

Family Planning in India: A Study of Law and Policy

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I INTRODUCTION

At the United Nations World Population Conference in Belgrade, in 1965, out of some one thousand participants and observers, there was only one lawyer, and none of the hundreds of papers presented at the conference dealt with the legal aspects of the population problem and the family planning.¹ The scenario perhaps, is not different in 2010 Annual Meeting of Population Association of America. The subject of law, population and family planning, unfortunately, has been almost neglected, despite the fact that law has an important role to influence the human behavior.²

II POPULATION POLICY

National Population Policy

Population policy in India has a history lasting more than 50 years. The official stand about population related issues and concerns as they affect the process of social and economic development and well being of the people is reflected in different Five year Development Plans³ that have been the basis of planned social and economic development in the country right since independence. In addition to the official statements about population control and family planning imbedded in the Five-year Development Plan, there have been policy announcements outside the development planning framework. The first announcement was in 1976⁴ when there was considerable emphasis on pushing family planning through political and bureaucratic pressure. The policy stressed that simply waiting for education and economic development to bring about a drop in fertility was not a practical solution. The time factor was so pressing and population growth so formidable, that the country had to get out of the vicious circle through a direct assault as a national commitment.

Specific measures suggested in the National Population Policy 1976 included: raising the minimum age at marriage to 18 years for girls and 21 years for boys by enacting suitable legislation; freezing the representation in Lok Sabha and State Legislatures on the basis of 1971 population census until the year 2001; special measures for raising the level of female education; special attention to research in reproductive biology and contraception; permitting State Legislature, in exercise of their own powers, to pass legislation for compulsory sterilization, incentives to the government employees for the adoption of the small family planning throughout the nation. The 1976 National Population Policy, however, could remain effective for a short period of just about one year only. The new Government that came in the office after the 1977 general elections, discarded major provisions made in the 1976 policy statement.

The second population policy was announced in the year 2000. The immediate objective of the National Population Policy 2000⁵ was to address the unmet needs for contraception, health care infrastructure and health personnel and to provide integrated service delivery for reproductive and child health care. The policy envisages that by meeting the above stated unmet needs, it would be possible to achieve population stabilization by the year 2045. Specific measures proposed in the policy include :addressing the unmet need for basic reproductive and child health services, supplies and infrastructure; making school education up to age 14 free and compulsory, and reducing drop-outs at primary and secondary levels to below 20 per cent for both boys and girls; reducing IMR to below 30 per 1000 live births; reducing MMR to below 100 per 100000 live births; achieving universal immunization of children against all vaccine prevented diseases; achieving 80 per cent institutional deliveries and 100 per cent deliveries by trained persons, achieving universal access for information/counseling and services for fertility regulation and contraception with a wide basket choices; achieving 100 per cent registration of births, deaths marriage and pregnancy; containing the spread of the Acquired Immune Deficiency Syndrome (AIDS) and promote greater integration between management of RTI and sexually transmitted infections and the National AIDS Control Organization; prevent and control communicable diseases; integrate the Indigenous System of Medicine in the provision of reproductive and child health service and in reaching out to the households; promote vigorously the small family norm to achieve replacement fertility, bringing out convergence in the implementation of social sector program so that family welfare becomes a people centered program.

India has reached one billion populations on 11th May 2000. On that day the Prime Minister announced the formation of the National Population Commission⁶ with him as the Chairman and the Deputy Chairman Planning Commission as Vice Chairman. The Chief Ministers of all States, Ministers of the related Central Ministries, secretaries of the concerned Departments, eminent physicians, demographers and the representatives of the civil society are Members of the Commission.

The Commission has the mandate to: review , monitor and give direction for implementation of the National Population Policy with the view to achieve the goals set in the Population Policy; promote synergy between health, educational environmental and developmental programs so as to hasten population stabilization; promote inter sectoral coordination in planning and implementation of the programs through different sectors and agencies in center and the states; promote inter sectoral coordination in planning and implementation of the programs through different sectors and agencies in center and the states.

Criticism

In February 2000 the Government of India announced the National Population Policy. But the Census 2001 report⁷ made it very clear that the NPP had already become invalid, as in 2001 itself, India has already exceeded the estimated population in NPP for the year 2002 by about 14 million. One fails to understand the logic behind finalizing NPP in February 2000 when it was known that only about a year later, in March 2001, the census data would become available with more updated information, essential for preparing a realistic and effective population policy.

Family Planning Changing Scenario

Family planning has been and remains the basis of population policy in India irrespective of whether the emphasis has been on the reduction in the birth rate or on improving the health, especially of women and children.⁸ However, approaches adopted to promote family planning were changed frequently. Table 1 below presents a synoptic view of various approaches adopted to promote family planning since 1951 along with their rationale:⁹

Table 1
Changes in the intervention strategy of the family planning programme in India

Period	Intervention strategy	Rationale for the strategy
1951-61	Clinic approach	The strategy was based on the assumption that there existed a latent demand for family planning in the community. Availability of services and supplies through clinics established for the purpose was expected to be sufficient for voluntary adoption of family planning for fertility reduction.
1962-69	Extension approach	Rapid growth of population during 1951-61 signaled the dismal impact of voluntary adoption of family planning approach as the latent demand, if any, could not be translated into the practice of family planning. The extension approach comprised of motivating couples for family planning through house to house visits, incentives for sterilization and targets to service providers.
1969-77	Intensification of family planning efforts	The 1971 census recorded further increase in the population growth rate although there was a slow down in the rate of increase indicating that both voluntary adoption and motivational approach had limited impact on fertility reduction. Political and bureaucratic authority was used to 'push' family planning. Increased reliance on the 'push' resulted in coercion and force to adopt family planning during the days of political emergency. Family planning became a politically sensitive issue and contributed to the defeat of the popular government.
1977-	Return to voluntary	Political backlash resulting from the 'push' towards family planning

80	birth control	during emergency forced a return to voluntary adoption of family planning. The phrase family planning was replaced by the phrase family welfare. Targets were stayed, but there was little stress on achieving them. Increased attention was given to health of women and children.
1980-94	Integration with minimum needs programme under health	Slump in programme performance instigated a cautious revival of the push approach. Family planning was seen as one component of development. Focus on family planning started waning in the development planning process.
1994-2002	Target free or community needs assessment	Paradigm shift in the basic approach to family planning. Abolition of targets. Focus on identifying and meeting felt health and family welfare need of the people. Announcement of a new population policy. Family planning perceived as a component of the broader reproductive and child health package. Dominance of health rationale of family planning over the demographic rationale of family planning.
2002 onwards	Community needs assessment	Push or pull for family planning in the context of broader reproductive and child health framework only and not in the context of fertility reduction. Administratively, Department of Family Welfare was merged with the Department of Health at the national level.

III MODES OF FAMILY PLANNING

Contraception

The Government's Policy, Facilities and Services

The Policy of the Government of India is to induce more eligible couples to adopt contraceptives for family planning. In pursuance of this policy advice, facilities and services to help eligible couples plan their families are provided free of charge in all Sub-centers, Primary Health Centers (PHCs) Community Health Centre (CHCs) and Rural Family Welfare Centers, District Hospitals, etc. throughout the country. Services are provided through medical and paramedical staff.¹⁰ A cafeteria approach is followed whereby eligible couples may select any contraceptive of their choice offered in the National Family Welfare Programme.¹¹

Oral Contraceptive Pill (Mala-N) and IUDs are procured centrally and distributed to various States/Union Territories (UTs), Railways and Defense establishment under free distribution scheme. With effect from 1st April, 1996, need-based decentralized participatory approach to family planning has been adopted. In the new approach, no targets have been set for the States. The demands have to be assessed on the basis of the needs of the community.¹²

Department of Family Welfare has been procuring condoms with effect from 1994-95. Under the free distribution scheme, condoms under brand name 'Nirodh' are made available to acceptors free of charge through Primary Health Centers and sub-centers in rural areas and through hospitals, dispensaries, MCH centers and post-mortem centers in urban areas. This scheme also meets the requirements of condoms by states/UTs under the STD/AIDS control programme.

The scheme of social marketing of oral pills was launched in 1987. The brand name Mala D has been given to the product under social Marketing Programme. The raw material for manufacture of OCPs is received as commodity assistance from UNFPA and supplied free to domestic companies for tableting. Voluntary organizations working in the field of health and family welfare and social marketing companies are also allowed to sell oral pills in their own brand name under the programme.¹³ These branded products are sold at prices fixed by the concerned marketing organization in such a way

that these prices are less than the prices of commercially sold brands, but not less than the retail prices of Mala D.

Department of Family Welfare has undertaken advertisement campaign for promotion of Mala 'D' on television, radio, newspaper and magazines. In order to encourage distributing companies, a scheme for providing incentive has been introduced w.e.f. 1st October 1996.¹⁴ Weekly oral contraceptive pills, 'SAHELI AND CENTRON' are being manufactured and marketed by a public sector undertaking and a private sector company.¹⁵ A National Centre for testing of Intra-uterine Device (IUDs) and tubal rings was set up by Department of Family Welfare at the Bio-medical Engineering wing at IIT New Delhi in 1988-89 with the financial assistance from UNFPA. With effect from April 1992 onwards the centre is being funded entirely by Government of India.¹⁶

Legal Regulation of Contraceptives

India has no specific statute governing or controlling the manufacture, advertisement and sale of contraceptives in an exclusive manner. The manufacture, intra and inter-state transmission by mail or public carrier, advertisement, sale, export and import of contraceptives related materials is regulated by Government orders. Manufactures of any commodity have to obtain a license and various permits from the Government before they can set up a factory or go in to business. They have to obtain a permit to buy certain raw materials, which are on a short supply on a quota basis. If the raw material or semi-manufactured component for the manufacture of a contraceptive has to be imported from abroad, there are laws and regulations dealing with customs clearance, import duties and foreign exchange. Besides these, there are general statutory and other regulations covering the license and registration of pharmacists, druggists and medical practitioners as well as the supply and sale of drugs of various kinds.¹⁷

As many as five types of laws regulate the availability of contraceptives. These are laws which affect import, manufacture, sale and distribution, advertising and publicity and the use of mails.¹⁸

(i) Import

Under the import policy of the Government of India, framed under the Import and Export Control Act, 1947, provision for the import of family welfare

equipment is made under item 25 Appendix X which deals with import items under Open General License. It prescribes that, family welfare equipment instrument appliances, namely the following (i) (a) Laparoscope; (b) Culdscope; (c) Hysteroscope; (d) Vacuum suction apparatus; (e) as well as their all accessories and spares' (ii) Rubber contraceptives (diaphragms only)' (iii) Intrauterine contraceptive devices (Other than the Lippies; Loop and CU-T 200) Colored condoms diaphragms, jells and foam tablets, as approved by the Drugs Controller (India), New Delhi can be imported under Open General License by all persons.¹⁹ Thus, import of contraceptives has been very much liberalized.

Under the prevailing customs and central excise laws, contraceptives can be categorized as:-Chemical preparations based on hormones/spermicides, and Sheath contraceptives. Under Custom laws chemical contraceptives based on hormones/spermicides can be freely imported at nil rate of duty, without requiring any license. Sheath contraceptives can be imported by paying custom duty of 40 per cent. Here also there is no requirement of any license for the purpose. Under Central Excise laws chemical contraceptives are charged to nil rate of duty. Sheath contraceptives are also chargeable to nil rate of duty.

(ii) Manufacture

According to Drugs Control Act, 1950; Drugs and Cosmetics Act, 1940 and regulations there-under, pills and condoms are both subject to the regulation of the Central Government. Condoms are also covered by schedule R, Rule 125, Drugs and Cosmetics Act of 1940. Drugs and Cosmetics (Amendment) Rules, 1993²⁰ amend the Drugs and Cosmetics Rules, 1945 to include within schedule R of the Rules, standards for Copper T and Tubal ring contraceptive devices laid down by the Bureau of India standards.

The manufacturing of contraceptives has been undertaken by the Central Government itself to reduce the cost and to save foreign exchange. The Government has set up a loop factory in Kanpur (Uttar Pradesh) and a condom factory at Trivendrum (Kerala), the Hindustan Latex Limited, as public sector undertakings. The pill is

manufactured by both Indian and foreign pharmaceutical manufacture mainly in Bombay. Condoms are also manufacturers by private firms in Madras and elsewhere.²¹

(iii) Sale and Distribution

As stated earlier condoms are at a specially subsidized price and distributed free of charge in the Government family planning centers and NGO funded by the Government. Pills are sold in pharmacies on prescription only according to the schedule of Drugs and Cosmetics Act of 1940 and distributed free through all urban Family Welfare Centers and through such Primary Health Centers as can monitor the oral pills programs. As steps were being taken by the Government under sections 10-A and 26-A of the Drugs and Cosmetics Act, 1940 to ban the import, manufacture, sale and distribution of the drug 'Quinacrine' for use as contraceptive, their Lordships of the Supreme Court declined to pass any further orders.²² A particular drug would be banned only if the Government is satisfied about the hazardous nature of the drug. Above all, the Government is also to be satisfied that public interest warrants such prohibition.²³

(iv) Mails

The Indian Post Office Act, 1898 prohibits the transmission by mail of any indecent printing, painting, photography, lithograph, engraving, book or card or any other indecent or obscene article. However, transportation of contraceptives within the country is allowed.²⁴ The Government of India has been progressing in not including contraceptives- both literature and applications under pornography.²⁵

(v) Advertising and Publicity

The drugs and Magic Remedies (Objectionable Advertisement) Act, 1954 is designed to prevent misleading advertisements, false labels and claims of efficiency for any drug. The purpose of this statute is to prevent the manufacture, distribution, advertisement and sale of spurious and harmful medical preparation, by making it an offence. Section 3 the Act prescribes that no person shall take any part in the publication of any advertisement referring to any drug for the procurement of miscarriage in women or prevention of conception in women; or the maintenance or improvement of the human being for sexual pleasure; or the correction of menstrual disorder in women; or the

diagnosis, cure, mitigation, treatment of prevention of any venereal disease or condition which may be specified in rules under the Act.

Section 15 of the Act, however, gives the Central Government the power to grant exemption in this regard if in the opinion of the Central Government, public interest so requires. The fact is that contraceptives are advertised in the newspapers, radio and television by the Government of India itself. The Central and State Governments have undertaken the dissemination of family planning information by all the available mass media- bill boards, cinemas, dance, drama, post offices, press, radio, song, television, etc, so that the married couples may have the vital knowledge to plan conception.

The Government seeks to utilize groups and their leaders as channel of communications by, for example, appointing influential members of the community as honorary family planning education leaders. In fact, the Government is exploring various possible means for carrying the small family message. Even match-boxes carry the family planning message.²⁶

Suggestions

A comprehensive legislation in the field of contraceptives consolidating and updating the scattered law is the need of the hour. Such law should: (a) provide a definition of contraceptive for the purpose of family planning ; (b) be such which insures that there is no unnecessary restrictions on the advertisement and publicity of contraceptives; (c) ensure that the contraceptive advice is easily available and that the contraceptives are also freely available; (d) prescribe the minimum standards for the quality of such contraceptives sold in the market; (e) remove the import as well as other duty restrictions on contraceptives for providing quality and advanced contraceptive devices in the country; and (f) provide for the availability of all contraceptives and devices in all Primary Health Centers established throughout the country free of charge. While enacting a law on contraceptives due regard has to be given to their impact on the matrimonial relations. It should be enacted in such a way as not to adversely affect the marriage laws bearing particularly on consent, cruelty and divorce.

Sterilization

Government's Policy, Facilities and Services

The sterilization program was initiated in the India's family welfare programmed sometime in 1956. Starting with a low tempo in earlier years, later on it became popular method of family planning.²⁷ In early stages, the Government issued directions requiring the doctors to obtain written consent of both husband and wife for sterilization of either. Later in April 1968, the Government decided that for vasectomy it would be sufficient to get a statement from the person concerned to the effect that he has obtained the consent of his wife. The application form for vasectomy was, therefore, revised accordingly. In case of tubectomy, the instructions required that written consent of both husband and wife be obtained as originally stipulated. However, in 1974, this rule was relaxed further and now in case of tubectomy instructions requires that wife is to get the written consent of husband or she is to give a statement to the doctor in presence of a witness that her husband has no objection to this operation.

Besides, the Government of India, the State Governments have also laid down rules and policy guidelines requiring the doctor to strictly assess the eligibility of the applicant in terms of age, number of living children, marital status and similar other criteria. No person is to be sterilized unless she/he has attained the age of 35 years, is married and the consent of both the partners has been obtained for such operation.²⁸

The operating doctor is further obliged to explain the nature of this operation to the patient and preferably, if possible, to both the marriage partners. The doctor has to explain that, for all practical purposes, the operation is a permanent measure. Only the gynecologists and surgeons are competent to perform such operations. Generally, male sterilization is to be done by male doctors and they cannot perform sterilization operation upon female patients except under special circumstances. Sterilization Manual 1971 issued by the Government of India lay down clinical standards for operation and maintenance of certain minimum physical facilities. However, in actual practice, there is frequent violation of the legal and administrative requirements and safeguard. No penal sanction exists in case of violation of these official directives and administrative instructions.²⁹

The Government has established various central Laparoscopic training centers in different parts of the country. Training in Laparoscopic sterilization techniques is imparted by reputed and experienced gynecologist and obstetrician in the medical college/hospital to a team consisting of a doctor, an operation theatre nurse/sister and an operating theatre attendant as and when they are deputed for training by the state government concerned.³⁰ The minimum educational qualifications required by the doctor for this training programme are MD (Obst & Gynae) or MS (General Surgery) or MBBS with DGO having worked for a minimum period of three years in a Government hospital or any other medical institution. This training is of two weeks duration.³¹

The Government has modified the earlier compensation scheme for sterilization and has increased the payment to compensate for loss of wages to those accepting sterilization. Government introduced a National Family Planning Insurance Scheme which provides compensation to sterilization acceptors as well as to provide indemnity insurance to the provider (qualified doctors) against failures, complications and deaths following sterilization. These measures are introduced as confidence building mechanisms among the family planning clients.³²

Legal Regulation of Sterilization

The legal status of sterilization is ambiguous and undefined.³³ As such the legality of such sterilization may be examined, generally with reference to the relevant provision of Indian Penal Code, 1860 (hereinafter referred to as IPC).

(i) Therapeutic Sterilization

A therapeutic sterilization is performed where a patient of sound mind consents to such operation to preserve the life or the health. Therapeutic sterilization is common all over the world. It is legal on common law basis.³⁴ In other words, the legality of therapeutic sterilization is seldom in question unless performed without the patient's consent. A medical practitioner performing therapeutic sterilization operation in good faith and with the consent of the patient should have little fear of criminal prosecution as no one can be able to claim benefit arising out of such act which the patient himself/herself had authorized. However, a medical practitioner performing such operation in good faith without the consent of other spouse may be exposed to civil liabilities as well.³⁵ For instance, if therapeutic sterilization of one spouse without the

consent of other leads to nervous shock, the other spouse may be able in certain circumstances to claim exemplary damages for disappointment of one's parental expectations.³⁶ It may also have consequences with respect to the laws of marriage and matrimonial causes. Sterilization by one spouse may be covered under cruelty as a ground for divorce for other spouse.

(ii) Eugenic Sterilization

Eugenic sterilization is performed in case where further child bearing will weaken the mother's health (physical or psychological) or is likely to adversely affect the off-spring, Mentally feeble persons and destitute come under this category.³⁷ In India, there is no specific legislation authorizing eugenic sterilization. In most of the American States, legislation provide for eugenic sterilization. Eugenic sterilization legislation exists in other countries too. Since in India there is no specific legislation authorizing eugenic sterilization a person performing such an operation stands the prosecution risk.

(iii) Voluntary Sterilization for Socio-Economic and Family Planning Purposes.

The Government of India and its States have laid down certain policy guidelines for voluntary sterilization for the purpose of family planning. These policy guidelines require among other things that the patient undergoing the operation should be advised that the procedure is irreversible and that his understanding of this fact and consent thereto must be obtained in writing usually on a printed form supplied by the Government.³⁸

That being so, the sterilization causes permanent disability of an organ of human body to discharge its normal function of carrying sperm or ovum as the case may be and permanently impairs the reproductive functions. Section 320 of IPC defining grievous hurt includes emasculation and destruction or permanent impairing of the powers of any member or joint. The term emasculation means depriving a person a masculine vigor, castration, injury to the scrotum. The term member, used here means nothing more than an organ or a limb, being a part of human body, capable of performing a distinct function.

Another relevant provision is section 87 of IPC. Reading sections 87 and 320 IPC together it seems that an operation performed other than on purely medical grounds, with the intention of emasculating the patient or destroying or permanently injuring the

powers of any of his or her members is an illegal operation. Where an act is itself unlawful consent can never be an available defense.³⁹ According to section 88 IPC, the surgeon is not liable for any operation done in good faith for the benefit of the patient and done with his or her consent.⁴⁰ Explanation to section 92 of IPC explicitly mentions that pecuniary benefit is no benefit within the meaning of section.⁴¹ In the absence of any clear definition the inferences have been drawn that it may be pecuniary benefit if it is also a benefit of some other kind as for instance, it may be for the benefit of his life, health or body. A person may expect a legacy if he lives up to a certain age. It may also be for his pecuniary benefit. But if the harm causes only a pecuniary benefit it is not a benefit within the comprehension of the rule.⁴² For instance, a person may desire, as did the beggar mentioned by Lord Coke, to amputate his arm so as to be able to beg successfully. The harm contemplated would have conferred a mere pecuniary benefit on the sufferer, but that benefit would be the result of imposture.⁴³ Similarly, there is ambiguity as to whether the word 'benefit' can be interpreted in the present socio-economic context, i.e. if voluntary sterilization is performed on a female to curb socio-economic hardships, due to large number of children.

Suggestions

It is found that in actual practice there is frequent violation of the administrative instructions concerning requirements of consent, age, licensing of individuals or agencies performing the sterilization. No penal sanction exists in case of violation of these official directives. In the absence of proper regulatory law, the executive authorities at different places may adopt different standards, which may lead to arbitrariness in the implementation of the family planning programs. It is, therefore suggested that a proper detailed law about various types of sterilization should be enacted by the Central government which should lay down the relevant norms and guidelines for sterilization as a family planning measure.

Abortion

Government's Policy, Facilities and Services

In 1971 a law was enacted to improve the accessibility and availability of scientifically approved services and facilities for termination of pregnancy in proper cases and thereby reducing number of illegally induced abortions. However, despite the Act and service provision made under it by the Government, a large number of illegal abortions are still performed in rural areas by persons who are neither skilled nor authorized under the Act.

The major factor responsible for it is identified as lack of access to safe abortion clinics due to non availability of such clinics in rural areas and lack of financial resources to reach the clinics in urban areas, lack of information about availability of safe abortion services, lack of privacy and impersonal atmosphere in government run clinics and reluctance of unmarried and widowed women to go to the clinics/hospitals for MTP services.

Under the rule, a place/clinic in the private sector has to be recognized by the State Directorate of Health Services. The facilities for training and equipment have also been made available for private clinics which want to take up the MTP services. Government of India is taking steps to improve the situation and increase access of the rural population to MTP services. Under the RCH Program, it is envisaged that equipment for MTP will be supplied to all PHCs where a lady doctor trained in MTP procedures will be posted by the State Government. In order to improve awareness in the community on the availability of free and safe abortion services, the States are being constantly advised to undertake IEC activities.⁴⁴

Legal Regulation of Abortion

I Pre-1971 Law on Abortion

Prior to the passage of Medical Termination of Pregnancy Act in August 1971 abortion came under the purview of Indian Penal Code 1860.⁴⁵ Sections 312-318 deal with various offences of induced miscarriage, injury or unborn children and exposing infants etc. Under section 312 IPC any one voluntarily causing miscarriage to a woman with child, other than in good faith for the purpose of saving the life of woman

shall be punished with imprisonment of either description for a term which may extend to three years or with fine or with both. If the woman is quick with child, then it provides greater punishment for voluntarily causing miscarriage. For all the offence mentioned in section 312 IPC, the abortionist as well as the mother is punishable.

II The Medical Termination of Pregnancy Act, 1971

The Medical Termination of Pregnancy Act, 1971 (hereinafter referred as MTPA) is supplement to the provisions relating to abortion in the Indian Penal Code. The relevant provisions both in IPC and MTPA are analyzed below:

(i) Grounds for Terminating the Pregnancy

(a) Risk to the Life of Pregnant Woman

Section 312 of the Indian Penal Code allows miscarriage in good faith only to save the life of the pregnant woman. The MTPA provides, among other grounds, for termination of pregnancy where the continuance of pregnancy would involve a risk to the life of the pregnant woman.⁴⁶ Where the risk is such that the termination of pregnancy is immediately necessary to save the life of pregnant woman, such termination may be made at any time irrespective of the length of the pregnancy.⁴⁷

The difference which has been made by the Act between the different grades of risks to the life to the pregnant woman any lead to difficult situations. There are cases where it is reasonably certain that a woman will not be able to deliver the child with which she is pregnant. Where the doctor expects, basing his opinion upon the experience and knowledge of her profession, that the child can not be delivered without the death of the mother, operation may be necessary with a view to saving the life of the mother. The doctor can't wait until the unfortunate woman is in peril of immediate death and then at the last moment snatch her from the jaws of death.⁴⁸ In this regard the provisions of sections 312 IPC are better which provide the termination of pregnancy at any time for saving the life of the pregnant woman.⁴⁹

(b) Risk of Grave Injury to the Physical or Mental Health of the Pregnant Woman

Under MTPA, a pregnancy could be terminated if the continuance of the pregnancy would involve a grave injury to the physical or mental health of the potential

mother.⁵⁰ It is further stated in the Act that in determining whether the continuance of a pregnancy would involve grave risk of injury to the health, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.⁵¹ Where the risk to the physical or mental health of the pregnant woman is a grave one, the pregnancy may be terminated only if the length thereof does not exceed 20 weeks. If the length of the pregnancy has exceeded 20 weeks, the pregnancy cannot be terminated on this ground. In determining whether the risk to the physical or mental health of the pregnant woman is or is not a grave one, the registered medical practitioner is empowered to take into account the pregnant woman's actual and reasonably foreseeable environment. The environment, which may be taken into account need not thus be an actual environment but may be a reasonably foreseeable one. For example, where a pregnant woman is suffering from a serious ailment and does not have a domestic or other aid to help her in domestic chores, has already two children to look after and is living in one room tenement, the registered medical practitioner may after taking these facts into account form the opinion in good faith, that the continuance of pregnancy would constitute a grave risk to the physical or mental health of such women.

(c) Eugenic Ground

Where the pregnancy is sought to be terminated on eugenic grounds, the registered medical practitioner must be satisfied, in good faith, that there is a risk that the child, if born, would suffer from such physical or mental abnormalities as to be seriously handicapped, and the risk is a substantial one.⁵²

A pregnancy may be terminated on eugenic grounds only, if the length thereof has not exceeded 20 weeks. If the length of pregnancy has exceeded 20 weeks, the pregnancy is not terminable on this ground.⁵³ The medical practitioner must decide where there is a "substantial" risk that child if born would be seriously handicapped. However, no definition is given of the term substantial risk. In determining whether a substantial risk is involved in a particular case, a doctor must make an individual judgment based on his observations of that particular patient. Supposing his judgment is that her prospects are poor if the pregnancy continues, how poor must that be for the risk to be substantial? There is no definite answer to this question.

(d) Rape

With a view to assist the registered medical practitioners to form the opinion as to whether the continuance of the pregnancy would or would not involve a grave risk to the physical or mental health of the pregnant woman, two explanations have been provided in section 3 of the Act. Under the first Explanation, an allegation by the pregnant woman to the effect that the pregnancy was caused by rape will lead to a compulsory presumption to the effect that the anguish caused by rape constitutes a grave injury to the mental health of the pregnant woman. No distinction has been made by this explanation between a married woman and unmarried woman or a widow. The expression which has been used in this Explanation is 'shall presume'. Accordingly, when an allegation is made by the pregnant woman that the pregnancy was caused by rape, the registered medical practitioner will have no option but to draw the presumption specified in the Explanation. The plea of rape may be a convenient excuse for abortion as here the registered medical practitioner had no option but to concede to the requests. Rape is a cognizable offence but no one is under an obligation to report its commission. Thus, if the rape is not reported to the competent authority, it will go unrecorded, and the victim may visit the medical practitioner for termination of pregnancy only after detecting the conception. However, the allegation of rape may not be much of embarrassment to a woman in view of the statutory secrecy of the records.⁵⁴ Furthermore under the Penal Code, marital rape has been made punishable, if a husband performs sexual intercourse on his unwilling wife where she is below fifteen years of age.⁵⁵ This offender husband, being her guardian may in such a case withhold his consent for the abortion on this ground under the Act.⁵⁶ Such a situation is liable to defeat the very purpose of these provisions.

(e) Failure of Contraceptive

Second explanation to section 3 of the Act provides the termination 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 an unwanted pregnancy, resulting from the failure of any family planning method or device used by the pregnant woman or her husband may be presumed to constitute a grave injury to the mental health of the pregnant woman. While the Act

emphasized its importance as a health measure, the permission granted under section 3(2) to permit such termination for married women in cases of contraceptive failure, has emphasized its importance as an instrument of population control. This has given rise to a strong difference of opinion among medical personnel, who are averse to using abortion for such purpose. Many of them insist on tubectomy as a condition for abortion. In their view, based on experience, abortion often leads to frequent pregnancies apart from its health hazards.⁵⁷

The MTPA is one of the few statutes in the world providing the failure of contraceptive as an additional ground for the termination of pregnancy and it has been reported to be the most common reasons given for termination of pregnancy. Unlike the first Explanation, the expression "may presume" has been used. According to this, the medical practitioner is not bound to act on the allegation of the pregnant woman, and is entitled, under the law, to call for the evidence to substantiate that the pregnancy was caused by the failure of a contraceptive device or method used either by the pregnant woman or her husband for the purpose of family planning. This Explanation specially assists the married couples who have taken recourse to various family planning methods for the purpose of limiting the number of their children. There is no doubt that the MTPA was passed to emancipate women by giving them a choice about having a child⁵⁸ and was intended to end the illegal and unsafe abortions that were affecting the health and life of a large number of married and unmarried women. At the same time family limitation through abortion is a concept that is neither officially propounded nor accepted under the liberalized abortion law. However, in practice, it has remained more of a family planning measure, than a law merely to safeguard the health of women and children. One finds an express though unemphasized intention of the MTPA to promote the policy of Planned Parenthood by making abortions available if contraceptive fails.⁵⁹

The expression by necessary implication excluded, unmarried women, and widows from its scope. The Act has not made any distinction between device and method used for the purpose of limiting the number of children. Device ordinarily means any contraceptive used either by the pregnant woman or her husband to prevent conception. This includes both mechanical (Pills, Jellies, etc.) as well as chemical (chemical preparation etc.) devices. However, the word "Method" has not been defined and it

would be difficult to establish as to which of the several methods for the prevention of conception was used by the married couple. A method for the prevention of conception includes both clinical as well as traditional (withdrawal. etc.) Again when doctors are asked to provide abortion in cases of contraceptive failures without there being any reliable medical test for it, the law is in effect, making abortions available on demand⁶⁰ but for married women only.

(ii) Period within which Pregnancy can be terminated

Under IPC in order to save the life of the pregnant woman, miscarriage could be caused at any stage of the pregnancy. If the life of the pregnant woman is not in danger, than miscarriage even in the earliest stage of pregnancy is punishable.⁶¹

The period within the pregnancy can be permitted is clearly regulated by MTPA. A registered medical practitioner is authorized by the MTPA to terminate the pregnancy of a woman on the specified grounds when the pregnancy does not exceed the period of twelve weeks.⁶² In case of a pregnancy exceeding twelve weeks but not exceeding twenty weeks, the concurring opinion of at least two registered medical practitioners is required.⁶³ These provisions of the Act relating to length of the pregnancy and the opinion of not less than two registered medical practitioners shall not apply to the case of termination of pregnancy where the registered medical practitioner forms an opinion in good faith that the termination of pregnancy is immediately necessary for saving the life of the pregnant women.⁶⁴ Thus in this respect MTPA has to this extent upheld section 312 of the Penal Code which permits miscarriage for the purpose of saving the life of the woman at any stage of the pregnancy.⁶⁵

(iii) Place where Pregnancy can be terminated

Under the IPC if miscarriage is caused to save the life of the pregnant woman, the place where it is done is not material, as it has not been specified in the Code. Under the MTPA the pregnancy of a woman on the specified grounds may be terminated: (a) in a hospital established or maintained by the Government, or (b) at a place for the time being approved for the purpose of the Act by the Government.⁶⁶ The 2003 Amendment Act to MTPA provides for decentralization of power for approval of places and enlarging the network of safe MTP service providers.⁶⁷

Suggestions

With respect to law of abortion, the following suggestions may be noted: (a) according to section 4 (a) MTPA, the consent of the minor girl is not required for operation. In other surgical operations on children above 12 years, such consent is necessary. This discrepancy is uncalled for and may lead to guardians compelling young girls not to undergo this operation even when they do want it; (b) section 8 of the Act provides an overriding protection to the doctor for any damage caused by the operation. Since no such protection is given for other operations, this seems unnecessary and may lead to negligence. Hence, it may be dropped; (c) the medical practitioners from other traditional and indigenous system like Ayurveda, Homeopathy and Unani be also provided a basic training course for performing abortions under MTPA; (d) section 6 of the Act empowers the Central government to make rules to carry out the provisions of the Act, but nowhere in MTPA any penalty or punishment is provided for the contravention or non-compliance with these rules. This is a glaring omission, for in the same Act, section 7 (3) provides a penalty for the contravention of any regulation made by the State Government.

IV BEYOND FAMILY PLANNING

Constitutional Provisions

The Constitution of India adopted in 1950 had no direct or specific provision having a bearing on the population problem of the country. In 1976⁶⁸ a new entry 20A to List III-Concurrent List- had been added which reads as “Population Control and Family Planning”. By adding this Entry to the Concurrent list, an important step has been taken in order to enable the Central Parliament to legislate without any authorization from the States. Further, it was reported by some States to the Centre that while on the one hand the Centre was urging them to limit their population, those States which did well in this field face reduction of representation in Parliament while those with weak performance in family planning tended to get the increased representation. In order to remedy this situation, 42nd Constitutional (Amendment) Act 1976, had introduced in Article 81 a proviso, according to which the reference in Clause (3) to the last preceding census of

which the relevant figures have been published shall, until relevant figures for the first census taken after the year 2000 have been published, be construed as a reference to the 1971 census. Similar provisions had also been added to Article 55 (Manner of Election of President), Article 82 (Readjustment after each census), Article 170 (Composition of Legislative assemblies of States), and Article 330 (Reservation of Seats for scheduled Castes and Scheduled Tribes in the House of the People). In 2000⁶⁹ the current freeze on the number of seats in Lok Sabha and State assemblies has been extended till 2026. Thus the Constitution 42nd amendment, 1976 and 91st Amendment, 2000 has brought certain important changes in the constitution of India from the point of view of family planning.

Disqualification Laws

Some States like Rajasthan, Orissa, Haryana, Delhi and Andhra Pradesh have enacted a law in order to have an effective check on the tendency of growing population to give a boost to the national family planning program. A disqualification is introduced with certain exceptions for being elected as a member of the local self government. The validity of the impugned provisions has been upheld by the Division Bench of Rajasthan High Court, Orissa High Court, Andhra Pradesh High Court and now by the Supreme Court of India.⁷⁰

Status of Women

There is a direct link between the status of women and the ability of the women to practice family planning. The higher the level of education, lower the fertility. After seeking higher education women seek appropriate job. They become mature and responsible to plan their children. At the same time if women are employed they have limited time at their disposal for domestic work and they are compelled to have small family for their convenience and for doing justice to their children.

Apart from the constitutional protection to women, the labor legislation in India has also provided certain welfare and safety measures for proper working conditions. However, women in actual practice are at a great disadvantaged position in the matter of employment opportunities and working conditions. The worse part is that even the existing legal measures are not being enforced effectively. Because of certain legislative requirements pertaining to the safety of working conditions of women⁷¹ and also due to

biological sensitivity of female workers in comparison to males, there is great reluctance on the part of an employer to give employment to female workers.

The Maternity Benefit Act, 1961 was enacted with object of bringing uniformity with regard to maternity benefits available to women under the various labor legislations. However, certain anomalies still exist. Firstly the Maternity Benefit Act applies to every establishment, which is a factory, mine or plantation including those belonging to the Government. The Employees State Insurance Act, 1948 on the other hand applies to all factories including factories belonging to the Government but excluding seasonal factories. Secondly, under the Maternity Benefit Act, a woman worker resuming duty after child birth is entitled to get two nursing breaks of the prescribed periods taking care of her child, till the child attains the age of 15 months. There is, however, no such provision under the Employees State Insurance Act. Thirdly, the employer under the Maternity Benefit Act cannot compel a pregnant woman to do any work of arduous nature. The employer cannot make any deductions for giving the woman workers easy or less arduous work. No such provision exists in the Employees State Insurance Act. Thus, in view of the disparities a woman worker getting benefits under the Employees State Insurance Act finds herself in a disadvantaged position in comparison to a woman covered under the Maternity Benefit Act.

Coming to Family Law, in India each community is governed by its own personal law. Different religious communities –Hindu, Muslim, Christian and Parsi each have their separate personal laws. India is also having a secular marriage law⁷² which permits any two Indians regardless of their religion to marry. In matters of marriage, majority of the population in India, which is Hindu, is governed by Hindu Marriage Act, 1955. The relevant conditions for marriage which provide an opportunity to think in terms of family planning relate to monogamy, age of marriage and consent to marriage. The personal laws in India except Muslim Law recognize monogamy. A bigamous marriage is not only void but is also punishable under the Penal Code.⁷³ The Muslim Law in India permits polygamy to the extent of four wives. Most Muslim countries such as Turkey, Iraq, Iran, Syria, Tunisia, Indonesia, Pakistan and Bangladesh have introduced reforms of varying degrees to correct the abuse of polygamy, but no legislative effort has so far been made in India to remove the hardship caused to the Muslim women by the continuation of the

practice of polygamy. Further, though Goa, Daman and Diu are part of India, but no effort so far has been made to extend Hindu Marriage Act, commanding strict monogamy, to these areas. The result is that a section of Hindus continue to be governed by the law which permits polygamy. Still, further, Hindu Marriage Act is not applicable to the members of any Scheduled Tribes within the meaning of Clause 25 of article 366 of the Constitution, unless the Central government, by notification in the official gazette, otherwise directs.

Female's age at marriage is an important determinant of fertility.⁷⁴ The various personal laws in India regulating marriage though require that the bride and the bridegroom must have completed certain age at the time of marriage, but none has regarded an under-age marriage to be void. It is only the secular law⁷⁵ that declares such marriage null and void. As far as the legal status of under age marriage under Hindu Marriage Act, which is applicable to more than eighty percent of Indian population, is concerned, it is neither void nor voidable but perfectly valid marriage.⁷⁶ The Child Marriage Restraint Act, 1929 also did not render such marriage void; it simply made such marriage punishable. The newly enacted Prohibition of Child Marriage Act, 2006 makes a provision to declare child marriage as voidable at the option of the contracting party to the marriage, who was a child at the time of marriage⁷⁷ It also makes a provision for declaring the child marriage as void in certain circumstances.⁷⁸

Suggestions

In the Constitution of India, more prominent mention than hitherto provided should be made of population stabilization and family planning. A Directive Principle on 'small family' should be included in Part IV. The duty to promote small family must also be included in Part IV-A dealing with Fundamental Duties. In Part III of Fundamental Rights, right of access to the means of family planning measures must be included. Various studies of differential fertility reveal that the status of women and fertility are inversely related to each other. As the position of the women in society is a key factor in the strategies for family planning, legal measures need be strengthened to improve the status of women.

V CONCLUSION

India has a long history of addressing population issues through policy and programs, which have not been able to yield the desired results. In the world today India ranks second in population numbers. She is set to overtake China, which at present is most populous country, very soon. There is an important legal aspect of population phenomena and family planning, which has not been sufficiently explored so far. Indian legal regime could not systematically compile all of its laws bearing on family planning. The various statutes, administrative guidelines and judicial pronouncements are often scattered throughout the general body of law. The significance of law to facilitate family planning lies in helping the State to secure Constitutional guarantee of socio-economic justice to the people of India.

There is a need to enact a social welfare legislation⁷⁹ which could be titled “The Responsible Parenthood Act”. The proposed legislation should encourage, facilitate and constrain the people to adopt small family. In particular it should raise the marriage age for all communities in India to 21 for both the boys and girls. Before marriage, it must be obligatory for the parties to an intended marriage to attend a short course of 2-3 days on responsible parenthood. The eligible couple must be told that child should not be simply the result of a sexual act, parenthood should be planned. Scientific and natural birth control measures should be explained to them. A certificate must be issued for attending this course. The law should provide for compulsory registration of marriages. Production of certificate on Responsible Parenthood must be made compulsory for getting the marriage registered. No compulsion should be prescribed with respect to the method of family planning. It should be left to the choice of the eligible couple. The proposed legislation should also contain the rules regulating various family planning methods. The emphasis must be that these measures are safe and easily available. The various suggestions given in Part III of this paper with regard to contraception, sterilization and abortion should be incorporated here. A duty must be cast on the State to provide a comprehensive, effective and easily accessible family planning infrastructure to assist people to adopt family planning methods of their choice. Parents having small family and either of them having voluntarily undergone sterilization shall be entitled to certain

incentives. Disqualification provisions should be extended to local bodies elections, members of House of State legislature and House of Parliament.⁸⁰

End Notes

¹ L.T. Lee, "Law and Family Planning", *Studies in Family Planning*, the Population Council, Vol. 2 (4), 81 (1971).

² For details see U. Tandon, *Population Law*, 5-16 (2003).

³ See Government of India, Planning Commission *First Five Year Plan (1951-56) to Eleventh Five Year Plan (2007-12)*.

⁴ Government of India, Ministry of Health and Family Welfare, *National Population Policy Statement (1976)*.

⁵ Government of India, Ministry of Health and Family Welfare, *National Population Policy Statement, 2000*.

⁶ No. A-43011/17/2000- Admin-I Government of India, Planning Commission, 11 May, 2000.

⁷ Registrar General and Census Commissioner of India, *Census of India, 2001*, Series 1, India-Paper 1 of 2001

⁸ In this paper the conceptual basis of family planning, primarily, relates to the reduction in birth rate.

⁹ Government of India, National Commission on Population, Ministry of Health and family Welfare, *India, The State of Population, 2007*.

¹⁰ Government of India, Ministry of Health and Family Welfare, *Annual Report*, 15 (1996-97).

¹¹ *ibid*

¹² *ibid*

¹³ Such branded pills now available in the market are ECROZ, MOTI, CHOICE and SUVIDHA. Recently, 'Janani' a voluntary organization and 'Conthech Devices.' a pharmaceuticals company have been allowed to sell oral pills under their one brand name of APSARA and 'MARILIN' respectively, *ibid*.

¹⁴ *Ibid*.

¹⁵ In order to popularize weekly OCP and bring a within the reach of common man the market price of SAHELI has been reduced from Rs.3.50 per tablet to Rs.1.50 per tablet. During 1995-96 a quantity of 55.10 lac such tables were sold, *Ibid*.

¹⁶ Government of India, Department of Family Welfare, *Annual Report*, 24 (1993-94).

¹⁷ S.Chandrasekha, *Population and Law in India*, 72 (1978).

¹⁸ J.Stephen and E.H. Kellog, "The World's Laws on Contraceptives", *Law and Population Monographs Series*, No. 17, 15 (1974).

¹⁹ Govt. of India Import Policy- April 1979 March 1980, Department of Commerce, in P.S. Sangal, "Law & Fertility Regulation." *Health and Population- Perspectives and Issues*, Vol.3, Nos. 1 & 2. 134 at 138 (1980).

²⁰ Gazette of India, Part-II, Section 3(i) Extraordinary supplement 108, 19 Oct. 1993 in *Annual Survey of Indian Law*, Vol. 29, 414 (1993).

²¹ S.Chandrasekhar. *op. cit.,supra* n. 17 at 73.

²² *A.I. Democratic Women Association V. UOI*, AIR 1998 SC 1371.

²³ *M/s E.Merck (India) Ltd. v.UOI*, AIR, 2001 Del. 326 at 334.

²⁴ UNFPA, *Survey of Contraceptive Laws* (1976).

²⁵ S.Chandrasekhar, *op. cit .supra* n.17 at 74.

²⁶ S.G.Singh 'India' in the Lee and Larson (eds.) *Law and Population*, 108 (1971).

²⁷ S.G. Singh, *India, id* at 111.

²⁸ *ibid*.

²⁹ B.P.S. Sehgal, *Women, Birth Control and the Law*, 74 (1991).

30 *Ibid.*
31 *Ibid.*
32 Government of India, *Economic Survey*, 256 (2007-08).
33 S.G.Singh. "India", *op. cit. supra* n.26 at 111.
34 G william, the Sanctity of the Life and the Criminal Law," in S.G. Singh, *ibid.*
35 B.P.S. Sehgal, *Women, Birth Control and the Law*, *op. cit. supra* n. 29.
36 *M.V. Mc. Murthy*, 470 (1965) 381 US.
37 L.C. Green, 'Sterilization and the Law', 5 *Malaya Law Review*. 105 (1963) in BPS Sehgal. *op. cit.*,
supra n.29 at 75.
38 Government of India, Technical Division, Ministry of Health and Family Welfare, No.11011/1/84
Ply dated 18.3.1996
39 B.P.Singh Sehgal. *op. cit.*, *supra* n 29 at 78.
40 Sec.88 IPC states that nothing which is not intended to cause death, is an offence by reason of any
41 harm which it may cause or be intended by the doer to any person for whose benefit it is done in good
faith and who has given a consent. Whether express or implied to suffer that harm to take the risk of
that harm.
42 Section 92- explanation mere pecuniary benefit is not a benefit within the meaning of sections 88, 89
and 92.
43 See H.S. Gour. *Panel Law of India* ,682 (1980).
44 *Ibid.*
45 Government of India, Ministry of Health and Family Welfare, *Annual Report*, (2001-02)
46 Act XL.V. of 1860.
47 MTPA Section 3 (2) (i).
48 *Ibid.*, Section 5.
49 *R.v. Bourne*, (1983) 3 AII ER 615 at 618.
50 B.P.S. Seghal. *op. cit. supra* n. 29 at 58.
51 MTPA, Section 3 (2)(i).
52 *Ibid.* Section. 3 (3).
53 MTPA, section 3(2)b(ii).
54 R.Shaw, *Abortion on Trial*, 93 (1968).
55 MTPA Regulation, 1975, Regulation 6.
56 Exception to Section 375 Indian Penal Code, 1860.
57 MTPA, Section 3(4)(a).
58 M.K.K. Menon, *Termination of Pregnancy* (Papers submitted to Seminar on abortion held on the
India International Centre (1974).
59 J.M.Thomas, B.M. Ryniker and Kaplan, 'Indian Abortion Law Revision and Population Policy, An
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60 Sec. D.C. Pande, "Some Inhibiting Factors in the Implantations of Medical Termination of
Pregnancy Act, 1971- A study of Acceptability." 16 *JILI* 673 (1974).
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63 MTPA section 3(2) (a).
64 *Ibid.*, section 3(2) (b).
65 *Ibid.*, section 5(7).
66 B.P.S. Sehgal, *op. cit.*, *supra* n. 29 at 56.
67 MTPA, section 4.
68 Government of India, Planning Commission, *Eleventh Five Year Plan*, 89 (2007-12).
69 The Constitution (Forty-second Amendment) Act, 1976, s. 57 (w.e.f. 3.1.1977)
70 The Constitution (Ninety-first Amendment) Act, 2000.
71 *Saroj Chotiya v. State of Rajasthan*, AIR 1988 Raj. 28; *Mukesh Kumar v. State of Rajasthan*, AIR
1997 Raj. 250 (DB); *Malaya Kumar Mohanta v. Collector Mayurbhanj*, AIR 1999 Ori. 5; *BK Parthasarthy*
v. Andhra Pradesh, AIR 2000 AP 256; *Javed v. Haryana*, AIR 2003 SC 3057.
72 See The Factories Act, 1948, S. 22(2), 27; Plantation Labor Act 1951, S.25; Mines Act, 1953,S 46
(1)(a) etc.

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- ⁷² The Special Marriage Act, 1954.
- ⁷³ Indian Penal Code, 1860, S. 494.
- ⁷⁴ For a detailed account see U. Tandon, “Law Relating to Marriage Age of Female and Population Control,” *Journal of Constitutional and Parliamentary Studies*, Vol. XXV, Nos. 1-4, 185 (1991).
- ⁷⁵ Special Marriage Act, 1954, S 24 (1).
- ⁷⁶ See *Smt. Nauni v. Narotam*, AIR 1963 HP 15; *Ms Ma Hari v. Director of Consolidation*, 1969 All LJ 623; *P.V. Venkataramana v. State*, AIR 1977 AP 43 (FB).
- ⁷⁷ The Prohibition of Child Marriage Act, 2006, S 3.
- ⁷⁸ *Ibid*, S 12.
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