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WOMEN'S EMPOWERMENT IN INDIA: A HEALTH PERSPECTIVE WITH A LEGAL LENS

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Abstract

Women's empowerment in India is inextricably linked to their health, encompassing not only reproductive rights but also physical, nutritional, and mental well-being. Despite constitutional promises and statutory guarantees, systemic barriers continue to obstruct women's equal access to quality healthcare. A particularly neglected dimension is postpartum depression (PPD), which affects nearly one-fourth of Indian mothers yet remains absent from mainstream legal and health policy frameworks. This article adopts a socio-legal approach, situating women's health within the broader project of gender justice and empowerment. By analysing constitutional jurisprudence, statutory frameworks such as the Maternity Benefit Act, 1961, the Medical Termination of Pregnancy Act, 1971 (as amended 2021), and the Mental Healthcare Act, 2017, alongside empirical insights from NFHS-5, NIMHANS (National Institute Of Mental Health and Neuro Sciences), and comparative global practices, it argues that empowerment requires integrating maternal mental health into enforceable health rights. The article concludes with recommendations for reform, including PPD screening mandates, expanded maternity protections, community-level mental health interventions, and judicial oversight, thereby reframing women's health rights as a constitutional imperative central to empowerment.

Keywords: *Women's Empowerment, Health Rights, Postpartum Depression, Mental Health, India.*

I. Introduction

The Constitution of India sets forth an aspirational vision for equality, dignity, and the conditions necessary for citizens to lead flourishing lives. Embedded within this vision are obligations to secure public health, maternity relief, and non-discrimination—norms that directly implicate the project of women’s empowerment. Yet the lived reality for many Indian women remains at odds with constitutional promises. Progress has been made: institutional deliveries have increased, certain maternal mortality metrics have improved, and landmark judicial pronouncements have expanded the right to health under the ambit of Article 21. Nevertheless, persistent deficits—high rates of anaemia, inadequate postnatal care, and almost complete invisibility of maternal mental health in routine public health metrics—reveal that legal rights have not yet translated into full empowerment.¹

Women’s empowerment must be understood not only as an expansion of formal civil and political rights but also as the substantive freedom to lead a life of dignity and capacity. Theories of capability and human development frame health as the foundational capability that enables agency across other domains. Yet Indian healthcare governance, law, and policy tend to remain fragmented along programmatic lines: reproductive and maternal health are prioritized in targeted schemes, while mental health, nutritional health, occupational safety, and the particular vulnerabilities of informal sector women receive less systematic attention. Postpartum depression (PPD) exemplifies this lacuna: epidemiological studies estimate that between approximately 22% and 25% of new mothers in India experience significant postpartum depressive symptoms.² Yet, the condition is rarely screened for in routine antenatal or postnatal programs and receives scant attention in legal discourse.

This Article investigates whether and how the Indian legal system — constitutions, statutes, and case laws- empowers women in the health domain, with a special focus on PPD as a test case for the sufficiency of legal protections. It proceeds by (1) outlining the theoretical relationship between health and empowerment; (2) reviewing empirical indicators that reveal the state of women’s health in India; (3) critically appraising the constitutional and statutory frameworks; (4) placing postpartum depression at the center of the empowerment conversation; (5) identifying structural and administrative barriers; (6) examining international obligations

¹ Int’l Inst. for Population Scis. (IIPS) & ICF, *National Family Health Survey (NFHS-5), 2019–21: India* (2022).

² Nat’l Inst. of Mental Health & Neuro Scis. (NIMHANS), *National Mental Health Survey of India, 2015-16* (2016).

and comparative models; and (7) recommending legal and policy reforms calibrated to produce measurable empowerment outcomes.

II. Theoretical Framework: Empowerment and Health

A. Capabilities and Human Development

Amartya Sen's capabilities approach emphasizes that true freedom lies not merely in formal rights but in the substantive capabilities individuals possess to lead dignified lives.³ Health is among the most foundational of these capabilities: without physical and mental well-being, women cannot meaningfully exercise rights to education, work, or political participation. Martha Nussbaum similarly identifies bodily integrity and health as central elements of human flourishing.⁴

B. Legal Foundations of Health Rights

The Indian Supreme Court has repeatedly recognized health as an integral part of Article 21. In *Consumer Education & Research Centre v. Union of India*, the Court held that "the right to health and medical care is a fundamental right under Article 21."⁵ Similarly, in *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, it imposed positive obligations on the State to provide adequate medical facilities.⁶

Thus, health is not a benevolent welfare measure but a fundamental entitlement, without which women's empowerment remains illusory.

III. Empirical Insights into Women's Health in India

A careful empirical grounding is necessary to move beyond rhetoric. The National Family Health Survey-5 (NFHS-5, 2019–21), the most recent large-scale household survey, provides important indicators:

- A. Institutional deliveries have increased substantially, with national coverage nearing 89%.⁷ However, institutional delivery alone is not a proxy for quality — postnatal care

³ AMARTYA SEN, *DEVELOPMENT AS FREEDOM* (1999).

⁴ MARTHA C. NUSSBAUM, *WOMEN AND HUMAN DEVELOPMENT: THE CAPABILITIES APPROACH* (2000).

⁵ *Paschim Banga Khet Mazdoor Samity v. State of W.B.*, (1996) 4 S.C.C. 37 (India).

⁶ *Id.*

⁷ Int'l Inst. for Population Scis. (IIPS) & ICF, *NFHS-5*, supra note 1.

within 48 hours is reported for only about 65% of mothers, leaving a significant gap in critical early postpartum monitoring.⁸

- B. Anaemia among women aged 15–49 has increased to approximately 57% nationally, a worrying reversal that undermines both maternal and neonatal health prospects.⁹
- C. Adolescent marriage and pregnancy remain significant: NFHS-5 reports that a notable proportion of young women marry early, increasing the risk of adverse maternal outcomes.
- D. Geographical and social disparities persist. States such as Kerala and Tamil Nadu display strong maternal health outcomes; other states, notably in the northern belt, lag behind sharply. Scheduled Caste and Scheduled Tribe women register worse nutrition and maternal health indices than other groups.
- E. Crucially, NFHS-5 does not routinely collect standardized metrics on postpartum depression or maternal mental health, a lacuna that reflects and reinforces policy neglect.

Complementary sources deepen the picture. The National Mental Health Survey (NIMHANS, 2015–16) estimated millions of Indians with mental health disorders and a large treatment gap (roughly 70–80%), with women disproportionately affected in certain conditions and with limited access to services.¹⁰ Global medical literature, including large-scale meta-analyses, associates untreated maternal depression with increased morbidity, poorer breastfeeding practices, impaired mother–infant bonding, and adverse child developmental outcomes (growth, cognition), suggesting intergenerational consequences.

These data reveal a paradox: India's policy and program architecture has made measurable gains in some maternal indicators while simultaneously failing to institutionalize comprehensive, integrated care that includes mental health and nutrition and addresses the needs of informal sector women.

IV. Legal and Constitutional Framework:

A Critical Evaluation on paper, India's legislative framework for women's health seems strong, but upon closer examination, it becomes clear that statutory enactments and constitutional pledges sometimes work in isolation, leaving women's empowerment lacking.

⁸ Id.

⁹ Id.

¹⁰ Nat'l Inst. of Mental Health & Neuro Scis. (NIMHANS), *National Mental Health Survey*, supra note 2.

A. Judicial Silence vs. Constitutional Guarantees

The rights to reproductive autonomy, dignity, and health have all been added to Article 21 by the Supreme Court. Important affirmations include cases like *Suchita Srivastava v. Chandigarh Administration*¹¹ and *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*.¹² However, the majority of the jurisprudence is still reactive; courts intervene in cases involving serious violations, but they haven't established a proactive theory that calls for the rational integration of empowerment and health policy. Crucially, there has never been judicial recognition of maternal mental health, exposing a startling lack of clarity in constitutional interpretation.

B. A Tangled Statutory Environment

The legislative framework of India is dispersed across several laws:

The Maternity Benefit Act, 1961, provides paid leave, although only a small percentage of women in the official labour are covered by it.¹³ Although it promotes reproductive choice, the Medical Termination of Pregnancy Act, 1971 (as revised in 2021) medicalizes decision-making and underserves rural women.¹⁴

- Although it addresses sex selection, the Pre-Conception and Prenatal Diagnostic Techniques Act of 1994 ignores more general structural prejudices that contribute to gendered neglect in healthcare.
- Although the Mental Healthcare Act of 2017 establishes a justiciable right to mental health, it lacks implementation mechanisms for perinatal mental health disorders such as postpartum depression.

There is no comprehensive "Women's Health Code" under this patchwork approach. Rather, women negotiate conflicting, overlapping regimes.

C. Structural Exclusion of Informal Workers

Roughly, 90 percent of Indian women workers are in the informal economy—domestic workers, agricultural labourer's, home-based artisans—yet most statutory protections, including maternity benefits and workplace health guarantees, bypass them. The legal framework's formalist bias toward contractual, formal employment results in systemic exclusion.

¹¹ *Suchita Srivastava v. Chandigarh Admin.*, (2009) 9 S.C.C. 1 (India).

¹² *Paschim Banga Khet Mazdoor Samity v. State of W.B.*, supra note 6.

¹³ Maternity Benefit Act, No. 53 of 1961, INDIA CODE (as amended 2017).

¹⁴ Medical Termination of Pregnancy Act, No. 34 of 1971, INDIA CODE (as amended by Act No. 8 of 2021).

D. Enforcement Deficits

In reality, even the strongest legal rights are ineffective. According to claims of corruption and inconsistent audits, monitoring organizations under programs like the Janani Suraksha Yojana (JSY) or the Janani Shishu Suraksha Karyakram (JSSK) operate unevenly. Although they draw attention to state carelessness, judicial interventions—like *Laxmi Mandal v. Deen Dayal Harinagar Hospital*¹⁵—rarely result in systemic change. Rights are aspirational rather than transformative in the absence of accountability measures.

V. Postpartum Depression: A Central, Neglected Dimension

A. Medical Profile and Scope

Postpartum depression (PPD) is a clinically significant depression occurring after childbirth. Symptoms include low mood, anhedonia, fatigue, impaired concentration, changes in appetite and sleep, and in severe cases, suicidal ideation. Prevalence estimates in India vary by study and region, but pooled analyses and large hospital- and community-based studies suggest that roughly 20–25%¹⁶ of new mothers experience PPD symptoms of clinical significance.

The timing and severity vary: while “baby blues” are transient and common, PPD is more persistent and debilitating. Biological, psychosocial, and social determinants intersect hormonal shifts, poverty, and gender-based violence, lack of support, malnutrition, and anaemia increase risk. Importantly, PPD carries consequences beyond maternal suffering — it adversely affects mother–infant bonding, breastfeeding uptake and duration, child immunization adherence, and longer-term cognitive and emotional development of the child.¹⁷

B. Policy and Legal Implications

The recognition of mental health as a right under MHCA¹⁸ offers a legal entry point for PPD remedies. However, rights without implementation fall flat. There is no statutory requirement for routine PPD screening in antenatal or postnatal services under NHM or under PM-JAY. Mental health programs and maternal health programs operate largely

¹⁵ *Laxmi Mandal v. Deen Dayal Harinagar Hosp.*, W.P. (C) No. 8853/2008 (Del. H.C. 2010).

¹⁶ Nat'l Inst. of Mental Health & Neuro Scis. (NIMHANS), *National Mental Health Survey*, supra note 2.

¹⁷ S. Krishnan, *Gender, Caste and Health in India*, 61 *Soc. Sci. & Med.* 1761 (2005).

¹⁸ Mental Healthcare Act, No. 10 of 2017, INDIA CODE.

in silos; the former is underfunded and peripheral to primary maternal services. The absence of perinatal mental health protocols at primary and district health centres effectively denies women the right to mental health in the peripartum period — a critical window for prevention and intervention.

From a human rights perspective, failure to address PPD may amount to a breach of positive obligations under Article 21 (state duty to ensure conditions for dignified life) and Article 14/15 (non-discrimination) if systemic neglect disproportionately affects women or subgroups of women (rural, Dalit, Adivasi). At the international level, ignoring PPD could be read as falling short of CEDAW Article 12's obligation to ensure non-discriminatory access to healthcare services.

C. Comparative Jurisdictions

- **United Kingdom:** The National Health Service (NHS) integrates perinatal mental health screening into routine care and provides specialist mother-baby units.
- **Canada:** Provinces such as Ontario mandate postpartum depression screening during well-baby visits.
- **United States:** Under the Affordable Care Act, maternal depression screening and treatment are covered as preventive services.
- **South Korea and Japan:** Both countries run community-based maternal mental health outreach programs, with high screening coverage.

India, by contrast, lacks a systematic screening program, reflecting both policy invisibility and legal neglect.

D. Empowerment Effects of Addressing PPD

Addressing PPD is not merely clinical—it advances empowerment. When women receive effective PPD screening and treatment they are more likely to resume economic activity, participate in social life, and enjoy greater autonomy in family and community settings. Preventing and treating PPD reduces the risk of intergenerational disadvantage by improving early childhood environments. Legally, integrating PPD into enforceable health rights would help convert the abstract promise of Article 21 into tangible capability expansion.

VI. Barriers to Health Empowerment

Despite progressive constitutional interpretation, several systemic barriers persist:

- A. Structural Exclusion- The Maternity Benefit Act, 1961 (amended in 2017) primarily covers salaried employees in the formal sector, which constitutes less than 10% of India's female workforce. Informal workers—domestic, agricultural, and home-based—remain excluded from wage compensation and maternity leave protections.
- B. Cultural Stigma- The National Mental Health Survey (NIMHANS, 2016–18) found that nearly 80% of people with mental illness receive no treatment, with stigma as a major barrier. For mothers with PPD, family and societal expectations of resilience silence disclosure, forcing women into cycles of untreated illness.
- C. Budgetary Limitations- India's health expenditure is below 2% of GDP (National Health Accounts, 2021), far short of WHO's 5% benchmark. Within this, mental health receives less than 1% of the health budget. This chronic underfunding leaves maternal mental health services underdeveloped.
- D. Intersectional Disparities- NFHS-5 data shows that 62% of Scheduled Tribe women and 59% of Scheduled Caste women are anaemic, compared to 52% of women from other castes. Rural women are significantly less likely to receive postnatal check-ups within 48 hours (58%) compared to urban women (74%). These disparities reveal how caste, class, and geography intersect to produce unequal access.
- E. Administrative Neglect- Even flagship schemes like the Janani Suraksha Yojana (JSY) suffer from irregular audits, corruption, and weak grievance mechanisms. In *Laxmi Mandal v. Deen Dayal Harinagar Hospital* (2010), the Delhi High Court highlighted maternal deaths caused by state negligence, yet no structural accountability followed.

VII. International and Comparative Commitments

India is bound by multiple international instruments that frame health as a women's right:

- A. CEDAW (1979) – Article 12 requires states to eliminate discrimination in access to healthcare. ¹⁹ General Recommendation 24 clarifies that preventable maternal mortality is a form of discrimination.
- B. ICESCR (1966) – Article 12 recognizes the right to the highest attainable standard of physical and mental health. India's periodic reports have been criticized for inadequate

¹⁹ Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13.

funding and weak implementation.

C. *Alyne da Silva Pimentel v. Brazil* (CEDAW, 2011) – The Committee held Brazil accountable for preventable maternal death, establishing state responsibility for systemic failures. By analogy, India’s neglect of PPD could be framed as discriminatory.

D. Comparative Jurisdictions:

- UK: NHS perinatal mental health services.
- Canada: Mandatory PPD screening.
- South Africa: *Treatment Action Campaign v. Minister of Health* (2002) – denial of maternal services was held unconstitutional.

India lags in aligning domestic practice with these standards, particularly regarding maternal mental health.

VIII. Recommendations: Toward a Rights-Based, Integrated Model

To operationalize law as a lever of empowerment, reforms must be legal, programmatic, fiscal, and cultural.

A. Legal and Regulatory Reform

- Consolidated Women’s Health Rights Code. Draft a comprehensive statute that consolidates maternal, reproductive, occupational, and mental health protections; enshrine mandatory perinatal mental health screening; define entitlements and state obligations; and mandate budgetary commitments.
- Extend Maternity Protections to Informal Workers. Amend Maternity Benefit provisions or enact social security legislation ensuring portable cash benefits and job protection for women in informal employment. Linking benefits to Aadhaar/Jan Dhan accounts can improve delivery.
- Judicial Monitoring and Standards. Use PILs to secure time-bound State action plans for maternal mental health under Article 21; courts can require periodic reporting and monitoring by independent experts.

B. Programmatic Integration

- Mandatory PPD Screening. Integrate validated screening tools (e.g., Edinburgh Postnatal Depression Scale) into routine antenatal and postnatal check-ups at

primary health centres, community health camps, and through paediatric contact points.²⁰

- District Perinatal Mental Health Units. Establish perinatal mental health teams at district hospitals with clear referral pathways to tertiary care where needed.
- Task Shifting and Capacity Building. Train ASHA, ANM, and Anganwadi workers in basic detection, psychosocial first aid, and referral. Build partnerships with NGOs for community counselling and support groups.

C. Fiscal and Data Commitments

- Increased Budgetary Allocation: Commit to a stepped increase in public health spending (aim at least 2.5%–3% of GDP in the near term, moving toward 5% longer term) with a ring-fenced allocation for maternal and mental health.
- Data and Indicators: Add PPD prevalence and treatment coverage to HMIS and NFHS modules; publish state-wise dashboards linking budgetary inputs to maternal mental health outputs.

D. Social and Cultural Interventions

- DE-stigmatization Campaigns. National mass media campaigns to normalize postpartum mental illness, highlight success stories, and promote help seeking.
- Community Support Networks. Strengthen SHGs and mothers' peer groups to provide non-clinical support and facilitate linkage to health systems.

IX. Conclusion

Women's empowerment in India is inseparable from health justice. While the Constitution and statutes provide a framework for reproductive rights and maternity benefits, maternal mental health remains invisible in both law and policy. NFHS-5 data, NIMHANS surveys, and judicial precedents collectively reveal that empowerment cannot be reduced to survival through childbirth—it must ensure that women thrive physically, mentally, and socially in its aftermath. By integrating postpartum depression into healthcare frameworks, expanding maternity protections to informal workers, and embedding accountability into law, India can move closer to a rights-based model of empowerment. True empowerment lies not in rhetoric but in ensuring that every woman enjoys freedom from preventable illness, access to dignified care, and recognition of her mental well-being as a constitutional right. A coherent, rights-based approach— combining statutory consolidation, social protections for informal workers,

²⁰ Phuong H. Nguyen et al., Maternal Diets in India: Gaps, Barriers, and Opportunities, 13 *Nutrients* 3534 (2021).

mandatory perinatal mental health screening, community interventions, and robust accountability— can tip the balance from legal promise to realized empowerment. The future of gender justice in India depends on making health, including maternal mental health, central to the project of empowerment.

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