promise of preferential treatment in employment; or

(ii) implied or overt threat of detrimental in employment; or

(iii) implied or overt threat about the present or future employment status.

(iv) Conduct which interferes with work or creates an intimidating or offensive or hostile work environment; or

(v) Humiliating conduct constituting health and safety problems.


\textsuperscript{137} ‘Unsafe in India’, The Times of India, January 15, 2008.

\textsuperscript{138} Ibid. Mumbai watched as an ugly mob attacked women on new year’s eve. In Latur, a 14 year old was raped and killed by four young men. In Konark, four men were charged with dragging a woman out of a bus and gangraping her.

Equally horrific are news reports of foreign tourists being sexually assaulted. Recently, an American was molested in Pushkar, a British Journalist raped in Goa, Canadian Girls attacked in Kumarakom to list a few instances

\textsuperscript{139} See Supra chapter III for details.
feminists seek to eliminate the oldest profession because it is a creation of patriarchy and thus, an inherent act of violence against women as a class.\textsuperscript{140}

The practice of ritual dedication of girl children to prostitution has been reported from some parts of India, mainly Karnataka and Maharastra. In poverty, girl child is the first to be sold for a few thousand rupees who ultimately reaches brothels.\textsuperscript{141}

Sex work is prohibited in India under the \textbf{Immoral Traffic (Prevention) Act 1956}\textsuperscript{142} as amended in 2006. However, there are many sex rackets operating in all cities of India in which young girls are sexually exploited. Prostitution is a social evil and is an out come of poverty and disparity in distribution of resources. No women would like to indulge in prostitution until circumstances forces her to do so. It is indirect indicator of problem of drug, lower status of women, alcoholism, weak social fabric leading to female feticide.

Recently emergence of HIV and AIDS has once again forced the society to reconsider the need to change the concept of sexuality. High prevalence of sexual transmission of disease among commercial sex workers and deaths due to HIV and AIDS in them, need legal action beside health action from the government.\textsuperscript{143} However, it is definitely true that this profession is hazardous for woman who repeatedly suffers from various sexually transmitted diseases, frequent abortions and mental agony.

\textbf{(ix) Occupation and Women Health}

Traditionally, women have had main responsibility for seeing to the needs of families in their homes. But now women work longer...
hours and their work is more arduous than men’s.\textsuperscript{144} The health effects of occupation amongst women who are home workers are less visible than for other women. However, the insecurity of the work, lack of control over the allocation of work, the appalling rates of pay and long hours needed, and the isolation in which the work is performed have substantial effects on health of many women. Today call centres represent an expanding yet poorly understood sector of the business world. Unfortunately the rapid growth of the industry had lead to potential problems related to a lack of public policy regarding management guidelines and production standards. These issues place call centre women workers at risk for health problems.\textsuperscript{145} There is a need for legislation aimed at protecting the rights of part-time women workers. Due to high unemployment among women many get involved in various risky occupation such as prostitution, drug trafficking, robbery etc.

As seen in the previous chapter, in India, various legal measures have been taken to promote and protect women employment. It is argued that employment among women would help improving their economic status, which in turn would facilitate more concentration and other social and political matters of the society. But sexual discrimination, proves counter productive for promotion of women employment. Unequal wages for same or similar work also is a form of sexual discrimination. Therefore, equal wages for equal work for both men and women is purported to protect women from economic discrimination and exploitation. The Constitution of India

\textsuperscript{144} One of the study of Bangladesh estimated that women spent between 10 and 14 hours each day in productive work, including income generating and expenditure saving labour, in comparison with 10 or 11 hours spent by men. See Supra note 13 at 77.

\textsuperscript{145} The government should introduce media and public awareness campaigns to highlight the negative effects, on call centre workers. Government health initiatives and company policies should include health promotion strategies which include, on site , exercise facilities and healthy food dispensers, regular stretch breaks . lunch breaks of at least one hour and general health and wellness programs. \textit{Moving towards women’s health} – http://www.acewh.dal.ca/eng/reports/moving6.pdf. (accessed on July 31,2009)
ensures that there is an equal opportunity to both men and women and forbids discrimination against women at the time of recruitment.\textsuperscript{146}

In the significant judgement of \textit{Government of A.P. v. P.B. Vijay Kumar and another},\textsuperscript{147} the Supreme Court observed that creating job opportunity for women is the important limb of the concept of gender equality. Its object is to strengthen and improve status of women. In earlier case of \textit{Nergesh Meerza}\textsuperscript{148}, which still holds good, is a classical example of sexual discrimination. Indian Airlines corporation provided for retirement of Air Hostesses at the age of 35 years or on marriage if it takes place within 4 years of service or on first pregnancy. There was no such retirement condition for assistant flight pursurs. In this case, constitutional validity of these regulations was challenged through writ petition on the ground that these regulations were arbitrary and discriminatory. The Apex Court upheld the constitutional validity to the termination from service if marriage takes place within four years of service. The Supreme Court held unconstitutional the provision regarding retirement of Airhostess on her first pregnancy by holding that this is an 'insult to womanhood'. The court said it was not understandable as to how a young attractive Air hostess would be able to cope with difficult or awkward situation more effectively than others because smartness or beauty cannot be the only hallmark of competency.\textsuperscript{149}

\textsuperscript{146} The \textit{Factories Act, 1948} (amended upto 1976) provides for establishment of a crèche where 30 women are employed (including casual and contract labourers), as the number of women employees was increasing the Govt. also passed The Maternity Benefit Act, 1961 (amended 1971 upto 1995, \textit{Amendment Act of 2008}) with the object of doing social justice to women workers employed in factories mine, and plantations. It provides the maternity leave and other benefits to women employees and enabling them to fulfill their commitment to nurse their babies till attainment of an age of 15 months u/s 11 of the act.

\textsuperscript{147} \textit{AIR India v Nergesh Meerza} (1981) 4 SCC 335. The Bench comprised of Justice S. Murtaza Ali, A. Varadarajan and A.N. Sen, J.J.

\textsuperscript{148} \textit{Id}, at 339.

\textsuperscript{149} \textit{Id}, at 339.
We, in India, do not know how to treat our women as human beings who have a right to dignity and safety. This is despite the fact that in tune with various provisions of the Constitution, the Parliament has enacted many women specific and women related laws from time to time to protect women against social discrimination, violence and atrocities, and also to prevent social evils like child marriages, dowry, rape, practice of sati, etc.¹⁵⁰

In brief, fight for justice by females or cry for gender equality is not a fight against men. It is a fight against traditions that have chained them, a fight against attitude that are ingrained in the society – it is a fight against proverbial Lakshman Rekha which is different for men and different for women. Every effort must be made to ensure that a women is treated as an equal and an important member of the family.¹⁵¹ It would be useful to devise and extend package programmes for raising women status, male responsibility and youth awareness, in measures relevant to women health issues. More minds need not be corrupted by regressive ideas of discrimination on the basis of caste or gender, since wherever opportunities are made available, women have proved to be as efficient as men, besides, women possess unique ability of procreation. Women may be weak during the period of pregnancy and for a few weeks after that. But this is the period of creation; not to be considered as any sign of weakness; particularly by those who can never takeover this function.

¹⁵⁰The Equal Remuneration Act, 1976 provides for equal pay to men and women for equal work. The Hindu Marriage Act, 1955, amended in 1976 provides the right for a girl to repudiate a child marriage before maturity whether the marriage has been consummated or not. An amendment brought in 1984 to the Dowry Prohibition Act, 1961 makes women's subjection to cruelty a cognizable offence. A new criminal offence of 'Dowry Death' under section (304B) has been incorporated in the Indian Penal Code. The Child Marriage Restraint Act 1976 (the amended act known as the prohibition of child marriage Act, 2006) raises the age for marriage of a girl to 18 years and that of a boy to 21 years and makes offences under the Act cognizable. The purpose behind this is to stop pre-mature marriages and deliveries to save the adolescent girls health.

Women enjoy a unique position in the society and all countries of the world. However, so far efforts of the government in this direction reflect only de jure equality to women. Government has not been able to accelerate de facto equality to the extent the Constitution intended. Reflecting this the Delhi High Court in *Capt. (Mrs.) Dimple Singla v. Union of India* expressed that unless attitudes change, elimination of discrimination against women can not be achieved. There is still a considerable gap between constitutional rights and their application in the day-to-day lives of most women. The full development of personality, fundamental freedom and equal participation by women in political, social, economic and cultural scenarios are concommitment not only for international as well as national development, but also for social and family stability, and for women’s physical, mental, cultural growth.

The above study reveals that even after 61 years of the Universal Declaration of Human Rights, women’s rights have only recently been acknowledge conceptually while its practice and reality still remain tangled in complex issues of culture, inadequate or lack of enforcement, accountability systems and political will.

Hence, right to education and political participation as well as economic independence are some of the keys to women’s emancipation and empowerment, eradication of gender based discrimination and an assurance of all other human rights on equal footing, resulting ultimately also in good health to them.

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152 (2002) 2 AISLJ 161. (para 10,11) at 162 Justice Anil Dev Singh and Justice Madan B. Lokur were the judges who delivered this judgement. The appellant was married to an advocate who practised law at Chandigarh. She had a child of one and a half years. The appellant joined the Indian Army as a short service commissioned officer in the Judge Advocate General’s Department on March 8, 1997. During the short span of four and half years of her service career she was stated to have been transferred three times. The two important point said in the judgement are- (1) Gender discrimination is bad in law (2) A married lady officer with a child cannot be treated as a ‘Lame duck’.

B) CHILDREN'S RIGHT TO HEALTH

Children being the most vulnerable section of the society need care, protection and affection for their survival and all round development. The quote of the great English poet John Milton that “Childhood shows the man, as morning shows the day,”154 aptly depicts the importance of the child in our lives.

The children are the future custodians of sovereignty, rule of law, justice, liberty, fraternity and international peace and security. They are the potential embodiment of our ideals, aspirations, ambitions and future hopes. In fact, they are the only messengers of our ideologies, philosophies, knowledge and cultural heritage. This is why the Universal Declaration of Human Rights adopted way back in 1948, has proclaimed that childhood was entitled to special care and assistance.155

In our society, unscrupulous and haphazard growth of population and living resources, has created a large number of social evils like poverty, starvation deaths, illiteracy, exploitation, unemployment, prostitution in children of tender age and so on. From the dawn of human society, the child has been the person who has been exploited mercilessly and indiscriminately. Industrialization at a large scale led to the employment of children in factories, workshops and in other unregulated occupations better known as unorganized sector.156 They have been working not only at home but outside the house too i.e. in hotels, restaurants and in various other hazardous occupations.

Earlier, children were recipients of welfare measures. It was only during the twentieth century that the concept of children’s

154 http://quotationsbook.com/quote/42981/ (accessed on September 14, 2009)
155 See supra chapter III for details.
rights emerged. This shift in focus from the ‘welfare’ to the ‘rights’ approach is significant. The right approach is primarily concerned with issues of social justice, non-discrimination, equity and empowerment. And rights perspective is embodied in the United Nations Convention on the Rights of Child in 1989, which is a landmark in international human rights legislation.

The Government of India has ratified this convention in December 1992, with the solitary rider in relation to article 32 of the convention. The Government of India undertakes to take measures to progressively implement the provisions of Article 32.157

It is not a simple matter to define who is a ‘child’. This is because age criteria can vary across different systems or different cultures. Almost everywhere age limits formally regulate children’s activities: when they can leave school; when they can marry, when they can vote; when they can be treated as adults by the criminal justice system; when they can join the armed forces; and when they can work. But age limits differ from activity to activity and from country to country.158 In India, the census of India defines persons below the age of fourteen as children. While making use of standard demographic data, social scientists includes, females in the age group of fifteen to nineteen years under the category of girl child. Most of the government programmes on children are targeted for the age group below fourteen years.

The legal conception of a child has thus tended to vary depending upon the purpose. According to Article 1 of the United Nations Convention on the Right of the Child 1989, “a child means every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier”. This article,

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thus, grants the discretion to individual countries to determine by law whether childhood should cease at 12, 14, 16 or whatever age they find appropriate. In India the age at which a person ceases to be a child varies in different laws.\textsuperscript{159}

There are around 380 million children below the age of fourteen years in India and 157, 863,145 children in the age group of 0-6 years.\textsuperscript{160} Children with disabilities are approximately thirty-five million and the proportion of girls marrying below the legal age of eighteen years is 39 percent. There are around 36,528 children living in institutions and the number of children living in streets is around 5,000,000. Children in India face many health hazards, and many die young for lack of timely health care. About 80 percent of Indian live in rural and tribal areas, but only 30 percent of doctors in the country are available there. The existing maternal and child health services reach only to a small proportion of the women and children who need them.\textsuperscript{161}

In order to prevent the child abuse there is a need of well planned legal approach and honest implementation of policies. The government departments as well as non-government organizations

\textsuperscript{159}\textsuperscript{} C.K. Shukla, S. Ali, “Child Labour and the Law” at 118, 43 (2006). The word ‘child’ has been used in various legislation as a term denoting relationship, as a term indicating capacity, and as a term of special protection in some laws, as in Child Marriage Restraint Act 1929 the minimum age of marriage for girls is eighteen but the age of sexual consent under the rape laws is sixteen and it is fifteen if she is married. As provided under section 2(a) of Immoral Traffic Prevention Act, 1956 a child is a person who has completed 16 years of age. According to The Factories Act 1948, child means a person who has not completed 15 years. As per sec 2(ii) of the Child Labour (Prohibition and Regulation) Act, 1986, a child means a person who has not completed the age of 14 years. The act prohibits employment in certain occupations and processes. These include the transport of passengers, hazardous work in Railways and Ports, the process like Beedi making, Cement manufacturing, manufacturing of matches micacutting, soap manufacturing, wool cleaning, building and construction industries. In Juvenile Justice (care and protection of children) Act 2000 juvenile or ‘child’ means a person who has not completed eighteen years of age. The Mines Act 1952, defines children as those below eighteen years and the various state shops and establishment Act defines the age between twelve and fifteen years.

\textsuperscript{160}\textsuperscript{} Supra note 158 at 1.

\textsuperscript{161}\textsuperscript{} Supra note 159 at 83.
are required to take effective measures to eradicate child prostitution and to implement social welfare programmes for protection, treatment care, development and rehabilitation of children.

The framers of the Indian Constitution were aware of rampant exploitation of children in all most all walks of life. Therefore, they have enacted special provisions in the Constitution for welfare of children. The Constitution of India provides a protective umbrella for the rights of children. There are certain Fundamental Rights especially for children. These rights are necessary because of their physical and mental immaturity; the children are especially vulnerable and need special protection. Hence, Special provisions ensuring justice to children have been incorporated in part III as Fundamental Rights and in part IV known as Directive Principles of State Policy and part IVA as Fundamental Duties. As per the provisions relating to child, clause 3 of Article 15 says; ‘Nothing in this Article shall prevent the state from making any special provision for women and children.’ Therefore, laws can be made giving special protection to children.

Under the Constitution, it is the duty of the state to secure that children of tender age are not abused and forced by economic necessity to enter vocations unsuited to their age and strength and to ensure that children are given opportunities and facilities to develop in a healthy manner and in condition of freedom and dignity.

To ascertain the constructive role of the state in relation to children, in the landmark judgement of *M.C. Mehta v. State of Tamil Nadu*, the apex court held that children, below the age of

\[^{162}\text{Inserted by the Constitution (forty Second Amendment) Act, 1976.}\]
\[^{163}\text{Article 15(3) of The Constitution of India.}\]
\[^{164}\text{Art. 39 (e) of The Constitution of India.}\]
\[^{165}\text{Art. 39 (f) of The Constitution of India.}\]
\[^{166}\text{AIR 1997 SC 699. The Bench comprised of Hon'ble Justice Kuldip Singh, B.L. Hansaria and S.B. Majumdar JJ.}\]
14 years cannot be employed in any hazardous industry or mines or other works. This matter was brought before the apex Court through the public interest litigation. Under Article 32 of the Constitution, the petitioner not only told the court about the plight of children engaged in Sivakasi cracker Factories and how the constitutional right of these children guaranteed by Article 24 was being grossly violated but also requested the Court to issue appropriate directions in this regard to the governments. The court directed the government to take steps to establish child labour Rehabilitation-cum-welfare fund and asked the offending employers to pay for each child a compensation of Rs 20,000 to be deposited in the fund and suggested a number of measures to rehabilitate them in a phased manner. The court also held that in view of the provisions contained in Article 39(f), the employment of children within the match factories directly connected with the manufacturing process of matches and fireworks can not be allowed as it is hazardous however, children can be employed in the process of packing. But it should be done in area away from the place of manufacturing to avoid exposure to accidents.

Those who argue for abolition of child labour thinks that anything that affects the physical, mental or moral growth of children, needs to be held as hazardous.

The word ‘hazard’ is defined as the capacity or the potential of an object, substance or condition to produce a particular type of adverse effect to a person or group of persons. Hazards are generally classified into four types: physical, chemical; biological and ergonomics. Physical hazards include noise, heat, light, radiation, vibration, dust and general housekeeping conditions. Chemical hazards are mist, fumes smoke, liquid and solid materials, gas vapour and dust particulates. Biological hazards are insects, bacteria, viruses, rodents, mite, parasites and other organisms. Ergonomics hazards are those

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167 Id at 709 (para 27).
168 Id, at 702 (para 3A, 4).
pertaining to body positions in undertaking different tasks and using tools or equipment, monotony and boredom, repetitive movements, organizational or administrative issues, and psycho-social dimensions. In addition, safety concerns such as accidents, injuries, falls and slips may also be considered a separate classification of hazards. Such hazards may be further categorized according to the elements of occupational health, namely the worker, the task, the work environment and the tool or equipment, for easier delineation of control measure or preventive programmes.\textsuperscript{169}

This description of hazard does not take into account other hazards which children are prey to, viz, mental, social spiritual and psychological hazards. It can, therefore, be said that if the child is denied opportunity to develop as a full human being, it is a hazard; if it affects the physical health or mental growth, it is a hazard.\textsuperscript{170}

Not only low remuneration or long hours of work but also these children are exposed to many occupational risks. The risks are countless in number in different sectors. To list a few, the following table reveals the health hazards of child labour in organized sector.\textsuperscript{171}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|}
\hline
\textbf{S.No.} & \textbf{Occupation} & \textbf{Health Hazards} \\
\hline
1. & Beedi Industry & Chronic Bronchitis & tuberculosis \\
2. & Glass Industry & Asthma, Bronchitis, T.B., Eye Problems \\
3. & Handloom Industry & Asthma, T.B. \\
4. & Zari & Embroidery & Eye defects \\
5. & Gem & Diamond Cutting & Eye defects \\
6. & Construction & Stunts growth of child \\
7. & Rag Picking & Tetanus, skin diseases \\
8. & Pottery & Asthma, Bronchitis, T.B. \\
9. & Stone quarries/slate quarries & Silicosin \\
\hline
\end{tabular}
\end{table}

\textsuperscript{169} See National Survey on Working children, “Working Together Against Child labour” Available at http://ipecphilss.tripod.com/survey/paper2.htm#HAZARD. (accessed on September 27, 2009.)
\textsuperscript{170} Ibid.
\textsuperscript{171} Supra note 159 at 40.
After the decision by the constitution bench in *Unni Krishnan v. State of A.P.* Article 45 has been raised to high pedestal by this case and has acquired the status of a fundamental right, desiring that a child must be given opportunity and facility to develop in a healthy manner. The apex court observed that though other articles are part of directive principles, these are fundamental in the governance of our country and it is the duty of all the organs of the state to apply these principles. Judiciary, being also one of the three principal organs of the state, has to keep the same in mind when called upon to decide matters of great public importance. Abolition of child labour is definitely a matter of great public concern and significance.

Earlier, the hon'ble Supreme Court in *Sheela Barse and another v. Union of India,* has declared that a child is a national asset. It is the duty of the state to look after the child with a view to ensuring full development of its personality. A child is treated with cruelty when a rejected rather abandoned child by the parents, takes a job in a factory, hotel, small scale industry and other road side commercial establishment only for his own maintenance. The court issuing various directions in regard to physically and mentally retarded children as also abandoned or destitute children, held that children's programmes should find a prominent part in our national plans for the development of human resources, so that our children grow up to become robust childrens, physically fit, mentally alert and morally healthy, endowed with the skill and motivations needed by society.

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172 AIR 1993 SC 2178 *Unni Krishnan v. State of A.P.* Right to education upto age of 14 years is a fundamental right within the meaning of Article 21 of the Constitution. The right to education flows directly from the right to life. The full bench comprised of former CJI L.M. Sharma, Justice S. Ratnavel Pandian, Justice S. Mohan, Justice B.P. Jeevan Reddy and Justice S.P. Bharucha were the judges delivered this judgement.

In pursuance of the constitutional directive of primary education the Parliament enacted the **Punjab Primary Education Act, 1960** (Punjab Act No. 39 of 1960). The object of the Act is to provide for free and compulsory education for children in the State of (Haryana) substituted for the words "Punjab" by Haryana Adaptation of Laws Order 1968. Section 13 of the Act contains the penalty provisions. It states that:

"if any parent fails to comply with an attendance order passed under Sec. 9, he shall be punishable with fine not exceeding twenty five rupees and in the fine not exceeding one rupee for everyday during which such contravention continues after conviction for the first of such contraventions:

Provided that the amount of fine payable by any person in respect of a child in any one year shall not exceed three hundred rupees”.

Section 10 contains the provision that children not to be employed so as to prevent from attending school. Section 14 states that if any person contravenes the provisions of Sec. 10, he shall be punished with fine which may extend to fifty rupees and, in the case of a continuing contravention, with an additional fine not exceeding two rupees for every day during which such contravention continues after conviction for the first of such contraventions.

Now after 61 years of India’s Independence, the right of children to free and compulsory education has been recognized with the passage of **Compulsory Education Act, 2009** which has been notified after it received the assent of the President on August 26, 2009. The new enactment followed a constitutional (86th)

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174 The said Act received the assent of the Governor of Punjab on the 7th December, 1960 and first published for general information in the Punjab Government Gazette (extra ordinary) legislative supplement of the 9th December, 1960. This Act comprised of 23 sections.

Amendment Act 2002 which made free and compulsory education of India’s 6-14 years of age a fundamental right under Article 21A.\textsuperscript{176}

It is by now evident that working at young age directly conflicts with a child’s growth and education. The existing labour legislation and constitutional protection in India is working for child protection. Earlier \textbf{The Employment of Children Act 1938} prohibited the children below the age of fifteen years to work in any occupation connected with the transport of passengers goods or mails by railways or connected with a port authority within the limits of any port. But now this Act has been repealed by the Child Labour (Prohibition and Regulation) Act, 1986.

The Child Labour (Prohibition and Regulation) Act, 1986\textsuperscript{177} has also made certain provisions regarding health and safety. Section 13 of the Act deals with the health and safety measures of the child employed in occupations or in processes.\textsuperscript{178}

\textsuperscript{176} The law makes it obligatory for “the appropriate government to provide free elementary education and ensure compulsory admission, attendance and completion of elementary education to every child in the six to fourteen age group. It specifies duties and responsibilities of appropriate government, local authority and parents in providing free and compulsory education. 
\url{http://www.newkerala.com/nkfullnews-1-104873.html} (accessed on September 6, 2009)

\textsuperscript{177} The said Act 61 of 1986 received the assent of the president on 23rd December 1986. The Act contains 26 sections and one schedule.

\textsuperscript{178} The appropriate Government may, by notification in the official Gazette, make rules for the health and safety of the children employed or permitted to work in any establishment or class of establishments.

1. Without prejudice to the generality of the foregoing provisions, the said rules may provide for all or any of the following matters, namely:
   1. cleanliness in the place of work and its freedom from nuisance;
   2. disposal of wastes and effluents;
   3. ventilation and temperature;
   4. dust and fume;
   5. artificial humidification;
   6. lighting;
   7. Drinking water
   8. latrine and urinals;
   9. spittoons;
   10. fencing of machinery;
   11. work at or near machinery in motion;
   12. employment of children on dangerous machines;
   13. Instructions, training and supervision in relation to employment of children on dangerous machines;
Section 14 of the said Act, 1986 contains penalties.

It reads as: (1) whoever employs any child or permits any child to work in contravention of the provisions of Sec. 3 shall be punishable with imprisonment for a term which shall not be less than three months but which may extend to one year or with fine which shall not be less than ten thousand rupees but which may extend to twenty thousand rupees or with both. (2) whoever, having been convicted of an offence under Sec. 3, commits a like offence afterwards, he shall be punishable with imprisonment for a term which shall not be less than six months but which may extend to two years. (3) whoever - (a) fails to give notice as required by Sec. 9; or (b) fails to maintain register as required by Sec. 11 or makes any false entry in any such register; or (c) fails to display a notice containing an abstract of Sec. 3 and this section as required by section 12; or (d) fails to comply with or contravenes any other provisions of this Act or the rules made thereunder shall be punishable with simple imprisonment which may extend to one month or with fine which may extend to ten thousand rupees or with both.

Section 16 talks about the procedure relating to offences. According to the provisions under this section any person, police officer, or inspector may file a complaint of the commission of an offence under this Act in any court of competent jurisdiction (Metropolitan Magistrate or a Magistrate of First Class).179

Though the law is being successfully enforced and does not allude to the inadequacies inherent in the law and the problem of its

14. device for cutting off power;
15. self acting machines;
16. easing of new machinery;
17. floor, stairs and means of access;
18. pits, sumps opening in floors, etc;
19. excessive weights;
20. protection of eyes;
21. explosive or in inflammable dust, gas etc;
22. precautions in case of fire;
23. maintenance of buildings and;
24. safety of buildings and machinery;

implementation, yet there are less number of prosecutions under the Act, and very few of those convicted had served a jail sentence for their crimes. Regulatory provisions in the Act were not made for children working in the agricultural sector and some of those working in the unorganized sector. The definition precluded child labour employed in homes. Moreover, inadequate allocation of funds also resulted in its poor implementation.

In case of **Bandhua Mukti Morcha v Union of India and others**, the employment of children in carpet industry in the state of Uttar Pradesh was challenged before the apex court on the ground that it is violative of Articles 14, 21, 24, 39(e), (f) and 45.

The court observed that:-

"It is the duty of the state to provide facilities and opportunities to the children driven to child labour and also develop their personality and to eradicate the child labour through well planned and poverty focussed alleviation programmes. Such ban should be imposed regarding intolerable activities like slavery, bonded labour, trafficking prostitution, pornography and dangerous forms of labour...." The court further directed to provide such facilities like education, health, nutritious food, and sanitation for children's development.

In the present case, the hon'ble apex court further observed that:

“Article 24 of the Constitution prohibits employment of children below the age of 14 years in any factory or mine or in any other hazardous employment but it is a hard reality that due to poverty a child is driven to be employed in a factory, mine or hazardous employment. Pragmatic, realistic and constructive steps and actions are required to be taken to enable the child belonging to poor and weaker sections and also dalit tribes and minorities, to enjoy the childhood and develop in a fully blossomed personality, educationally, intellectually and culturally with a spirit of inquiry, reform and enjoyment of leisure. The child labour, therefore, must be eradicated through well planned manner. Total banishment of

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181 *Id*, at 2219 (para 1).
employment, however, may drive the children enmass up to the destitution and other social risks. Therefore, while exploitation of child must be progressively banned, other simultaneous alternatives to the child should be evolved including provision of education, health care, food, shelter and other means of livelihood with self respect and dignity of person immediate ban of child labour would however, be unrealistic and counter productive...."182

The court directed the Government of India to convene a meeting of concerned ministers of the respective state governments and their principal secretaries, holding concerned state governments departments, to evolve the policy for progressive elimination of employment of children below 14 years in all employments, their health checkups, and regarding providing these children nutritional foods.

As a result, in 2006 ban was imposed on engaging children under 14 years of age in any kind of work including domestic through amendment in Child Labour (Prohibition & Regulation Act,) 1986. According to the Ministry of Labour Press release on 9.5.2007, 22,29 violations of the recent notification banning employment of children under 14 as domestic help and in hospitality sector were detected. 38,818 inspections were carried out by some state governments from whom reports were received, and 211 prosecutions were filed.183 Conviction are some thing, that activists like Kailash Satyarthi whose Bachpan Bachao Andolan rescued 22 children from a Delhi plastic factory, feel, it only a dream. To quote:

"The ban is being fragrantly flouted in your neighbour’s home and mine, in hotels, dhabas, factories your name it problem is that if government shows no political will, the ban will lose its meaning."184

182 Id at 2222 (para 10).
184 ‘Ban or no ban, they’re labouring on’, Times of India June 12, 2007 on Oct. 16, 2006 the notification to existing Child Labour Prohibition (and Regulation) Act 1986 came into effect, but child labour is still rampant despite the ban. More than 12
It is rightly stated that the law cannot tackle problem that has economic and social implications. The ban also does little to address the reasons of family to put the children to work, poverty debt, and marginalized kids have no option but to work, parents have no option but to put them on work. Till then, ban remains only in letter and not in spirit. And would ultimately keep affecting the health of these children who will keep working in their tender age as child labourers in different occupations.

A number of childcare programmes for improving the health status of children are being implemented by the government of India.

(i) **Day care and crèche facilities**

The provisions for crèches for children of working mothers is obligatory under certain labour laws in the organized sector. Laws with reference to crèches exist primarily in relation to the organized sector. The Factories Act 1948, (as amended on 1987) the Mines Act 1952, (as modified in 1983) and the Plantations Labour Act 1951 make it obligatory for the employer to provide crèches for children aged 0-6 years wherever more than a stipulated minimum of women are employed in factories, mines, and plantations. Modelled on those of industrialized countries, Unfortunately these laws have not been amended to keep pace with the changing economic situation and are largely irrelevant to the present day working conditions, besides being applicable to only a small minority of working women.

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186 Ibid.

This becomes evident when it is noted that similar legislation has not been passed for the benefit of women working in the tertiary sector (service trades, and professions) in whose numbers there has been a spectacular increase in last three decades.\textsuperscript{187} A new 2008 NGO report to the United Nations says, despite its upward economic growth, India has failed to put into place even the most basic entitlements that will ensure the right to survival, life and dignity for women. The report articulates the myriad voices from Indian civil society. Majority remain in the unorganized and informal sector, outside the purview of most protective legislation. The provision of creches should be implemented and monitored at work sites in accordance with existing laws and policy recommendations.\textsuperscript{188}

Analysis of the laws reveal several lacunae, chief among which is the insistence on a minimum number of women workers for the law to become applicable. This not only makes it easy for evasion by various simple strategies, but even assuming no evasion is attempted this makes it of limited applicability, since it omits certain categories of workers such as those employed in small establishments, temporary and casual workers, contract workers, etc.\textsuperscript{189}

Further, if one considers childcare as a fundamental right of children, the question of stipulating numbers or their use and misuse become irrelevant. Within the broader framework of the Constitution which allows equality to all citizens with no discrimination, every child has a right to holistic care and development and every mother the right to demand such facilities irrespective of what she contributes to the national statistics. Another shortcoming is the placing of administrative as well as financial responsibility on employers, who may lack the willingness

\textsuperscript{187} supra note 158, at 410.

\textsuperscript{188} Also see http://web.worldbank.org/wbsite/external/topics (accessed on September 3, 2009)

\textsuperscript{189} Ibid.
and expertise to run crèches, rather than on professionals or agencies specialized for the purpose.\textsuperscript{190} This only results in reducing attention to the quality and nature of day care focusing instead on numerical targets.

A number of programmes like the maternal and child health and child survival and safe motherhood followed a top down approach to achieve health goals and so did not reflect use needs and preferences. Realizing this, the government is taking bold steps to reorient the health programmes to make them more client oriented with an emphasis on the quality of services and care. This has brought about a paradigm shift in the health policies which is reflected in the \textbf{Reproductive and Child Health Programme (RCH) 1996}.\textsuperscript{1996}

(ii) \textbf{The Reproductive and Child Health Programme (RCH) 1996.}

This national programme was launched in October 1997 incorporating new approach to population and development issues, as exposed in the international conference on Population and Development held at Cairo in 1994. The programme integrated and strengthened the services under the child survival and safe motherhood programme and family planning services and added to the basket of services, new areas on reproductive tract/sexually transmitted infections. The RCH Programme is the umbrella programme of the department within whose framework and approach all the services being provided by Department of Family Welfare are to be planned, and delivered. The programme aimed to universalize the immunization, antenatal care, skilled attendance during delivery as well as for common childhood elements. The greater stress on improving neonatal care in and at all levels, i.e. hospital, homes and community will be paid, so as to reduce the infant mortality. The

\textsuperscript{190} \textit{Supra} note 158 at 412.
RCH programme aims at eradication of polio virus while selectively introducing hepatitis B in UIP package.

The second phase of India’s RCH II is an integral and important component of the National Rural Health Mission (NRHM) 2005. RCH-II has been commenced from 1st April, 2005 for the five year till 2010. The main objective of the program is to bring about a change in mainly three critical health indicators i.e. reducing total fertility rate, infant mortality rate and maternal mortality rate with a view to realizing the outcomes envisioned in the Millennium Development Goals, the National Population Policy 2000, and the National Health Policy 2002 and Vision 2020 India.191 Salient features of RCH-II Program are given below:

- Adoption of sector vide approach which effectively extends the program reach beyond RCH to the entire family welfare sector.
- Building State ownership by involving states and UT’s from the outset in development of the program.
- Decentralization through development of District and State level need based plans.
- Flexible programming with a view to moving away from prescriptive scheme based micro planning and instead allowing states to develop need based work plans with freedom to decide upon program inputs.
- Adoption of the logical frame works as a program management tour to support and outcome driven approach.
- Performance based funding to ensure adherence to program objectives, reward good performance and support weak performers through enhance technical performance.
- Pool financing by the development partners to simplify and rationalized the process of assessing external assistance.

191 http://www.mohfw.nic.in/NRHM/RCH/index.htm (accessed on September 6, 2009)
• Convergence, both inter sectoral as well as intra sectoral to optimize utilization of resource as well as infra structural facilities.

For this, the World Bank launched an investigation and worked with the Government of India to build it a strong remedial plan.192

(iii) Children's Health Scenario in India

Children in India suffer from various health problems since early childhood. Some come across fatal diseases and problems even before birth leading to shortened and unhealthy lives. The major findings of the mid-decade review193 highlighted many aspects.

1) Remarkable progress had been made in the eradication of polio and the goal of polio eradication by 2000. Nationwide immunization days were declared in December 1995 and January 1996.

2) There was an improvement in the management of diarrhoea at home. Oral Rehydration Therapy (ORT) became popular in 80 percent of the villages under the child survival and safe motherhood programme and many families had access to Oral Rehydration Salts (ORS) through depots.

3) Malnutrition as manifested in underweight and stunted children continued to be a major problem. It was particularly acute amongst infants and pre-school children in the poorest socio-economic groups. With international pressure building on India to deliver on the Millennium Development Goal of fighting poverty and hunger, Prime Minister Manmohan Singh has said that he would

content (accessed on September 2, 2009)

personally review the progress of country's nutrition programmes every year.\footnote{National Nutrition Mission, chaired by the PM, could be recast soon. Setup in 2003 for policy direction and effective coordination of nutrition programmes being implemented by the government, the mission has not met so far this year. “Nutrition Schemes to be reviewed annually” The Tribune July 26, 2009. Also see infra Nutrition}

4) Deliberate discrimination against girl children took several forms: nutritional denial such as inadequate breast-feeding; insufficient delayed medical care, lack of intention, causing emotional deprivation, and insufficient investment in resources. All these have been documented as leading to excess mortality in the female child. According to World Breast Feeding Trends Initiative (WBTI) India Report Card 2008, there are key gaps in the state of infant and young child feeding as there is no policy framework for protecting and supporting breastfeeding in private sector and informal sector for working women. No practical training of doctors and nurses regarding infant and young child feeding in pre service education. Further, crèches, as an essential service to support working mothers to breastfeed are completely inadequate in terms of number and quality with respect to the existing need. There existed too large a time gap between two consecutive national family health surveys to monitor infant and young child feeding indicators.

5. According to the latest figures released by the Registrar General of India, the infant mortality rate in the country went down only by two percentage points from 57 to 55 per 1,000 live births between 2006 and 2007. While the latest 2008 UNICEF figures shown the infant mortality rate in the country as 57 per thousand live births and neonatal mortality stands at 43 per thousand live births.\footnote{While the overall figure has shown a decrease but the number has gone up in Chandigarh, Uttarakhand and Andaman and Nicobar and North east states. IMR has gone up from 23 to 27 per 1000 live births in Chandigarh. http://www.hindu.com./2009/05/13/stories/2009051361002200.htm.} The infant mortality rate is a sensitive indicator of the
socio-economic development of a country. IMR has two distinct components, viz, the neonatal mortality (death during first month of life). India has made significant progress in reducing infant mortality (death less than one year) in recent decades. Every year, in India, 2.1 million die before their fifth birthday. Half of these children die even before they are 28 days old, accounting for one-fourth of global infant deaths of the 9.7 million child deaths worldwide annually, one third occur in India.\textsuperscript{196}

6. Vitamin – A Deficiency is one of the major public problems in India. A rough estimates shows that 30,000 to 40,000 children lose their sight every year. This deficiency is also aggravated by infections which reduce the absorption and utilization in the body. AIIMS study shows that the deficiency of vitamin D and calcium are prevalent in most parts of India. These vitamin are very essential for strong bones. Data suggests that children up to one year requires in take of 20mcg and children 1 to 13 years requires in take of 50 mcg. Otherwise deficiency leads to numbness muscle weakness cramps, diarrohea, congestive heart failure, constant back pain.\textsuperscript{197}

This is a “hidden” disaster, larger in scale than the Tsunami of December 2004. In a true democracy every child must be regarded as indispensable and the government must be held accountable for the deaths of children and mothers. Continuous failure on this account has to be perceived as a threat to the nation’s progress. It is in the process of responding to the most vulnerable, the pregnant women, poor mothers and infants in their weakest moments that democracy is tested.

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\textsuperscript{197} ‘Mother and Child’, Times of India, January 24, 2008.

As seen earlier, the Constitution of India has recognized the fact how crucial children's well being is to the functioning of India's democracy when it stated:

"that the state shall direct its policy towards ensuring that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment."\(^{198}\)

Further, article 47 provides that the state shall regard the raising of the level of nutrition and the standard of its people, and the improvement of public health as among its primary duties. The state shall also endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and drugs which are injurious to health.\(^{199}\)

Thus, it is the responsibility of the state to provide nutrient food to the children as the word "people" includes children as well. This provision becomes more relevant in case of children as the malnutrition causes irreparable damage to the personality of the children through mental retardation and blindness. Since these directive principles are for the welfare of children, the governments are required to implement it.\(^{200}\)

(iv) Nutrition

It is well established that the good health of mother has a distinct and direct bearing on that of the child, effecting the store of nutrients in the foetus, a full term well developed baby at birth, a risk free delivery, and breast milk of good quality during the lactation period. Pregnancy is a period demanding a support system that ensures additional dietary allowances, systematic antenatal care, life

\(^{198}\) Art. 39 (F), Directive; Principles of State Policy, The Constitution of India.

\(^{199}\) See supra chapter IV for details.

\(^{200}\) supra note 156, at 24.
free from stress and risk, and a positive attitude from family and society. This is extremely important as it has long term effects on the birth and development of the child. Almost half of children under age five are stunted, or too short for their age, which indicates that they have been undernourished for sometime. Children not only in rural areas are more likely to be undernourished, but even in urban areas, amongst disadvantaged groups, almost two in five children suffer from chronic undernutrition.  

The three indices of nutritional status, viz weight for age, height for age, weight for height still indicate a high prevalence of malnutrition among children under three years of age. In India 47 percent of children are malnourished. There are 60 million underweight children under the age of five, and 67 percent of preschool deaths are associated with malnutrition. In absolute number there are as many as 2.42 million malnutrition deaths under the age of five each year. The rate of malnutrition is decreasing at only one percent per year. According to UN Education Watchdog Report, 46 percent Indian children are malnourished, which have severely affected their learning ability in schools. Linking malnourishment to learning abilities, the UNESCO’s Global Monitoring Report 2008 said, malnutrition impaired brain development of about 40 percent of children in South Asia including India. Child malnutrition affect a child in the first two years of life when 80-90 percent of the brain develops. The impact is irreversible. The report also said that 45% of children in Standard III could not read a text designed for students of Standard I and only 50 percent could read a simple text. The report criticized India for failing to ensure the benefits of high

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economic growth reaching poor children. UNESCO quoted the latest National Family Health Survey to state that India reduced malnutrition only by a percentage point to 46 percent since 1998, while its economy grew by over nine percent during that period. Global strategy for infant and young child feeding was adopted at 55th World Health Assembly in May 2002, and the Unicef executive board adopted the strategy in September 2002, bringing a unique global consensus on issues related to optimal infant and young child feeding. This global strategy sets out targets for improving child survival through enhancement of optimal infant and young child feeding, includes difficult circumstances like HIV and emergency situations. The HIV and infant feeding framework for priority action is endorsed by UN agencies. The first among those is to ensure optimal feeding for all babies, particularly exclusive breastfeeding for the first six months.

National commitments to this effect are enshrined in the national guidelines on infant and young child feeding, and in The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, also known as “IMS Act as amended in 2003”.

This Act regulates the production supply infant milk substitutes, feeding bottles, and infant feeds with a view to the protection and promotion of breastfeeding and ensuring the proper

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204 Ibid. According to the global strategy for infant and young child feeding, "Malnutrition has been responsible directly or indirectly, for 60 percent of the 10.9 million deaths annually among children under five. Well over two-thirds of these deaths, which are often associated with in appropriate feeding practices occur during the first year of life.

Arun Gupta, "Infant and Young Child Feeding, Economic and Political Weekly, at 3667 (August 28, 2006).

206 Ibid. The National Guidelines on infant and young child feeding point out that malnutrition among children occurs almost entirely during the first two years of life and is virtually irreversible after that In short, child mortality is closely linked with malnutrition and inappropriate feeding.
use of infant feeds and other incidental matters. Section 20 of the said Act 1992 contains the penalty provision. It says that if any person contravenes the provisions of the Act, shall be punished with imprisonment for a term which may extend to three years, or with fine which may extend to five thousand rupees, or with both. In addition to this if a person contravenes the provisions of Section 6, and Section 11(1) the Court may, for adequate and special reasons to be mentioned in the judgement, impose a sentence of imprisonment for a term which shall not be less than three months but may extend to two years and with fine which shall not be less than one thousand rupees. Section 13 provides for seizure of infant milk substitutes etc. or containers by the food inspector or authorized officer who can seize such substitute or bottle or food or container.

The Government of India, recognizing the need to protect and promote breastfeeding and to protect expectant and nursing mothers from adverse influences undermining the practice of exclusive breastfeeding has amended the IMS Act 1992 to make it more effective and eliminate all possible loopholes in this Act. The new Act was enacted on 2nd June, 2003. In addition to the provision of the previous Act prohibiting promotion of infant milk substitutes and feeding bottles, the modified Act also prohibits promotion of these products on the pretext of distribution of educational or informational material. The promotion of bottle feeding is in contravention to the Act which are seen in the media and daily life but got unreported because of lack of active intervention on our part. The said Amendment Act 2003, was given a wider ambit to control advertisements in the electronic media as audio or visual transmission.

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209 Sec. 2(i) of the said Act 2003.
But there is no provision to promote the culture of breast feeding, educate the masses about the importance of exclusive breast feeding and health hazards of improper use of breast milk substitutes and ensure adequate nourishment for pregnant and lactating women below poverty line. There is a need to develop social support systems to protect, facilitate and encourage breastfeeding and eliminate factors that inhibit it. There should be provision to establish a mechanism involving NGOs to monitor the implementation of the provisions of the Act.\textsuperscript{211}

In \textit{People’s Union for Civil Liberties v. Union of India \& Others},\textsuperscript{212} the apex court ordered the Central government to implement both revised nutritional and feeding norms as well as the financial norms of supplementary nutrition under the ICDS scheme. It is noted that the nutritional norms have remain unchanged since inception of the Scheme (in 1975). The revised nutritional and feeding norms in ICDS Scheme stated that children in the age group of 6 months to 3 years must be entitled to food supplement of 500 calorie of energy and 12-15 gm of protein per child per day in the form of take home ration (THR). For the age group of 3-6 years, food supplement of 500 calorie of energy and 12-15 gm of protein per child must be made available at the Anganwadi centres in the forms of a hot cooked meal and a morning snack. For pregnant and lactating mothers a food supplement of 600 calories of energy and 18-20 gm of protein per beneficiary per day would be provided.

After the rapid decline of breastfeeding globally in the 1960s, science has had to revisit breastfeeding during the last three to four decades. This led to clear evidence that breastfeeding provides the

\begin{footnotesize}
\begin{itemize}
  \item \textsuperscript{211} http://parfore.in/pdf/A-souvenir_is-good-economics-not-good-politics-working-with-Parliamentarians-pdf. (accessed on September 1, 2009).
  \item \textsuperscript{212} Writ petition (C) No. 196 of 2001. Dr. Arijit Pasayat and S.H. Kapadia were the judges who delivered this judgement. The order was made against an affidavit filed by Union of India on 22 April, 2009. http://wcd.nic.in (accessed on July 21, 2009).
\end{itemize}
\end{footnotesize}
ideal and irreplaceable nutrition for the baby. In particular, breastfeeding protects the baby against infections, allergies and asthma promotes physical, physiological, mental and psychosocial development and gives protection against obesity and some adult diseases such as diabetes, hypertension, breastfeeding has also been related to possible enhancement of cognitive development. There are advantages for the mother also as breastfeeding reduces the incidence of post partum bleeding, leads to faster uterine involution, reduces the risk of breast cancer and ovarian cancer, delays resumption of ovulation, and increasing child spacing after birth in women with reduction in hip fractures in post menopausal period.\textsuperscript{213}

Find below the table depicting nutrition status in 2005-06.

**Nutrition Status in 2005-06\textsuperscript{214}**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants with low birth weight</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>44%</td>
</tr>
<tr>
<td>Exclusive breastfeeding 0-3 months</td>
<td>69%</td>
</tr>
<tr>
<td>Breast milk with complimentary feeding 6-9</td>
<td>53%</td>
</tr>
<tr>
<td>Breast milk continued 12-15 months</td>
<td></td>
</tr>
<tr>
<td>Children 0-3 years underweight</td>
<td>43%</td>
</tr>
<tr>
<td>Moderate and severe (below 2 SD)</td>
<td>16%</td>
</tr>
<tr>
<td>Moderate and severe wasting (below 2 SD)</td>
<td>20%</td>
</tr>
<tr>
<td>Moderate and severe stunting (below 2 SD)</td>
<td>24%</td>
</tr>
<tr>
<td>Anemic children less than 3 years</td>
<td>70%</td>
</tr>
<tr>
<td>Children 12-35 months who received at least one</td>
<td>25%</td>
</tr>
<tr>
<td>dose of vitamin A</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{213} Supra note 205.


Note: SD Standard Deviation score or Z score is a statistical unit. Although the interpretation of a fixed percent of median value varies across age and height and generally the two scales can be compared; the approximate percent of the median value for ISD and 2 SD are 90% and 80% of median respectively (Bulletin of world health organization).

(v) Anaemia

Anaemia along with malnutrition is a major health problem in India, especially among women and children. Anaemia can result in maternal mortality, weakness, diminished physical and mental capacity, increased morbidity from infectious diseases, perinatal mortality, premature delivery, low birth weight and (in children) impaired cognitive performance. Among children between the ages of 6 and 59 months, the great majority 70% are anaemic. This include 26% who are mildly anaemic, 40% who are moderately anaemic and 3% who suffer severe anaemia. 215 According to National Family Health Survey III 83.3% children in the age group of 6-35 months are found to be anaemic. 216

(vi) Immunization and Vaccination of Children

Immunization remains the single most feasible and cost-effective way of ensuring that all children enjoy their rights to survival and good health. In the developing world, immunization saves the lives of 2.5 million children every year. Because of its recognized power and efficacy, renewed efforts are being made globally to mobilize more resources for another push to ensure that all children are protected by immunization and that new vaccines for

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215 supra note 201.
216 An alarmingly high percentage of rural women and children in Haryana have been found anaemic. 56.9% married women and 71.7% expectant women in the age group of 15-49 years in the State are suffering from anaemia. Haryana that lacks in the intake of pulses, green vegetables, and fruits is not the only state afflicted by anemia. While Punjab’s health card is equally dismal, the nation as a whole has a high prevalence of iron deficiency anaemia, especially among women and children. See ‘Fighting anaemia’ The Tribune, July 28, 2009.
other common killer diseases are developed. The series of immunization known as DPT can prevent diphtheria, pertussis (Whooping cough), and tetanus, but these three diseases still kill 600,000 children and afflict millions of others every year in developing countries. To be fully protected, children must receive three doses of the vaccine, administered at the ages of one month, one and a half month, and three months. The percentage of children receiving the final dose (DPT3) is, therefore, a revealing and vital gauge of how well countries are providing immunization coverage for their children.\textsuperscript{217} Immunization also consists of one dose of BCG, three doses of OPV, and one dose of measles vaccinations to be given to infants. This prevents infants and young children from contracting six common, vaccine preventable diseases, namely, measles, diphtheria neonatal acute paralytic poliomyelitis and childhood tuberculosis. Also, pregnant women are given tetanus toxoid injections.\textsuperscript{218}

India launched its Expanded Immunization Programme (EPI) in 1978. There has been a steady rise in coverage of children under the immunization programme. Immunization coverage has improved substantially since National Family Health Survey (NFHS) – I, when only 36 percent of children were fully vaccinated, and 30 percent had not been vaccinated at all. There is very little change, however, in full immunization coverage between NFHS -2 (42 percent) and NFHS – 3 (44 percent).\textsuperscript{219} There was very little improvement in full vaccination coverage between NFHS-2 and NFHS-3.

\textsuperscript{217} The progress of Nations 2000, UNICEF. http://www.unicef.org/pon00/ (accessed on September 1, 2009).
\textsuperscript{219} www.mohfw.nic.in/nfhs3cd.htm (accessed on Feb. 3, 2008).
According to NFHS-3 (2005-06), coverage of individual vaccines has increased considerably and is much higher than would appear from information on full coverage alone. Coverage for BCG, DPT, and polio vaccinations is much higher than the coverage of all required vaccination combined. According to the report of NFHS-3 coverage of all vaccination is 44% (12-23 Months of age).²²⁰

With the objectives of increasing the coverage levels of immunization to each district, improving the quality of services, and achieving self-sufficiency in vaccine productions as well as indigenous manufacture of cold chain equipment. The Government launched universal immunization programme in 1985 with the support of the UNICEF, the WHO and the Indian Academy of Pediatrics.²²¹ India has also been known for its countrywide initiative to wipe-out polio. Fixed-day drives of the pulse polio immunization cover a maximum of 127 million children on single day session twice a year. According to the Global Polio Eradication Initiative Data, India has recorded 82 polio cases till February 27, 2008.²²² However, on August 6, 2009, India has 236 confirmed polio cases.²²³

²²⁰ National Statistics (NFHS III) reflects full immunized children as 44% with individual coverage for BCG, DPT, Polio, measles as 78%, 55%, 78%, and 59%, respectively which is comparatively high but is nowhere near the target of 85% of complete immunization. http://www.jcm.org.in/article.asp?issn=0970-0218,year=2009 vol 34, issue, 2 page=152 (accessed on September 3, 2009)

²²¹ India Academy of pediatrics has been closely linked with the development of Pediatrics at some centres in India. Its head office is in Mumbai while Delhi is the seat of its official publication. Cold chain system is one of the most crucial component of the programme as its effective functioning will ensure the potency of the vaccines stored like walk in cooler, freezer, vaccine carriers, cold box etc. The maintenance of cold chain equipment was under the contract between UNICEF and commercial agencies. See for more details http://en.wikipedia.org/wiki/Indian_Academy_of_Pediatrics. http://mohfw.nic.in/reports/anualischapVI.pdf. (accessed on September 3, 2009).


²²³ Prime Minister Manmohan Singh expressed concern over the on spurt in polio cases in Uttar Pradesh and Bihar and directed the Health Minister to closely monitor the situation and take effective steps to eradicate the diseases. http://www.polioeradication.org/casecount.asp. (accessed on September 1, 2009)
Vaccination Act 1880

Earlier to ensure compulsory vaccination of children only in certain municipalities, the Vaccination Act 1880 was enacted. Vaccination Act 1880 gave power to prohibit inoculation and to make the vaccination of children compulsory in certain municipalities and cantonments. According to the Act, in any place to which the Act applied, inoculation was prohibited. There was also a provision for vaccination of unprotected children. An unprotected child was a child who had not been protected from small pox by having had that disease either naturally or by inoculation or by having been successfully vaccinated and who had not been certified under this Act to be unsusceptible to vaccination. Various other provisions were made relating to vaccination, such as the procedures to be adopted when vaccination was unsuccessful or when vaccination was successful or when the child was unfit for vaccination. The Act also provided for the giving of certificates. Sec. 22 of the said Act contained punishment of offences. It by stating that whoever, violated the provisions of the act, broke any of the rules, should be punished with simple imprisonment for a term which might extend to three months, or with fine which might extend to two hundred rupees, or with both. This outdated legislation, not in tune with the present day health scenario, has been repealed by vaccination (Repeal) Act 2001.

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225 Supra note 158 at 401.
226 See for details Sec. 22 The vaccination Act 1880.
227 This was repealed by notification dated August 3, 2001. visit www.commonii.org/inlegis/num-actva1880121/. (accessed on September 3, 2009)
Special Health issues Relating to Children

Children Affected by HIV/AIDS

The global pandemic of AIDS appears to have started in mid 1970s. By 1980; an estimated 100,000 people worldwide had become infected by HIV. In 2007, it was estimated that 2.1 million children under age 15 were living with HIV. In 2009 thirty five million people are living with HIV/AIDS. Although HIV/AIDS has become a chronic, treatable illness in developed countries because of life saving drug cocktails or highly active antiretroviral therapy, millions of people in the developing world still lack access to treatment. The overwhelming majority of these children were born to mothers with HIV, acquiring the virus in the womb, around the time of being born (during labour or child birth), or during breastfeeding with their right to survive, grow, and develop threatened from their very beginnings, most of these children would live shortened lives, dying before they are in their teens. India has had a sharp increase in the estimated number of HIV infections. More than one percent antenatal women were suffering from HIV thus implying that these many children would contract the disease even before birth. It is a dreaded disease and more than awareness; the right attitude towards it, is still a big problem. In such a scenario, a child with its own limitations of understanding, facing the rejection of elders and society at large, has to go through a lot of emotional hurt. Also the onus of the problem does not lie on any specific institution – the government, AIDS societies, NGOs, or people but on each one of us.

There are many categories, of children living with AIDS who may have family/community support or may not have it. They include:

- Children who are confirmed as infected by HIV

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229 Supra note 158 at 416.
• The infections may be through mother to child
• Needing blood transfusion due to illness
• Drug abuse – IVD users
• Sexually abused
• Affected by the epidemic: where parents or siblings are HIV positive
• Vulnerable to HIV in high risk communities
• Living under the shadow of the epidemic, being born, growing and becoming sexually active in a world having added risk of infection.

Children with HIV/AIDS in a developing or poor country face many more problems than the children of developed countries due to lack of funds and proper health care services. This is reflected in the length of survival of an infected child from these countries. Many a times, a child affected with the infection does not get the required attention from the family or immediate social circle due to lack of funds on their part. Heavy health care costs and lack of government support, create difficult situations. Such children also are seen not getting enough nutrition to fight against the disease.  

On the other hand, children having infected parents or siblings have other types of problems. They do not get outside support to take care of their parents. Very often, they have to take the burden of taking care of their parents and other younger siblings. This might also affect their education. The parent’s capacity to earn reduces leading to malnourishment of children. They might also have to resort to income earning due to financial pressures. Such situations create a lot of emotional and physical vulnerability for children.  

Though India is a signatory to the UN Convention on Rights of the Child adopted in 1989 and ratified it in Dec. 1992, yet children

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230 Id, at 417.
246

ibid.
are suffering from discrimination, exploitation and abuse. Infected children face several denials or limitation of their rights. Some of the violations of their rights are:

- Right to education
- Health and social services – as a result of inadequate or inaccessible health services.
- Treatment, care, education and social programmes.
- Societal and family abandonment and rejection.
- Children and mothers being forced to live on the streets.
- Lack of nutrition to fight against infection
- Children’s proneness to infection/epidemics related to their own communities
- Right to family being affected from challenge to immediate family environment and support through sickness, disability and premature death from AIDS of one or both parents.
- Reduced ability of infected parents to sustain their livelihood and care for them.
- School dropout due to need for caring for parents and younger siblings and need to earn.
- Right to information, education and services
- Understanding of circumstances that makes them especially vulnerable to sexual exploitation and abuse.

Based on the Convention on the Rights of the Child, the following standards should be established and affirmed for children living with HIV/AIDS:

- Children have a right to survival and development. Therefore, realization of all rights must be protected from the impact of HIV/AIDS. Children have a right to health services/non-

\[\text{Ibid.}\]
\[\text{Ibid.}\]
\[\text{Id, at 418-419.}\]
discrimination in health services. The medical personnel including doctors need to be sensitized on this issue.

- Children have a right to information and opportunities to develop life skills. Therefore, children should have access to HIV/AIDS prevention education, information, and the means for prevention, including attention to the ability to negotiate safer sex practices. Media should be encouraged to disseminate information of social and cultural benefits to children, taking into account their linguistic needs.

- Voluntary testing and counselling must be available in antenatal clinics to provide information on what women can do if they are HIV positive and given their situation what acceptable alternatives to breastfeeding exist.

- Children have a right to a safe and supportive environment free from exploitation and abuse.

Therefore, special measures should be taken by governments to prevent and minimize the impact of HIV/AIDS caused by such factors as sexual abuse and trafficking, forced prostitution, sexual exploitation, use of illicit drugs, and harmful traditional practices. Sexual exploitation of girls of all ages was fuelled by the AIDS fear and was taking a heavy toll. Sexual abuse within the family also needed to be addressed. Educating the parents and reaching out directly to the children were essential in preventing the exploitation.

- Children have a right to be protected from discrimination and exploitation, irrespective of their own HIV/AIDS status or that of members of their families. In relation to HIV/AIDS, to which a strong stigma was attached, protection from non-discrimination was particularly important. No discrimination should be suffered by children on any grounds, including in education, leisure, recreation, sports and cultural activities because of their HIV/AIDS status. Children have a right to
access health and social services on an equitable basis, irrespective of their own HIV/AIDS treatment and care. Attention must be paid to ensure that orphans receive adequate support services.

- Children have a right to be heard and to have their aspirations, views and needs reflected in decision affecting them and their future.
- Children’s right to privacy and confidentiality should be protected. The identity of the child and of his family should always be protected in the media.

According to National AIDS Control Organisation currently India has 2.5 million people living with HIV, with infection, out of which ratio children under 15 years is 3.8% of all infection.\(^{235}\)

It is pertinent to mention at this stage that only statute prevalent so far to prevent sexual abuse of children and their trafficking in India is The Immoral Traffic Act, known as The Immoral Traffic (Prevention) Act 1956,\(^{236}\) which was amended in 1986, with the objective to curb trafficking in young persons both boys and girls. Children are particularly vulnerable to sexual abuse and exploitation both commercial and non commercial. The commercial sexual exploitation of girls is a global, multimillion dollar industry, pouring money into the hands of private citizens, governments, and the police. Trafficking in persons is an issue of growing concern in the international community. In 2007, the Ministry of Women and Child Development reported presence of 2.8 million sex workers in India, with 35.47% of them entering the trade

\(^{235}\) ‘India has time to reverse its HIV epidemic: expert’, Hindustan Times, New Delhi, November 10, 2008.

before the age of 18 years. The immoral Traffic (prevention) Amendment Bill, 2006 introduced in Lok Sabha on May 22, 2006. The Bill has been referred to the Parliament’s standing committee on human resource development, which has not yet been passed.237  

(viii) Child Paedophilia: An unholy nexus

The international tourism aims at supporting tourism to contribute to the economic development, international understanding, and promotion of peace, wealth and maintenance of human rights and freedom for all human beings without discrimination of race, sex language or religion.238

Sexual exploitation of children is not a new term for the third world countries. The phenomenon started in a small scale but mushroomed in several third world countries in wide scale as a result of rapid industrialization and urbanization after the second world war. Many foreign visitors however attracted not only for tourist activity but also for the purpose of exploitation of women and children. A few years later, in 1995, the general assembly of World Tourism Organization, adopted its first resolution on this, and it was then called as the prevention of “organized sex tourism,” wherein child sex tourism was denounced and condemned,” considering it as violation of Article 34239 of the Convention on the Rights of the child which requires strict legal action by tourist sending and receiving countries.

239 Id at 541. (Art. 34 state parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, state parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent).
(a) the inducement or coercion of a child to engage in any unlawful sexual activity
(b) The exploitative use of children in prostitution or other unlawful sexual practices.
(c) The exploitation use of children in pornographic performance and materials.
Paedophilia, in fact, pertains to the manifestation and practices of sexual desire that some adults develop for prepucescent children (13 or under) of both sexes.

AIDS has also increased the incidence of child prostitution by enhancing the demand of virgins, indeed there have been reports from Thailand, that children have been surgically adjusted to appear to be virgins for more than one client. Certainly the price change radically.

Since India is a signatory to this convention, as required under Art. 35 of the said convention, state should take all measures necessary to be taken to prevent the abduction of the sale of or traffic in children. In the significant Supreme Court judgement of Sakshi v. Union of India & Others, the court had highlighted the procedure of trial for the cases of child abuse and rape which are increasing at an alarming speed, and therefore appropriate legislation to this effect is needed urgently. While delivering the Judgement Justice G.P. Mathur observed that:

“The mere sight of the accused may induce an element of extreme fear in the mind of the victim or the witnesses or can put them in a state of shock. In such a situation he or she may not be able to give full details of the incident which may result in miscarriage of justice. Therefore, a screen or some such arrangement can be made where the victim or witnesses do not have to undergo the trauma of seeing the body or face of the accused. Often the questions put in cross examination are purposely designed to embarrass or confuse the victim of rape

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240 Id at 547.
241 (2004) 6 SCALE 15. (para 26) This judgement was given in a public interest litigation filed by a social organization “Sakshi”. The relief claimed in the said petition was primarily in regard to the enlargement of the definition of “Sexual Intercourse” as given in Section 375 of the Indian Penal Code. The SC laid down that certain procedural safeguards had to be followed to protect the victim of child sexual abuse during the conduct of the trial. The court only focused on reducing the trauma of the victim by directing that she can not be forced to answer insensitive and crude questions during court trials and that a screen may be used so that the victim did not have to undergo the trauma of seeing the perpetrator. CJI S. Rajendra Babu along with Justice G.P. Mathur, were the judges who delivered this judgement
242 Id at 34 (para 32).
and child abuse. The object is that out of the feeling of shame or embarrassment, the victim may not speak out or give details of certain acts committed by the accused. It will therefore, be better if the questions to be put by the accused in cross examination are given in writing to the Presiding Officer of the court, who may put the same to the victim or witnesses in a language which is not embarrassing”.

This protection is most clearly awarded in the **Optional Protocol 2002** on the sale of children, child prostitution and pornography. However, despite new legislation and ratification of such convention, the global rise of child sex tourism and the trafficking of children raise serious concerns for the safety of children and the detrimental long-term effects on them.

Indian Parliament 2006, had come up with a new bill, Offences Against Children Act, 2006, proposed by the Ministry of Women and Child Development, and it has been circulated among the state for their comments. The bill outlines the intent to crack down on those who sexually assault or abuse children, or committing heinous acts of crime against children. It for the first time brings oral sex with in the purview of law. It is submitted that if this bill soon be

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243 The Optional Protocol on the sale of children, child prostitution and child pornography became legally binding on 18 Jan. 2002. By October 2008 129 countries have signed and ratified this protocol. The protocol supplements the convention by providing state with detailed requirements to end the sexual exploitation and abuse of children. It also protects children from being sold for non-sexual purposes such as other forms of forced labour, illegal adoption and organ donation. The protocol provides definitions for the offences of sale of children, child prostitution and child pornography. It also creates obligations on governments to criminalize and furnish the activities related to these offences. It requires punishment not only for those offering or delivering children for the purposes of sexual exploitation, transfer of organs or children for profit or forced labour, but also for anyone accepting the child for these activities. The protocol also protects the rights and interests of child victims. This obligation includes considering the best interests of the child in any interactions with criminal justice system. Children must also be supported with necessary medical, psychological, logistical and financial support to aid their rehabilitation and reintegration.


**Supra** note 238 at 554.

244 Imprisonment for trafficking in children, physical abuse, maximum punishment is ten years simple imprisonment with fine and the minimum punishment will depend on the child age. A person guilty of grooming a child for sexual purpose (Abusive parents and teachers) can be jailed for five year and fine. See Sections 18, 12, 13,
converted into law, will be highly commendable step in the direction of checking sexual exploitation of children.

(ix) Children as Victims of Drugs

Children, because of their tender age, are particularly prone to be swayed into addiction under unhealthy influences and to be used as an instrument in drug trafficking. There is widespread use of illicit drugs among street children. Even amongst children in educational institutions, use of drugs is increasing. There are innumerable documented instances to show that children of the poor are introduced and addicted to drugs only to be manipulated as tools in drug trafficking by organized criminal syndicates.246

Under the Juvenile Justice (care and protection of children) Act 2000, it is an offence to give or cause to be given to any juvenile or child, any intoxicating liquor or any drug or psychotropic substance except upon the order of a duly qualified medical practitioner or in case of sickness. The punishment for this offence is imprisonment for a term which may extend to three years and fine.247

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246 14 of the draft Bill of offences against Children Act 2006. www.wcdorissa.gov.in..%offences/20%against%20%children%20act2006 (accessed on September 1, 2009). To ensure that every child has his childhood, Goa children Act 2003 came into force against child sexual abuse, especially those related to tourism. The setting up of a children’s court to try all offences against children is a bold step prescribed by this law.

Today drug abuse has become a menace as it is prevalent amongst children belonging to all strata’s of the society. The district mental health programme is throwing up increasing evidence of inhalant drug abuse in the Chandigarh city. Camps conducted under the programme in different colonies show that children as young as five years are inhaling drugs like eraser fluids, solvents like taulene (used for fixing punctures), Petrol, diesel. This is happening, despite the ban on sale of correction fluids in Chandigarh. Experts demand curbs on easy and cheap availability of inhalants like whiteners.


247 Section 25 The Juvenile Justice (care and protection of children Act) 2000. This Act deals with the law relating to juveniles in conflict with law and children in need of care and protection, by providing for proper care, protection, and treatment by catering to their development needs, and by adopting a child friendly approach in the adjudication and disposition of matters in the best interest of children, and for their ultimate rehabilitation through various institutions established under the Act. The said Act received the assent of the President of India on December 30, 2000. The Act contains total 70 sections. The said Act also amended in 2006, known as

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There are several lacunae found in the Act. Although the Act gives the members of the Child Welfare Committee (CWC) power to function as a magistrate, and pronounce punishments, but members of the CWC have hardly ever used this opportunity. Though the formation of the commissions is a step forward in recognizing child rights. Despite the 2006 amendment in the said Act mandating that every district in the country must have a CWC and Juvenile Justice Board (JJB) within one year from the notification of the new Act, the Government itself admits that many states and UTs have not established any. Some states do not have enough JJBs to deal with the number of children coming in conflict with law. There is lack of implementation because of lack of role clarity within the judiciary, administration and lack of resources. Another problem with the said Act is that its members have a dual role of counselling children as well as awarding punishments. Since the implementation of Juvenile Justice Laws by most states was tardy. The National Human Rights Commission (NHRC) is playing a more proactive role in ensuring the monitoring of the implementation. The amended law makes it mandatory for the states to set up Juvenile Justice Boards and Protection homes at district levels. But states are dragging their feet on implementation of the Juvenile Justice (Care and Protection) Amendment Act, 2006.248

(x) Children and Disability

In India, estimating number of disabled people is not an easy task as it varies a great deal depending upon the definitions, the methodology, the source, and the appropriate use of scientific instruments in measuring degree of disability to identify the same.

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According to the report of the Rehabilitation Council of India on Manpower Development 1996, estimated on the basis of the NSSO report, the following are the population of children with disabilities in the educable age group of 5-14 years.\textsuperscript{249}

- Loco motor handicap: 8.94 million
- Mental retardation: 9 million
- Visual handicap: 4.01 million
- Speech handicap: 1.96 million
- Hearing handicap: 3.24 million
- Cerebral palsy: 3.00 million

There are 300 'special schools' in India which serve approximately 30,000 visually impaired school going children.\textsuperscript{250}

The National Policy on Education 1986, is implemented to achieve the goal of providing education to all including the disabled. The objective of the policy is to integrate the physically and mentally handicapped with the general community as equal partners to prepare them for normal growth and to enable them to face life with courage and confidence. Special schools with hostels will be provided as far as possible at district headquarters for severely handicapped children. Sarva Shiksha Abhiyan (SSA) launched by the Government has the goal of eight years of elementary schooling for all children including children with disabilities in the age group of 6-14 years by 2010. Physical rehabilitation measures including counseling, strengthening capacities of persons with disabilities and their families, physiotherapy, occupational therapy, psychotherapy, surgical correction and intervention, vision assessment, vision stimulation, speech therapy, audio logical rehabilitation and special

\textsuperscript{249} Data taken from Manual of Rehabilitation Council of India. For National Programme on orientation of medical officer working Primary Health Centres to Disability Management.

\textsuperscript{250} J. Kishore, 'National Health Programs of India', at 317 (2006). Louis Braille’s invention of Braille alphabet system in 1832 provided a tremendous impetus to education of visually impaired children throughout the world.
education shall be extended to cover all the districts in the country by active involvement and participation of State Governments, local level institutions, NGOs including associations of parents and persons with disabilities. Government of India has been assisting persons with disabilities in procuring durable and scientifically manufactured, modern aids and appliances of ISI standard that can promote their physical, social and psychological independence by reducing the effect of disabilities.  

Rehabilitation Council of India which is a statutory body and came into force with effect from June 1993 under The Rehabilitation Act, 1992. This Act was passed by the Parliament to regulate the manpower development programmes in the field of education of children with special needs and to regulate the manpower training by standardizing the various training programmes in the field of rehabilitation, so that quality services could be planned and provided to the disabled masses.

In some states there is failure of the government to frame guidelines to monitor working of the NGOs and rehabilitation centres. In addition to its normal activities, RCI has been engaging itself in the training of special educators and medical profession/personnel. This is not only outside RCI’s mandate but it also overlaps with the activities of other national institutes and agencies. It is submitted that regulating the training of rehabilitation

252 The Rehabilitation Act received the assent of the President on the Sept. 1, 1992. The said Act contains total 30 sections. The Rehabilitation Council of India (Amendment) Act 2000 Act 38 of 2000 is also made.
253 ‘No guidelines for regulating NGOs in Himachal Pradesh’. Shimla based society for Disability and Rehabilitation Studies has claimed that the National Policy for Persons with Disability Act requires the State to frame guidelines to regulate NGOs. This is highlighted when four teachers sexually exploited six girls at Centre-cum-Hostel in Himachal Pradesh.
professionals is a huge task, activities of the council should be confined to the mandate given to it under the existing provisions.254

Under Article 32 of the Constitution i.e. Right to Constitutional Remedies, the Supreme Court has the power to lay down guidelines for effective enforcement of fundamental rights of citizens. In a historical Judgment in *Gaurav Jain v Union of India*,255 the petitioner a public spirited advocate “Gaurav Jain” filed a PIL seeking appropriate direction, to the Union of India for the improvement protection and rehabilitation of children of prostitutes. The court held that it is the duty of government and all voluntary non-

254 http://planningcommission.gov.in/plans.mta/mta/990. (accessed on September 2, 2009)

255 The Court issued the following directions:

- The court directed that they should be provided opportunity for education, financial support developed marketing facilities for goods produced them. If possible their marriage may be arranged so that the problem of child prostitution can be eradicated. Marriage would give them real status in society. They should be given housing facilities, legal aid, free counselling assistance and all similar aids and services so that they do not fall into the trap of red light area again.

- The court held that economic empowerment is one of the major factors that prevent the practice of dedication of the young girls to the prostitution as Devadasis, Jogins etc. to Referring to the various measures taken by different states. The Court directed that that the social welfare Department should undertake similar rehabilitation programmes for the fallen victims so that the foul practice is totally eradicated that are not again trapped into the prostitution. The court gave example of state of Andhra Pradesh where the state Government is providing housing facilities, free treatment in hospital and pension to Devadasis women of 60 years or above and adult literacy programme. Such measures are being taken by non Government Organizations in the states of Maharashtra, Karnataka and Andhra Pradesh.

- The court directed that the rescue and rehabilitation of the child prostitutes and children should be under a nodal department, namely, Department of women and child Development under the ministry of welfare and Human Resources, Government of India, which will devise suitable schemes for proper and effective implementation. The court directed the Ministry of Welfare Government of India for the establishment of juvenile homes.

- The court directed to constitute a committee within a month from the judgment which would make a in-depth study in to these problems and evolve suitable schemes as are appropriate and consistent with the directions given above. It shall submit its report within three months on the basis of its report. Direction would be given to the state Governments for effective implementation of the schemes. The Nodal Department would enforce and regularly be supervised by minister of welfare. It is hoped the court said, the above law and direction would relieve the human problem by rehabilitation of the unfortunate fallen women caught in the trap of prostitution, their children would be brought into the mainstream of the social order. AIR 1997 SC 3021. (paras 24, 60) Justice K. Ramaswamy and Justice D.P. Wadhwa delivered this judgement.
governmental organizations to take necessary measure for protecting them from prostitution and to rehabilitate them so that they may lead a life with dignity of person.

Provisions are also made for creating awareness and training and taking measures for prenatal, perinatal and postnatal care of the mother and child under the **Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995.** Chapter V deals with education. As per the Act, the central and state governments shall ensure that every child with disability has access to free and adequate education till the age of eighteen years. Chapter VI of the Act provides for employment of the disabled Government and NGO schemes and initiatives for the disabled.

There are educational programmes available for different categories of handicapped children. Integrated Education Programme for children with mild disability in a regular school setup under the scheme of integrated education for disabled children formulated by the Ministry of Human Resources and Development is being implemented through SCERT. Moreover:

1. special school programme for the severely disabled children in a special school formulated under the Ministry of Social Justice and Empowerment, being implemented through state governments involving NGO’s

2. Apart from this, children with disability with in the age group of 14-35 are given the opportunity to education through the National Open School, an autonomous body under the Ministry of Human Resources Development, Govt. of India, through the support of

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256 Sec. 25, of Persons with Disabilities (Equal Opportunities, Protection of Right, and Full Participation) Act 1995.

study centres. Such children can complete education as parallel to formal education:

The National institute for the visually Handicapped was established in the year 1979. The institute concentrated on Braille Production, employment, training of staff, etc. It is known that other legislation also contain provision that deal with persons with disabilities within the ambit of law. However those provisions are not sensitive. Thus, protection against abuse, social security, custody of children, provision of basic needs such as shelter within the family are issues still need to be adequately addressed. Though the protection of persons with disabilities was made mandatory with the enactment of certain legislation including Disability Act 1995 and Mental Health Act, 1987. Yet, the main issues that come up before the courts are reservation of seats, relaxation of examination timing and provision of scribe for visually impaired candidates etc. On many occasions, courts have passed orders in favour of disabled people.258

Infact, physical punishment and humiliation forces children to run away from school, become withdrawn or exhibit anti-social behaviour. For protecting from physical torture from teachers the Delhi High Court struck down the provision of corporal punishment in the Delhi School Education Act as far back as 2000.259

(xii) Integrated Child Development Service Scheme

To further improve the overall health status of children Integrated Child Development Service scheme was launched in 1975 in pursuance of the national policy for the children 33 experimental blocks.260 It is the largest programme for promotion of maternal and child health and nutrition. At the end of December 2007, 5, 959 ICDS Projects and 932,000 Anganwadi and mini anganwadi Centres,

259 'Suicide in Jammu, when teachers become cruel', Tribune October 14, 2006.
260 Wcd.nic.in/childdet.htm (accessed on September 3, 2009)
were functional. The beneficiary count had increased to 629 lakh children and 132 lakh pregnant and lactating mothers. Now the goal is the universalization of ICDS throughout the country and the expansion of the ICDS scheme sanctioned in 2008-09, which include (792) projects, 1.89 lakh Anganwadi Centres, 77102 (Mini AWCs). Along side gradual expansion of the scheme, there has also been a significant increase in the budgetary allocation for ICDS Scheme from Rs. 10391.75 crore in 10th five year plan to Rs. 44,400 crore the XI plan period.

**Objectives of ICDS**

1. Improve the nutrition and health status of children in the age group of 0-6 years.
2. Lay the foundation for proper psychological, physical and social development of the child.
3. Effective coordination and implementation of policy amongst the various departments and.
4. Enhance the capability of the mother to look after the normal health and nutrition needs through proper nutrition and health education.

The scheme is funded by the Government of India and has a complicated administrative setup with the focal point at the village level being the Anganwadi. Unfortunately, there is rampant corruption found in the ICDS scheme in some of the states. For example, the most populous state, Uttar Pradesh, as far as children malnutrition levels are concerned there has been no progress in the

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261 The Chandigarh Administration is also on the way to progress of various developmental projects within this financial year (2009) gets 130 new Anganwadi centres in the city under the ICDS Scheme, that covers all eligible population living in village, colonies, and slum areas of the Union Territory. See for more details [http://pib.nic.in/archieve/others/2009/july/R2009071301.pdf](http://pib.nic.in/archieve/others/2009/july/R2009071301.pdf) and [http://merachandigarh.in/chandigarhnews/Chandigarh-gets-130-anganwadi-centres-icds.html](http://merachandigarh.in/chandigarhnews/Chandigarh-gets-130-anganwadi-centres-icds.html) (accessed on September 3, 2009).
last years. The food grains sent for children is being illegally used to fatten cattle. Anganwadi workers keep the food grain, at their home. Most children are not covered under this scheme.\(^{263}\) Need is that it must be universalized so that it covers all children and strict action be taken against guilty states or workers in the form of stopping of grant to the states to this effect and also imposing heavy fines anyone who is found to be guilty in this regard.

**(xii) National Charter for Children 2003**

In view of the status of children in India government affirms that the state, society, community and family have obligations towards children who deserve a sound sense of values which will ultimately be directed towards preserving and strengthening the family, society and the nation. The Government affirms that by respecting the child, society is respecting itself. Therefore, with the following objectives the India government announced the National Charter for Children in 2003.

**Objectives**

- To secure for every child its inherent right to be a child and enjoy a healthy and happy childhood.
- To address the root causes that negate the healthy growth and development of children.
- To awaken the conscience of the community in the wider societal context to protect children from all forms of abuse, while strengthening the family, society and the nation.\(^{264}\)

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Further, to secure and strengthen the health status of children, the National Plan for Children was initiated in the year 2002 by inviting comments and inputs from all concerned Ministries, Departments at the Centre level, from the State Governments and UT Administrations. An Advertisement was also published in the newspapers to invite comments from the public as well, resulting in framing of the National Plan of Action for Children 2005. This plan commits itself to ensure all rights to all children up to the age of 18 years. This calls for collective commitment and action by all sectors and levels of government and partnership with families, communities, voluntary sector and children themselves. This plan will be implemented throughout the country through national measures and through State Plans of Action for Children. In recognition of the fact, that 41% of India’s population is below 18 constituting, a significant national assets, the plan re-affirms the nation’s commitment wisely, effectively, and efficiently invest its national resources to fulfill its commitment to children. The National Plan of Action for Children, 2005 is divided into following four Sections:

- Child Participation
- Child Survival
- National Plan of Action 2005
- Child Development
- Child Protection


266 Ibid.
Guiding Principles of National Plan of Action, 2005 are:

a) to regard child as an asset and a person with human rights;

b) to address issues of discriminations emanating from biases of gender, class, caste, race, religion and legal status in order to ensure equality;

c) to accord utmost priority to the most disadvantaged, poorest of the poor and least served child in all policy and programmatic interventions;

d) to recognize the diverse stages and settings of childhood and address the needs of each, providing to all children the entitlements that fulfill their rights and meet their needs in each situations.

A) **Child health:** The goals relating to health lay down in the plan are:

- To reduce infant mortality rate to below 30 per 1000 live births by 2010.
- To reduce child mortality rate to below 31 per 1000 live birth by 2010.
- To reduce neonatal mortality rate to below 18 per 1000 live births by 2010.
- To explore possibilities of covering all children with plan for health insurance.
- To reduce Maternal Mortality Rate (MMR) to below 100 per 100,000 live births by 2010.
- To prevent and progressively eliminate child marriage and under age child bearing by enforcing the Child Marriage (Restraint) Act, 1929, now it is amended in 2006 known as the prohibition of child marriage Act 2006.
• To eliminate child malnutrition as a national priority.
• To reduce five malnutrition and low birth weights by half by 2010.
• To ensure adequate neonatal and infant nutrition.
• To reduce moderate and severe malnutrition among preschool children by half.
• To reduce chronic under nutrition and stunted growth in children.
• Universal equitable access to and use of safe drinking water and improved access to sanitary means of excreta disposal by 2010.
• All households to have sustained access to potable drinking water by 2012, to be undertaken in a phased manner with annual targets.
• 100% of rural population to have access to basic sanitation by 2012.
• To cover 100% urban population with low cost sanitation and safe water disposal facilities by 2010, and build an enabling environment for sanitation and hygiene that promotes prevention of pollution of all fresh water bodies.

The health of child has been taken by the government as a serious issue under different policies i.e. National Population Policy, 2000 and National Health Policy, 2002.

(B) Child Development: The goals lays down under this head are:269

269 Supra note 265.
• To universalize early childhood services to ensure children’s physical, social, emotional cognitive development.
• To ensure that care, protection and development opportunities are available to all children below 3 years.
• To ensure integrated care and development and pre-school learning opportunities for all children aged 3 to 6 years.
• To provide day-care and crèche facilities to parents in rural and urban areas.
• Assurance of equality status for girl child as an individual and a citizen in her own right through promotion of special opportunities for her growth and development.
• To ensure survival, development and protection of girl child and to create an environment wherein she lives a life of dignity with full opportunity for choice and development.
• To stop sex selection and female foeticide and infanticide.
• To ensure the girl child’s security and protect her from abuse, exploitation, victimization and all other forms of violence.
• To protect the girl child from deprivation and neglect and to ensure the girl child equal share of care and resources in the home and the community and equal access to services.
• To take measures to protect girl children from any treatment which undermines their self esteem and causes their enclose on from social mainstream and also to break down persistent gender stereotype.

In Haryana, State Government has introduced a new scheme for the girl child which is named ‘LADLI’. The objective of the scheme is to raise the status of the girl child in the family and in society and to change the mindsets of the people for proper rearing of the girl children and enduring their right to birth and survival. Under the scheme all parents residents of or domiciled in Haryana will be provided financial incentive @ Rs. 5000 per year for upto five years if their second girl child is born on or after 20th August 2005. National Report on ‘A World fit for Children’, Ministry of Women and Child Development, Government of India 2007.
• To ensure equal opportunity for free and compulsory elementary education to all girls.

• To ensure full opportunities to all adolescents girls and boys in the age group of 13 to 18 years to realize their rights and develop their full potential as human beings.271

• To provide the adolescents with education and development opportunities so that they can participate in the life and progress of community as productive citizens.

• To eliminate child marriages by 2010.

• To ensure right to survival, care, protection and security for all children with disability.

• To ensure the right to development with dignity and equality creating an enabling environment where children can exercise their rights, enjoy equal opportunities and full participation in accordance with the UN Convention on the Rights of the Child, and other laws dealing with Child Rights in India.

• To ensure inclusion and effective access to education, health, vocational training along with specialized rehabilitation services to children.

• To eliminate disability due to poliomyelitis by 2007.

• To conserve and protect the natural environment and safeguard natural resources, for the good and well being of all children.

• To ensure children's survival, health and food security through conservation and safe use.

271 The Government has also started Rashtriya Swasthya Bima Yojna under the women and children labour welfare schemes, transportation of pregnant women and children during emergency from the village to CHC/district. The Scheme of Kishori Shakti Yojana for adolescent girls has also been started to raise the level of nutrition. http://www.delhiplanning.nic.in/pd/2008-09 (accessed on July 19, 2009).
• To create and uphold a safe, supportive and protective environment for all children within and outside the home.
• To prevent children from getting into conflict with law.
• To recognize, promote and protect the rights of children in conflict with law through preventive, protective, reformative and rehabilitative policies, laws, plans, strategies, programmes and interventions.
• To protect all children, both girls and boys from all forms of sexual abuse and exploitation.
• To prevent use of children for all forms of sexual exploitation including child pornography.
• To develop new and strengthen existing legal instruments to prevent sexual abuse and exploitation of children.
• To stop sale of children and all forms of child trafficking, including for sexual purpose, marriage, labour, adoption, sports entertainment and illegal activities like organ trade, begging and drug peddling.
• To eliminate child labour from hazardous occupations by 2007 and progressively move towards complete eradication of all forms of child labour.
• To protect children from all kinds of economic exploitation.
• To stop the growth of HIV/AIDS and sexually transmitted infections by 2010.
• To reduce the proportion of infants infected with HIV by 20 percent by 2007 and by 50% of all such children by 2010.

(C). **Child Participation:** The goals laid down under this section are:
• To promote within the family, community, schools and institutions as well as in judicial and administrative proceedings, respect for the views of all children, including the
views of the most marginalized, especially girls, and facilitate their participation in all matters affecting them in accordance to their age and maturity.

- To make all children aware of their rights and provide them opportunities to develop skills to form and express their views, build self-esteem, acquire knowledge, from aspirations, build competencies in decision making and communication, and gain confidence which will empower them to become actively involved in their own development and all matters concerning and affecting them.

- To empower all children as citizens by promoting their participation in decisions that affect their lives, the lives of their families communities and the larger section of society in which live.

(D) Mobilizing Resources, Implementation of the Plan and Monitoring:

The National Plan of Action for Children, 2005 commits the allocation of required financial, material, technical and human resources from the central and the state government to ensure its full implementation, investing in children lays the foundation for a just society, a strong economy and a world free from poverty.272

- To secure financial, material, technical and human resources from all international organization civil society, private sector and non-governmental organization will be involved to ensure the rights and well being of all Indian children.

- The primary responsibility for the implementation of this National Plan of Action for children 2005 and for ensuring on enabling environment for securing the rights and well-being of children rests with the Central, State and local Governments.

272 supra note 265.
• Ensure inter-sectoral coordination and convergence of all departments, Ministries and programmes affecting children.

• Ensure that efforts are made by Government agencies for creating awareness and multimedia publicity through mass-communication in the print and electronic media, for promoting child rights.

• The National Plan of Action, 2005 shall be monitored by the National Coordination Group created for implementation and monitoring of the convention on the Rights of Child.

• The Department of Women and Child Department shall create suitable mechanisms to ensure this by establishing:
  a) National Commission for the Protection of Child Rights including the setting up of State Commissions.
  b) Central Nodal Authority for combating trafficking for commercial sexual exploitation, including the setting up of the State authorities.
  c) Creations of other needs based mechanisms for child protection as and when required.

• This plan will be regularly monitored at the National, State and District levels to assess progress towards the goals and targets. A comprehensive system would be developed and operated to collect and analyze disaggregated data on children, based on age, gender, cultural and socio-economic grouping.

• Efforts will be made to strengthen the existing data collection mechanisms so that quality data on various measurable development is generated.

• Periodic and annual reviews will be conducted at the national and state level in order to more effectively address the obstacles and accelerate progress on the NPA goals.

• Appropriate mechanisms for effective monitoring and evaluation will be set up at the national, state, district block
and village level for reporting and periodic review of the targets.


The UN General Assembly Special Session on children held in May, 2002 adopted on and come out with document titled “A world fit for children” containing the goals, objectives, strategies and activities to be undertaken by the member countries for the current decade. In this background, the Indian Parliament enacted the Commissions for Protection of Child Rights Act, 2005. It received the assent of the president on the 20th January, 2006. This Act provides for the constitution of National Commission and State Commission for Protection of Child Rights and Children’s Court for better protection of Child Rights and for matters connected therewith or incidental there to, for providing speedy trials of offences against children or of violation of child rights. The Act contains total 37 sections. Under section 3, the Central Government shall constitute a body to be known as the National Commission for Protection of Child Rights. It shall consist of a Chairman and six members, having experience in the field of education, child healthcare, welfare and child development, juvenile justice or care of neglected children with disabilities, child psychology or sociology, laws relating to children, out of which at least two shall be women. Section 13 prescribes the functions of the commission. The commission shall examine and review the safeguards provided by or under any law for the time being in force for the protection of child rights, examine all factors that inhibit the enjoyment of rights of children affected by terrorism, communal violence, riots, natural disaster, domestic violence, HIV/AIDS, trafficking, maltreatment, torture and exploitation,

pornography and prostitution and recommend appropriate remedial measures. Under section 14 the commission shall have all the powers of a civil court trying a suit under the code of civil procedure, 1908. The commission shall have the power to forward any case to a Magistrate having jurisdiction to try the same and the Magistrate to whom any such case is forwarded shall proceed to hear the complaint against accused as if the case has been forwarded to him (u/s 346) of the CRPC, 1973.274

As seen earlier in this chapter UNESCO’S 2008 report on the State of the world children presents an actively embarrassing picture of infant and child mortality in India. UNESCO’S officials points out the unusual challenge India faces in child survival even as its economic growth rates move up. Among the reasons cited for the poor state of infant and child health in India, are inadequate neonatal care, insufficient breastfeeding, malnutrition, low immunity and high incidence of communicable diseases.

As most women in India who deliver children are in poor health and so cannot breastfeed their babies. So any health project or plan directed to reduce child mortality in India has to boost first the health of mother. The above study shows that several official programme have been formulated to address maternal and child mortality. These include the effective implementation of Integrated Child Development Scheme, the Midday Meal Scheme275 and

274 The National Commission for Protection of Child Rights (NCPCR) was set up in March 2007 under the Chairmanship of Dr. Shantha Sinha. The NCPCR has issued the guidelines in May 2009 to all education department of all the states to conduct meetings for school headmasters on corporal punishment highlighting that serious action would be taken against school for violence on children issue instructions to district and block education officers and cluster resource centre staff holding them accountable for any violation of children rights. http://www.wcdorissa.gov.in/download/National%20commission%20for%20protection%20child%20right%20Act
Also see http://www.ncpcr.gov.in/infocus/final-august-infocus.pdf. (accessed on September 3, 2009)

275 In Midday Meal Scheme many irregularities are exposed every day. The ICDS and Mid day meal schemes have become more and more frequent raising doubts over
Supplementary Nutrition Programme. Our young members of parliament from different political parties have taken the initiative to form a Citizen’s Alliance Against Malnutrition to focus attention on the problem”.276

To sum up, it can be said that one of the focal aims of the Constitution of India is elimination of poverty, ignorance, and ill health, and it directs the State in this regard accordingly. Whereas health is a state subject in list II of 7th schedule,277 the Ministry of Health and Family Welfare at the Centre is responsible for policy formulation and allocation of funds for certain health programmes to various states. But so far, health as such is not a fundamental right of citizens and, therefore, as such it is not justiciable in courts. The Supreme Court has only through its various rulings from time to time has observed that the right to life includes the right to live with human dignity and not a mere animal existence and what goes along with it, namely the bare necessities of life such as adequate nutrition, clothing and shelter. In fact, health is a low cost, high

the State Governments seriousness in addressing malnourishment, after dead frogs and rats found in food served dead insects in their meals. Under the new policy government decided to provide different kinds of meals. But the new policy has been criticized for sacrificing micronutrient content in food for oily and high fat items. Micronutrients are crucial to the physical development of a child under six. According to NFHS III Malnutrition in the M.P. State has increased from 54% to 60% making M.P. Children the most undernourished in India. M.P. also top the list of states in IMR with 72 death per 1000 according to sample registration survey 2007-08. "Madhya Pradesh clueless as children die of malnutrition" The Hindu, Aug. 1, 2009.

276 'Mother and Child', Times of India January 24, 2008. In 2004, Jan Swasthya Abhiyan, BJP's thrust was on strengthening the Janani suraksha Yojana to care for delivery of mother and infants". NRHM 2005 had provided the opportunity to frame the Indian Public Health Standards. However the findings of the second Common Review Commission of MOH & FW, released in November 2008, show that the ASHA’s (Accredited Social Health Activist), a central functionary of NRHM had received no money the Janani Suraksha Yojana Scheme was poor. The incentives under the JSY needed to be reviewed as they were leading to conflict and corruption between auxiliary nurse midwives (ANM’s), ASHAs, dais and anganwadi workers. R. Ramachandran and T.K., Rajalakshmi, 'Unhealthy trend' Frontline at 24 (April 10, 2009). http://www.frontline onnet.com/stories/200911261802700.htm (accessed on September 4, 2009)

277 Issues of public health, sanitation, hospitals and dispensaries are part of Entry 6 of list II, 7th schedule to the Constitution of India.
return investment that can give a boost to every aspect of child development and also to a nation's overall progress and prosperity. Addressing the neglect of children's health care is a challenge for health care providers. Since the right to survival of a child includes:

(1) Access to health care services for children in emergency situation and for prevention of disease, through the existing health care network.

(2) Providing shelter

(3) Providing nutritional facilities for children in need of care and protection and

(4) Providing an identity.

Undoubtedly, there have been several provisions, programmes, policies dealing with health issues of citizens. However, for any of these programme to have desired impact, it is necessary to create general awareness of maternal and child mortality and the importance of health care for women and children. We must remember that it is not the question of survival; it is about survival plus. That is the key to a better quality of life. The government has not been able to do much to remedy the situation, despite the commitment made by it while ratifying the UN conventions, for reasons beyond its control. With the many competing demands on the country's resources, the government has not been able to give so far both, to the women and children, their due towards their all round growth and development.