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MATERNITY BENEFIT AS A FACET OF RIGHTS IN LABOUR WORKFORCE: IS IT A DISGUISE OF THEORETICAL ASPECT?

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ABSTRACT

The issue of gender equality and women empowerment has once again surfaced as an indispensable question that continues to divide civil society in the form of women's rights in the workplace. From time immemorial, this issue has been floating in almost every legal system around the world. Women in the labor workforce require protection in intricate situations like pregnancy so that they are not harassed in the name of employment. Thus, Maternity protection is recognized as an essential pre-requisite for women's rights and gender equality among the employees at work. In India, the underlying objective for the introduction of the maternity benefits program was to give full honor to the divine act of birth with utmost care and dignity by regulating the employment of women in various ways. Various Amendments can be seen in the light of varied issues faced by the women including postpartum depression. This research paper is an endeavor to study the question of law regarding the concept of maternity benefits schemes prevailing in India by giving an overview of the existing legislation. An analogy has been drawn by comparing the maternal health conditions in India and the United States of America. Moreover, the paramount questions that the papers pursue to answer is, "Whether the Code on Social Security, 2020 address the concerns of the women about the maternity benefits in reality or is just a plain disguise of theoretical aspect shattering before the complexities of the reality of the society?" and "Is United States of America an actual benchmark of comparison or just a glorified and patronized state in the global domain?". The authors have critically analyzed the prevailing policies and have also put forth some

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recommendations based on the analysis.

Keywords- *Maternity Benefit, Women Empowerment, Labor Workplace, India, USA.*

INTRODUCTION

"Maternity is divine"

India is a society which is predominantly a society based on the norms of patriarchy: a society ruled by an ideology of female subordination (the Confucian Three Bonds of Obedience-to father when young, to a husband when married, and to son when old-are the same and as abiding as the tenets of Manu,' the ancient codifier of Hindu social laws); a society that is accordingly composed mainly of cells of patrilineal-patrilocal families, with the economic controls (of land, -capital, and the labor processes of women and children) firmly in male hands. Thus, employment is critical for poverty reduction and for enhancing women's status. However, it is potentially empowering only if it provides the women an opportunity to improve their well-being and enhance their capabilities.

On the other hand, in case it is driven by distress and is low-paying, then it would only lead to an increase in a woman's drudgery. To safeguard the interests and rights of the women workforce, the Indian constitution guarantees a right to quality under Article 14 which precludes women from discrimination. Article 39 directs the government to take active measures and direct its policy towards securing that the citizens, men, and women equally, have the right to an adequate means to livelihood,[1] that there is equal pay for equal work for both men and women,[2] that the health and strength of workers, men, and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength. Article 42 ϵalls on the State to make provisions for securing justice and humane conditions of work and for maternity relief. The court reiterated in a number of judgements[3] that Article 42 of the Indian Constitution shall be kept in consonance

[1] INDIA CONST. art.39 (a).
[2] INDIA CONST. art 39(d).
[3] S*hah v. Presiding Officer, Labour Court, Coimbatore and others*, (1977) 4 SCC 384; ANURADHA ARYA V. PRINCIPAL GOVT GIRLS SENIOR SCHOOL (2013), gangama v. the secretary 2020.

while reading and deciding cases on The Maternity Benefit Act. Two countries stand out in maternal health issues while looking at the global level. India ranks second in the number of maternal deaths among developing countries in the world with 45,000 deaths in 2015. On the other hand, looking at developed countries, the United States is the only developed country with an increase in MMR from 7.2 in 1987 to 17.3 in 2013 a decade ago.[4] In this context, this journal seeks to establish a political discussion on reproductive health in India and the United States offers interesting differences in reproductive health status and reproductive health policy frameworks. Despite differences in reproductive health status and different policy approaches, there is a great need for policymakers to prioritize reproductive health, maternal mortality, and reproductive disease in both countries. The document first explains the health model of the female workforce and the concept of reproductive health.

Then, the state of reproductive health and reproductive health policies in India and the United States is reviewed. The next section provides a comparative perspective on reproductive health care between the two countries, focusing on similarities and differences between reproductive health and policy. This is followed by a brief background on the concept of maternal benefit in India. The Maternity Benefit Act, 1961, The Maternity Benefit (Amendment) Act, 2017, and Maternal Benefits under The Social Security Code, 2020 are discussed in detail. The last sections include the critical analysis of the Social Security Code, 2020, and the paper is concluded with some recommendations as suggested by the authors.

MATERNAL HEALTH POLICIES AND MATERNAL HEALTH IN INDIA AND THE US: HISTORY AND BACKGROUND

By the term maternal health, it is meant the health of women during pregnancy, the period of childbirth, and the postpartum period.[5] Maternal Mortality Ratio (hereinafter referred to as MMR) is the number of women who die from pregnancy-related issues or within 42 days of pregnancy termination per 100,000 live births.[6] Maternal mortality is considered to be the

[4] Pregnancy Mortality Surveillance System, Center for Disease Control and Prevention (Dec. 20, 2021, 9:29 PM), https://www.cdc.gov/reproductivehealth/maternalinfandhealth/pmss.html.

[5] World Bank (2017a), Health expenditure per capita (current US$) (Dec. 7, 2021, 11:00 AM), http://data.worldbank.org/indicator/SH.XPD.PCAP.

[6] World Health Organization (2016, November), Maternal Mortality Fact Sheet, (Dec. 10, 2021, 01:10 PM), http://www.who.int/mediacentre/factsheets/fs348/en.

extreme consequence of childbirth and almost 800 women die due to different pregnancy-related issues every day in 2015, with 99% in developing countries.[7]

The MMR declined from 556 per 100,000 live births in 1990 in India to 174 per 100,000 in 2015.[8] On the other hand, the MMR in the U.S. has virtually stagnated from 12 per 100,000 live births in 1990 to about 14 per 100,000 in 2015.[9] By all these data, it can be concluded that economic growth and development are insufficient in it for decreasing MMR, with other underlying reasons influencing maternal health.

MATERNAL HEALTH POLICIES IN INDIA

The highest number of maternal deaths in the world are unfortunately recorded in India and Nigeria. Although MMR for India was decreased in 2015, then also it varies from state to state. For example, it ranges from 81 per 100,000 in Kerala to 390 in Assam and even higher in rural areas.[10] Currently, India practices a mixed health care system that is dominated by private healthcare providers. It has been seen that nearly 72% of Indian households are opting for private outpatient care despite free public healthcare.[11]

When the private healthcare system is compared to that of public health care infrastructure, it can be seen that the latter suffers from acute shortages in human resources, financial support, as well as infrastructure which leads to low-quality public healthcare. Less than 5% of the annual gross domestic product is spent on health expenditure in India.[12] Approximately, only

[7] L Alkema, D Chou, *et. al*, Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group, 462–474 (2016).

[8] World Bank (2015a), *Maternal Mortality Ratio India*, (Dec. 16, 2021, 02:45 PM), http://data.worldbank.org/indicator/SH.STA.MMRT?end=2015&locations=IN&start=1990&view=chart.

[9] World Bank (2015b), *Maternal Mortality Ratio United States of America*, (Dec. 25, 2021, 03:56 PM), http://data.worldbank.org/indicator/SH.STA.MMRT?end=2015&locations=US&name_desc=false&start=1990 &view=chart World Bank.

[10] Census, *House listing, and Housing Census Data Highlights*, India: Government of India, (Jan. 01, 2022, 04:34 PM), http://censusindia.gov.in/2011census/hlo/hlo_highlightshtml.

[11] A Krishna, *Escaping poverty and becoming poor: who gains, who loses, and why?* World Development, 32(1), 121–136 (2004).

[12] P Berman, India's health: more practical solutions needed, The Lancet (Jan. 05, 2022, 06:22 PM) https://pubmed.ncbi.nlm.nih.gov/26700534/.

7 physicians and 17 nurses and midwives are available per 10,000 population in India.[13] On the other hand, in the labor workforce, the women do not have resources for consulting private outpatient care, they are limited to the health care facilities which the employer provides.

Infant mortality is closely related to reproductive education and participation in the women's workforce, but a separate analysis showed that women's workforce participation has no effect on infant mortality among women under seven years of education. The relative impact of maternal education on infant mortality is three times greater than that of women's participation in the workforce. The high mortality rate of girls in some parts of India is also closely linked to the length of maternal education and participation in the women's workforce. Participation in a women's workforce has a greater impact on infant mortality than infant mortality altogether.

Factors affecting healthcare utilization include the maternal age, education of women and society, social and economic status, cultural factors.[14] Health experts recommend allocating more resources to improve the public health system and the overall health system towards an integrated national health system built around a strong public basic health care system with a clearly defined role of support for the private and traditional sectors.[15] Reproductive health policies in India rely on public health care providers to provide medical care for reproductive health in rural areas. In the early 1950s, with a health imbalance in maternal mortality, the government relied on traditional birth attendants, many of whom were elderly women from the community who experienced an assisted delivery.

Along with the initiative made by the UN in the 1980s on safe motherhood, India also initiated the Reproductive and Child Health Policy in 1997, which was followed by the initiation of the National Population Policy in the year 2000, then the National Health Policy in the year 2002 and then the establishment of the National Rural Health Mission (NRHM) in the year 2005 took place which was based on the global health commitments for MDGs. NRHM aimed to

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[13] Government of India, *Annual Report 2013-2014*, New Delhi: Ministry of Health and Family Welfare, Government of India, (2014).
[14] Y Balarajan, S Selvaraj, & S V Subramanian, *Health Care and Equity in India*, The Lancet (Jan. 14, 2022, 12:53 AM) https://pubmed.ncbi.nlm.nih.gov/21227492/.
[15] A Bang, Health insurance, assurance, and empowerment in India, The Lancet (Jan. 13, 2022, 01:13 AM) https://www.thelancet.com/journals/lancet/article/PIIS0140-6736 (15)01174-5/fulltext.

improve the availability and accessibility to quality health care and to encourage women to access public healthcare.

Several health policies related to maternal healthcare were implemented at both the federal as well as state-level in India. Conditional cash incentives to pregnant for in-hospital childbirth were offered at the federal level by Janani Suraksha Yojana in 2005. The Janani Shishu Suraksha Karayakaram was formulated for free medical assistance which would include nutritional supplements, checkups free hospitalization, etc. during pregnancy. Indira Gandhi Matrutva Sahyog Yojana was formulated which provided cash to compensate a pregnant woman for the loss of wages which was suffered by her during pregnancy, subject to age and parity conditions.

These federal policies have been complimented by cash incentives and services to other levels of government at the discretion of the government. In all policies, tested in some way or for all, rural or urban, direct cash incentives or free medical services were provided through the public health system. These policies have produced mixed results from inconsistent implementation. There is not enough evidence to show that money and free medical care are associated with better reproductive health.

MATERNAL HEALTH AND MATERNAL POLICIES IN THE U.S.

For the US, there is a difference in MMR. MMR is referred to as "pregnancy-related deaths" which includes the death of a woman while pregnant or within 1 year of pregnancy termination. This period is regardless of the duration or site of the pregnancy that is from any cause that is related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. This is a broader conceptualization, which is limited to 42 days and the pregnancy-related causes.

Regardless of classification, pregnancy-related deaths have not decreased in the United States. The United States, with 14th MMR, is far behind in other countries such as Singapore (10), France (8), Canada (7)), and Poland. (3).[16] On the other hand, the United States spends about 17% of its gross domestic product per year on healthcare services, the highest rate in the

[16] World Bank (2017c), World Maternal Mortality Ratio (Jan. 15, 2022, 08:44 PM), http://data.worldbank.org/indicator/SH.STA.MMRT.

world.[17] Health care per capita in the United States was approximately $ 9,400 per person in 2014, the third-highest in the world.[18]

In the United States, health care is largely privatized by people who are supposed to purchase private health insurance. Maternal and child health insurance is also provided by Medicaid, the Child Health Insurance Program, the Affordable Care Act, and private insurance providers. Under the Affordable Care Act, maternity care and maternity services are covered by significant health benefits. However, payments for the cost of pregnancy, childbirth, and postpartum care may vary depending on the health plan and some individual "grandparent" plans that do not include pregnancy and childbirth.

COMPARATIVE ANALYSIS AND DISCUSSION: MATERNAL HEALTH IN INDIA AND THE U.S.

There are parallels as well as sharp distinctions in the state of maternal health and health policies in India and the U.S. In this section, first maternal health trends are compared between India and the U.S. followed by a discussion about the differences in health care policy structures.

1. Despite medical advances and a sharp decline in infant mortality, reproductive health care is still scarce in both countries. Complete MMR rates vary between India and the United States but are still higher for each country than their counterparts (developing countries in India, developed countries in the United States).
2. There are significant differences and differences between states within each country.
3. There are significant differences in MMRs between different income groups, between races and ethnicities, suggesting structural differences in access to, access, and use of health care.

India has adopted a direct subsidized medical care system through its comprehensive public health care system and direct money transfers aimed at encouraging the use of health care. In contrast, reproductive health care in the United States is more personal and insurance-based. The following comparative analysis highlights the similarities and differences

[17] World Bank (2017b), *Health expenditure, total (% of GDP)* (Jan. 20, 2022, 03:47 PM), http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS?locations=IN.

[18] Id.

between these two approaches and highlights the few missing links between health policy attitudes and reproductive health care.

Both countries recognize economic disparities and cater for low-income women, and almost free public health services in rural India and Medicaid in the United States. In India, social classes and class groups are also recognized and free health care is provided. However, enrollment in certain reproductive health policies is limited to 19 years and older, with the basic assumption that women are not legally allowed to marry before the age of 18, so only pregnant women over the age of 19 can send applications. These age limits do not apply to insurance structures in the United States.

However, both countries fail in addressing the broader conceptualization of maternal health and choice in the following ways:

1. Systematic data collection is absent for maternal morbidity in India as well as the United States.[19] In the -United States, there was an increase of approximately 26% in hospitalization and at least one indicator of severe gynecological diseases from 2008-2009 to 2010-2011.[20] In India, the gynecological disease is not included in reproductive health policies, unless health problems occur during childbirth.
2. Negative psychological outcomes do not take priority in health policy. The medical system does not accept psychological factors such as stress, contraceptive area, depression, or postpartum depression as medical conditions. In India, only 1 in 4 women is diagnosed with postpartum depression.[21] It is more likely to occur in women under the age of 20 or over 30, in school under the age of five, unhappy marriages, victims of physical abuse, favoritism for a boy, low birth weight, and family history of pain.[22]

   In the United States, 1 in 7 mothers suffers from postpartum anxiety and depression which may require intervention.[23]
3. Reproductive health policies may not include and address high health risks such as

[19] A Creanga, C Berg, *et al*, *Maternal Mortality and Morbidity in the United States: Where Are We Now?* Journal of Women's Health, 23(1), (Feb 10, 2022, 10:15 PM), https://doi.org/10.1089/jwh.2013.4617.
[20] Id.
[21] R Savarimuthu, P Ezhilarasu, *et al*, *Post-partum depression in the community: a qualitative study from rural South India*, International Journal of Social Psychiatry, 56(1), 94–102, (2010).
[22] Id.
[23] American Psychological Association Postpartum Depression (Feb. 15, 2022, 11:22 PM), http://www.apa.org/pi/women/resources/reports/pos tpartum-depression.aspx.

substance abuse, chronic anxiety, depression, obesity and obesity, and malnutrition in young people can have serious consequences for the health of mother[24] and child in the future.[25]

4. The role of politics in reproductive health is extremely rare in evaluation. In India and the United States, reproductive health has not been influenced by the party, politics, and the judiciary in formulating and implementing policies. In India, recent laws provide for the extension of monetary policy incentives from rural areas only to the rest of the country, with a significant financial burden, making a unique identification number (equivalent to a social security number) for receiving cash.

These changes have had an impact on the inclusion or exclusion of eligible women in the policy, the suitability of cash incentives, and the adoption of policies. In the United States, a review of contraception (Burwell v. Hobby Lobby Stores case),[26] family planning funding, review of abortion laws, clinical and current clinical needs, uncertainty about future health policy, there may be nothing missing. About the medical definition of pregnancy or childbirth, it will still have a long-term impact on reproductive health and maternal mortality rates.

MATERNITY BENEFIT AMENDMENT ACT, 2017

To promote women's participation in the workforce, the Maternity Benefit Act, 1961,[27] was amended to provide more beneficial entitlements to women employees. However, they appear to impose the entire cost of these benefits on employers, which could lead to a negative trend in hiring women in meaningful roles. In 2017, the Parliament of India passed an amendment to the Maternity Benefit Act, 1961(MB Act),[28] which brought about three key changes.

While the MB Act had previously granted female employees maternity leave, the amendment increased the duration of leave entitlement from 12 to 26 weeks. In addition, the amendment also introduced leave for adoptive and surrogate mothers. Finally, the change provides that

[24] U. Ishwarya v. Director of Medical Education, Directorate of Medical Education, and Others, (W.A.No.374 of 2018).

[25] S L Ramey, P Schafer, *et al, The preconception stress, and resiliency pathways model: A multi-level framework on maternal, paternal, and child health disparities derived by community-based participatory research*, Maternal and Child Health Journal,19(4), 707–719 (2015).

[26] Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751 (2014).

[27] Maternity Benefit Act, 1961, No. 53, Acts of Parliament, 1949 (India).

[28] The Maternity Benefit (Amendment) Act, 2017, No 6, Acts of Parliament, 1949 (India).

every company with 50 or more employees must have a day nursery.

The Maternity Benefit Act, of 1961 was enacted to ensure that young mothers are not hindered in their work by childbirth and child-rearing obligations. Women have usually played a primary role in childcare, even if they have partners or spouses. For working women who are not adequately supported in care, this often becomes an obstacle to efficient work. To counteract this and to give employees the time and space they need for a new child, the law requires employers to grant employees paid leave. The change also introduced a requirement to provide a day nursery to encourage women to return to work without worrying about their young children being left unsupervised.

While the law certainly has good intentions, it is important to examine its social and economic implications. In the case of any law, especially those enacted for the benefit of specific groups, there must be no negative consequences that conflict with the good intentions of the law. Without this assessment, laws can be counterproductive, offering nothing but empty promises of equality.

According to the MB Act, the cost of maternity is looked after by the employer by providing the employee with paid leave during her absence.[29] The Supreme Court in the case of Municipal Corporation of Delhi v. Female Workers (Muster Roll) and another, considered the law regarding the grant of maternity leave.[30] This benefit is not available to male workers and is, therefore, a gender-specific benefit. Therefore, by hiring women, many employers run the risk of incurring additional gender-specific costs if these women choose to become mothers. Consequently, the MB Act will likely be counterproductive because employers will choose to cut costs by not hiring women at all, which will reduce female workforce participation. Therefore, it can be said that the law has the potential to foster gendered discrimination in the workplace.

However, the main problem with the MB Act is that the cost of maternity leave is borne directly by the employer, which makes hiring women a burden for them. This does not mean, however,

[29] Neetu Bala v. Union of India and Others, (CWP No.6414 of 2014); K Chandrika v. Indian Red Cross Society, (2007 (3) SLJ 479 Delhi).

[30] (2000) 3 SCC 224.

that women should not be eligible for maternity benefits, which means that the role of the State in supporting working mothers is crucial to minimize discrimination in the workplace and to promote the participation of women in the labor force. The government has a vital role to play in truly implementing it, even though private players can be made to work towards social issues, such as increased employment and equal opportunity.

For Instance, the Pradhan Mantri Protsahan Rozgar Yojana Scheme, under which the government makes a portion of provident fund contributions for certain employees in an endeavor to generate more employment. It is important to note that under the Employees State Insurance Act of 1948[31] (ESI Act), maternity allowance payments can be claimed by female workers under social security.

Although the employer incurs costs in the form of regular contributions to the state employee insurance, which in turn finances the maternity allowance, these contributions are not gender-specific, i.e. the contribution amount does not differ according to the sex of the employee. Employers and employees must pay the same contribution rate regardless of whether they are male or female. Under this system, the output may therefore be gender-specific (since only female employees can claim maternity benefit), the costs incurred by the employer are therefore not gender-specific.

MATERNITY BENEFIT UNDER THE CODE OF SOCIAL SECURITY, 2020.

The Social Security Code 2020 was approved by both houses of Parliament and received presidential consent on September 28, 2020, but the official gazette informing the effective date of the code has yet to be published. The SS Code was issued to amend and consolidate social security laws to extend social security to all employees and workers in the organized or unorganized or another sector.

Section 14 of the Maternity Benefit Act of 1961,[32] gave the competent government the power to appoint inspectors to apply the provisions of the Act. In terms of the Social Security Code 2020,[33] the responsibilities of implementing the provisions of the Code have been delegated to

[31] The Employees State Insurance Act, 1948, No. 34, Acts of Parliament, 1949 (India).

[32] Maternity Benefit Act, 1961, §14, No. 53 of 1961 Acts of Parliament, 1949 (India).

[33] The Code on Social Security, 2020, No. 36, Acts of Parliament, 1949 (India).

a new authority, the Auditor-General. The Assistant Auditor also can investigate complaints by non-compliance and make arrangements that he or she considers appropriate and appropriate depending on the nature of the complaint.

The inspector cum-facilitator, before introducing charges against the employer for failing to pay maternity allowance to a woman eligible under the Code, will provide the opportunity for the employer to comply with the relevant conditions through written instructions, which will set the time to comply and, if the employer complies with the order within that time, no such lawsuit will be brought against the employer.

However, this possibility has not been granted to the employer, if the non-payment of maternity benefit[34] is repeated within three years from the date on which the first violation took place. In that case, criminal action is instituted under the provisions of Chapter XII of the Code.

Under Section 142 of the new Code,[35] every employee or employee of the informal sector who requests maternity allowance under the Code is required to declare their identity and the identity of the person designated to receive the maternity allowance in case of his or her death, through Aadhaar Number. Without the Aadhar number, no woman will be able to access fertility benefits. This requirement was not included in the Maternity Benefit Act of 1961.[36] The new Code has also increased penalties if an employer violates the Code's provisions regarding maternity benefits. Under Section 133 of the Code,[37] anyone who as an employer does not provide maternity benefits to which a woman is entitled under the Code is punished with a prison sentence of up to six months or a fine that can extend to INR 50,000 or both.

CRITICAL ANALYSIS OF THE MATERNITY BENEFITS UNDER "THE SOCIAL SECURITY CODE, 2020."

After the research was done, it can be stated that the main objective of the introduction of the Social Security Code, 2020 was to consolidate laws to all employees, but the major question

[34] Smt. Neetu Choudhary v. State of Rajasthan and Ors. (RLW 2008 (2) Raj 1404).
[35] The Code on Social Security, 2020, § 142, No. 36, Acts of Parliament, 1949 (India).
[36] *Id* at 10.
[37] The Code on Social Security, 2020, § 133, No. 36, Acts of Parliament, 1949 (India).

which thus arises is whether the maternity interests of the female workers are getting protected or not. The Code has been proposed to subsume a few of the Central Labour Law Acts under the garb of 'simplifying and rationalizing' the said provisions. But in examining the provisions of the Code relating to reproductive benefits mentioned in Chapter VI of the Code, the intention cannot be fully covered.

Providing maternity benefits to every employee is a basic social responsibility of the state and the employer. But it is quite clear in India that generous maternity benefits provide benefits to only 1.3% of female employees in general. Ensuring maternity allowance is the cry of all.[38] This is important to ensure women's empowerment and gender equality.

A positive impact is yet to be seen from the Maternity Benefits (Amendment) Act 2017 on women's labor force participation. This is due to the drop in women's participation in more than five out of ten sectors since the implementation of the act.[39] Approximately 12 million women lost their jobs in the year 2018-2019 solely due to the Amendment in the Act. Even though there has been some help of the amendment in terms of the retention rate of women up to 56%, which earlier used to be just 33%, there has been a reduction in the total number of women in the workplace.[40]

A gross underrepresentation in the labor market is evident as only 22.3% of women participate in the labor market, resulting in a gender gap of approximately 72%. A targeted policy is required to cater to the issue of utmost importance. It is pertinent to note that the above findings are based on statistics from 2019 and it is a fair assumption to say that the COVID-19 crisis would have only exacerbated the above issue.[41]

The act was a progressive move towards encouraging female workforce participation.

[38] Manavi Kapur, *India's generous maternity leave policy fails to cover 99% of women who need it* (Jan. 20, 2022, 8:37 PM), https://scroll.in/article/938600/indias-generous-maternity-leave-policy-fails-to-include-99-of- the-women-who-need-it.

[39] ALFEA JAMAL, MATERNITY BENEFITS ACT YET TO HAVE A POSITIVE IMPACT ON WOMEN LABOR FORCE PARTICIPATION: REPORT, HINDUSTAN TIMES (JAN. 20, 2022, 10:00 PM), HTTPS://WWW.HINDUSTANTIMES.COM/SEX-AND-RELATIONSHIPS/MATERNITY-BENEFITS-ACT- YET-TO-HAVE-POSITIVE-IMPACT-ON-WOMEN-LABOUR-FORCE-PARTICIPATION- REPORT/STORY GKEABH8FTKQ8TH5OGPVAAL.HTML.

[40] Id.

[41] M**ADHU DAMODARAN AND ANIMAY SINGH**, *MATERNITY BENEFITS UNDER THE NEW LABOUR CODES: A MISSED OPPORTUNITY?* TIMES OF INDIA (JAN. 25, 2022, 8:05 PM), HTTPS://TIMESOFINDIA.INDIATIMES.COM/BLOGS/VOICES/MATERNITY-BENEFITS-UNDER-THE-NEW-LABOUR-CODES-A-MISSED-OPPORTUNITY/.

However, in the world, India still stands amongst the bottom 10 countries in terms of women's workforce participation. In FY 2019-20, the Women's Labour Force Participation Rate (LFPR) for India stands at 20.52% compared to 20.71%in FY 2018-19.[42] Moreover, a comprehensive analysis covering the views of all the stakeholders including male employees, felt the act was one-sided. As per the study approximately 36%[43] of the male respondents thought that both parents should get paid leave for childcare.

Due to the lack of awareness about the act, only 40% of all employers provide the mandated 26 weeks of paid maternity leave. As per the report, 53% believe that the act is not cost-effective at present, but that it will be beneficial in the long run. The report also suggests that an increase in the cost and increased burden on fellow employees are some of the fallout employers are attributing to the act.[44]

RECOMMENDATIONS AND SUGGESTIONS

There is a need to conceptualize these Maternity Benefit laws in terms of what they need to resolve and what they are purportedly resolving. In a developing country like India, there is a need to rectify the problem from a grass root level so that participation of women in the labor workforce remains intact and does not deteriorate further. Hence the authors propose the following rectifications-

1. The regulation under Section 59 (3) prohibits "hard work" performed by any woman within a specified period before the expected date of delivery. But the same has not been clarified, about what is considered in the context of "hard work". Therefore, there is a need for a specific and uncomplicated interpretation of the word "hard work" to put "assertiveness" so that employers are held accountable for unsafe work as female employees, especially in the informal sector, are often involved in risky activities as well as to ensure their correct and consistent interpretations in the Code.
2. The concept of paternity leave seems to be missing in the code. That eventually will miss out on the possibility of spreading the message that the responsibility of running a family should be of both the parents. According to the MB Act, the cost of maternity is

[42] *Id* at 35.
[43] Id.
[44] Id.

looked after by the employer by providing the employee with paid leave during her absence. This benefit is not available to male workers and is, therefore, a gender-specific benefit. Therefore, by hiring women, many employers run the risk of incurring additional gender-specific costs if these women choose to become mothers. This can also be supported by the judgements of Rakesh Malik v. State of Haryana[45] and Vijendra Kumar v. Delhi Transport Corporation, Govt. of NCD.[46] The respective courts in both the cases rejected the prayer of developing a policy related to Paternity leave.

3. The code shall also cover and extend all the maternity benefits to LGBTQ parents, as it was implemented in 2005 in the USA.
4. Maternal health, maternal mortality, and maternal morbidity are the subjects of major concerns and there is an urgent need for policymakers in India as well as the U.S. to prioritize maternal health.
5. Increasing focused general awareness campaigns for the general public either through efforts within organizations or through a popular media campaign. A Deeper investigation of reasons for non-access or non-utilization of public medical healthcare shall be conducted.
6. Conduct a legal study of powers of the Labour Commissioners that can be utilized to ensure compliance of the MBAs and how they need to be augmented and highlighted for effective action to implement the law. Conduct gender sensitivity programs to imbibe positive attitudes amongst Authorities.
7. To understand the gap between the authority's actions and the maternity benefit awareness among the stakeholders, a rapid assessment needs to be conducted. This would, in turn, identify the problems and also conduct an in-depth audit within the states to understand the reasons for gaps.
8. The focus of maternal health policies shall be moved beyond focusing on the MMR and shall also include monitoring of short-term and long-term maternal morbidity, social, psychological, and cultural factors.
9. The main problem with the MB Act is that the cost of maternity leave is borne directly by the employer, which makes hiring women a burden for them. This does not mean, however, that women should not be eligible for maternity benefits, which means that

[45] (2013) SCC OnLine P&H 3546.
[46] [226] 2015 SCC OnLine CAT 3012.

the role of the State in supporting working mothers is crucial to minimize discrimination in the workplace and to promote the participation of women in our force.

CONCLUSION

Since reproductive health is multifaceted, health infrastructure should be integrated vertically according to severity and needs and equally integrated with social development services in different organizations, policies, places, and activities. The integration of medical care involves integrating services with the non-health sector with traditional and non-traditional partners to support a full range of important prevention, promotion, and improvement activities. The public health perspective can promote greater participation and support for women. In India, where about 60% of the population still lives in rural areas, traditional systems symbolize the knowledge of one's authority, and greater confidence in the traditional style of care, even if it does not conform to medical practices.

In conclusion, reproductive health care services and policies must strive to achieve a positive health status for every woman that enables her to work at the highest level of ability to achieve her personal goals.[47] Only such a general understanding of reproductive health can direct political efforts to prioritize reproductive health not only in India and the United States but in other countries as well. Thus, it can be concluded that although the U.S. is a developed country and has better stakes in the field of MMR, both the countries including India as well the U.S. needs to be more advanced when compared with their subsequent countries. Also, it is very clear from the research that though the Maternity Benefit Act, 1961 has been amended in the year 2017, and not much improvement has been seen in the statistics of the number of working women. Instead, a steep decline can be seen in their number. Thus, it is believed that the situations may improve in the long run as it is presumed that the awareness among people would increase in the future. It can be concluded that in the present times, the practical reality is far different from the theoretical aspect of the same.

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[47] Air India v. Nargesh Mirza, AIR 1981 SC 1829.