Dataspeak
Early Marriage and Health

Highlights from the report produced by
Sama Resource Group for Women and Health

Sama

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[i] This summary contains edited excerpts from the main report of 2015, Dataspeak: Early Marriage and Health. For the full report, please see: www.samawomenshealth.in or contact Sama Resource Group for Women and Health, at sama.womenshealth@gmail.com Acknowledgements from the report: For assistance in coordinating the research for the report, we are grateful to Ruchi Bhargava and to Deepa V., Pooja Dhawan for the initial mapping of data and to Susheela Singh for her help with tabulation of data. We also thank Sarojini N. and Vaibhao Ambhore for conceptualizing the research and their inputs on the analysis and Anindita Majumdar for reviewing and contributing to some chapters of the main report. We are extremely grateful to the American Jewish World Service (AJWS) for supporting the research and this publication.

CONTENTS

GLOSSARY

National Health Mission (2012–2017), Ministry of Health and Family Welfare: The National Health Mission is a national health program that encompasses the National Rural Health Mission and the National Urban Health Mission.

National Policy for Empowerment of Women (2001), Ministry of Women and Child Development: The policy objective is to bring about the advancement, development and empowerment of women and to eliminate all forms of discrimination against women in political, economic, social, cultural and civil spaces.

National Policy for Children (2013), Ministry of Women and Child Development: The policy aims to promote and protect the rights of children to survival, health, nutrition, education, development, protection and participation. It is the first policy document in India that specifically highlights 'disability' as basis for discrimination.

National Youth Policy (2014), Ministry of Youth Affairs and Sports: The policy mandates empowerment of youth in the age group of 15–29 years to achieve their full potential and identifies and suggests policy interventions in 11 priority areas.

National Strategy Document on the Prevention of Child Marriage (2013), Ministry of Women and Child Development: The strategy document on child marriage reflects the commitment of the Government of India to curb child marriage and provides broad guidance to state and district governments to help shape their interventions to end child marriage.

National Family Health Surveys (NFHS): The surveys were initiated in the early 1990s in India and are a nationally important source of data on population, health and nutrition. Four surveys have been conducted: NFHS 1 (1992–1993), NFHS 2 (1998–1999), NFHS 3 (2005–2006) and NFHS 4 (2015–2016).

District-Level Household and Facility Surveys (DLHS): These surveys were initiated in 1997 to provide district-level estimates on health indicators as well as to monitor progress in the implementationof the Reproductive and Child Health Program. Four surveys have been conducted: DLHS 1(1998–1999), DLHS 2 (2002–2004), DLHS 3 (2007–2008) and DLHS 4 (2012–2013).

EARLY MARRIAGE AND HEALTH IN INDIA—LETTING THE DATA SPEAK

Why this review

Recent studies on early and child marriage in India emphasize that deep analysis of socioeconomic influences, including education, poverty and urbanization as well as cultural and social norms, is necessary to address the phenomenon. There is acknowledgement that early and child marriage have health linkages, but the research to date rarely extends beyond the consequences for maternal and infant health, thus excluding any comprehensive understanding of the impact of early marriage on other aspects of health.

The majority of efforts to address early and child marriage have been located outside the health system, despite its wide reach and its capacity to identify the implications of early marriage upon the health of girls and women.

According to Sama, a Delhi-based resource group working on issues of health and human rights, recent initiatives by the health system oriented toward adolescents provide opportunities to explore and conceptualize public health interventions and the role of the health system in addressing early and child marriage.

To understand how to maximize that potential, Sama initiated research on current national data and strategies in India—including those aimed at young people—to understand their implications for the health of women in early marriages.

Research design and questions

The research, conducted from August 2014 to January 2015, involved the systematic mapping and analysis of literature and data and a review of national and state health policies, programs and strategies relevant to early and child marriage and health outcomes in India.

The following questions guided the research:

- What information is available on early marriage in the context of health?
- What does analysis of the data highlight and what gaps are evident in the data?
- What are the existing public health responses to early marriage and what impact are they having?

- What are possible areas for future research and advocacy on early marriage and health?

Six national policies, seventeen national programs, two national strategies, thirteen five-year economic plans and eighteen state programs were reviewed and analyzed. Statistical data derived from:

- National Family Health Surveys, 1992–1993, 1998–1999 and 2005–2006
- District Level Household and facility Surveys, 1998–1999, 2002–2004 and 2007–2008
- Common Review Mission Reports, 2007–2012
- Joint Review Mission Reports, 2008–2011
- Annual Health Surveys, 2010–2013
- Sample Registration Surveys, 2010–2012 and 2011–2013
- Census of India, 2011
- Technical Report India HIV Estimates, 2012
- HIV Sentinel Surveillance reports, 2008–2009
- Medical Certification of Cause of Death reports, 2008, 2009 and 2010
- Statistics on Women in India, 2010
- National Crime Records Bureau, 2010, 2011, 2012 and 2013.

Research limitations

The primary data sources—the National Family Health Surveys (NFHS) and the District-Level Household Surveys (DLHS)—collect overall health-related data for the age cohort of 15 years to 49 years; hence presentation and analysis of data for the research was limited to this age cohort. In the surveys there was no collection of information either from or about anyone younger than 15 years. The review was therefore largely limited to the 15–24 year age group. For comparative analysis, information available for older age group cohorts, such as 25–49 years, was included where possible.

Existing data do not consistently define indicators, for example by age, marital status, geographical location or social group. While this is an important finding on its own because it highlights possible future improvements in data gathering, it also limited analysis in some areas.

Reading this summary

This summary highlights some of the central findings of the Sama review on early and child marriage and health, with selected excerpts from the report presented in bold (page numbers in brackets refer to the report page where the full citation is found). As the researchers concluded, the findings necessitate discussions at several levels toward future engagement on these issues: first, at the conceptual level to strengthen the understanding of early marriage and the implications for health in that context; second, at the level of gaps in information within the policies and programs as well as from available demographic and health data; and third, areas for future engagement through research and advocacy.

REVIEW FINDINGS

Marriage and early marriage in India

Marriage in India continues to be largely characterized by its imperative, universal nature. Strict prescriptions by social kin groups and communities, often reinforced by governance, legal and other institutions, shape norms and values governing marriage. Attempts to negotiate or breach patterns of marriage are met with negative repercussions, including sanctioned or condoned violence. For instance, exogamy marriages (inter-caste self-choice marriages and intra-caste marriages that violate village norms) are targeted through honor killings. Even when such marriages are arranged by the family, women are perceived as being taken away by those who are not eligible to do so, which thus denies men who are 'eligible'. This is intrinsically linked to the shortage of women for marriage—the 'marriage squeeze' that is happening due to the skewed sex ratio in certain parts of the country (Kaur, 2012).

According to the law in India, 'child marriage' is defined as marriage involving girls younger than 18 years and boys younger than 21 years (Child Marriage Prohibition Act, 2006). A marriage that involves someone younger than these ages is referred to as a child marriage and is thus voidable by law. 'Early marriage', however, continues to be a relative concept, remaining outside the parameters of a clear and consistently applied definition.

Early and child marriage is prevalent in many parts of the world, including India. In 2010, according to a United Nations Population Fund report (2012), one in three young women aged 20–24 (34 percent, or 67 million) globally were married as girls. Half were in Asia, one-fifth in Africa. About 12 percent of them were married by age 15. India has among the highest global rates of women married at age 20–24 years, at 77 percent. It is surpassed only by certain countries in western and middle Africa, which have rates up to 79 percent (Andrist, Manjistha and Desai, 2011).

Evidence links early marriage to poverty, migration, gender and sexuality norms (related to virginity, motherhood and family honor). Concerns around the sexuality of young women and negative perceptions tied to the inability to 'protect', along with perceptions of increased vulnerability and challenge to the honor of social kin groups motivate early marriage in situations of instability due to immigration and migration, vulnerability to natural disasters and violence (UNFPA, 2012; Nirantar Trust and Sadbhavana Trust, 2014). Situations of humanitarian crisis or disruption of social structures also hasten marriage, especially among young women (UNICEF, 2001).

Definition of early marriage presents complexities

The review of policy and program documents as well as other literature in India indicates that the term 'early' frequently overlaps with 'child' marriage. While 'early' broadens the scope with regard to the age at which marriage is culturally or legally acceptable across countries or regions, such an understanding was found limited in the literature reviewed in this study. In India, there is the legal prescription of age at marriage, which, as noted, differs for women and men (18 years and 21 years, respectively).

The difference in the legally acceptable ages at marriage for women and men contradicts the argument for attainment of legal 'majority'. Perspectives that determine the difference between what is an acceptable legal age for women and for men are gendered and closely linked to the control of girls' sexuality, the reinforcement of stereotypes or traditional notions about women's gender roles in families and society as wives and mothers.

The relativity in the understanding of 'early' poses further complexities: Early can be determined by choice, aspirations, situations and opportunities that women, men and communities may perceive as having. This raises questions and dilemmas regarding early marriage. According to the NFHS 3, 74 percent of women in India were married before they were 20 years old. Would marriage for women at 19 or 20 years not be considered early? And how do we understand self-choice marriages that may be early? Discussion of these considerations is missing in policy, program and strategy documents.

Population politics drives age-at-marriage concerns

While classical academic research explored the relationship between age and marriage at a conceptual level, later research began to inform policy regarding marriage and demography. The links between marriage and demography also arose in relation to the idea that age at marriage and population growth may be linked in significant ways (Caldwell, 2005).

Within population policies and programs, the motivation to delay age at marriage is linked to the control of fertility. Early onset of sexual activity and the pressure on young married women to prove their fertility as soon as possible after marriage results in high rates of fertility (WHO, 1999).

> **More than half of the married women aged 15–19 years (58.2 percent, or one in six women at that age) had begun childbearing at the time of the survey (NFHS 3); 12 percent of women aged 15–19 years were mothers; and 4 percent of the women in the same age group were pregnant with their first child. [p. 49]**

The continued preoccupation with fertility and demographic transitions has drawn attention to women in early marriages and toward increasing use of contraception to control fertility. Women, and to some extent men, in early marriages are thus viewed instrumentally for achieving larger public health goals.

Programs and schemes providing incentives for the delay of marriage for girls contain conditionalities that allow access to those families that do not have more than two children and/or have opted for a permanent method of contraception, according to Sama's analysis of several schemes.[ii] The focus of these initiatives is on improving the status of girl children and adolescents, but they create contradictory situations by adoption of the two-child norm, which has proven to have extremely negative implications, particularly for girls and women.

Programs and policies on health that include young people and early marriage

Adolescents and young people in India have through the years been largely perceived within a broad spectrum of public health, population or women's empowerment programs and policies. More recently, plans, policies and programs to address the particular needs of young people have started to evolve. However, the perspectives on the health of young people within these plans, policies and programs remain limited, falling largely within the frame of fertility control and/or maternal and child health. Such programs and schemes do not substantively address aspirations and concerns of adolescents or their overall physical and mental well-being. Nor do they substantially address the range of issues related to early and child marriage.

> **The Adolescent Reproductive and Sexual Health of 2006 (under the NRHM) aimed to reduce the incidence of maternal mortality and teenage pregnancy, meeting unmet contraceptive needs, lowering the incidence of STIs and preventing the rising incidence of HIV among young people aged 10–19 years. It acknowledged female mortality was due to discrimination, lower nutritional status, early marriage and complications during pregnancy and childbirth among adolescents. [p. 35]**

Health programs do not identify early marriage as a health concern

Although some programs that have addressed the health of girls and young women referred to child marriage, they did not treat such marriage as a public health concern.

[ii] Examples of such schemes include Bhagyasri Kalyan Bima Yojana (1999), Janani Shishu Suraksha Yojana (2011) and Dhana Lakshmi Yojana (2008).

> **The National AIDS Control Programme (1992) does not address any health issues arising from early and child marriage but aims to develop awareness and a positive attitude toward population and development issues, leading to responsible behavior among students and teachers and, indirectly, among parents and the community at large. [p. 31]**
>
> **The 2015 draft national health policy is still in the process of finalization but does not include a focus on adolescent health—only children's health. The only reference to early and child marriage is in the section on 'population stabilization' in the context of improved fertility levels. [p. 29]**

Even though the National Rural Health Mission includes a strategy on adolescent reproductive and sexual health (launched in 2006) and recognition that early marriage leads to many health complications, actual engagement on issues and strategies to address them continue to be limited.

The National Health Mission explicitly recognizes early and child marriage as a determinant of health. While this is an important acknowledgment, other social determinants of health, such as poverty or discrimination, need to be linked to early marriage, and the implications for health need to be explored substantively toward comprehensively addressing the issue.

> **The National Health Mission (2012–2017) recognizes numerous physical and mental health consequences associated with early age at marriage for girls. It states that girls aged 15–19 years are twice as likely to die in pregnancy or childbirth as women aged 20–24 years. It acknowledges the limited autonomy and mobility of young women in marital situations, which has negative consequences for access to health information and services. The National Health Mission also stresses the need to eliminate gender gaps in education toward addressing early marriage. The National Health Mission flags a system-wide response to gender-based violence, which includes strengthening of capacities for health care providers and referrals. It takes cognizance of convergence and concerted action on social determinants while also recognizing child marriage as a determinant of health. [p. 38]**

Strategies to address early marriage mostly operate outside the health sector

The majority of strategies to tackle the issue of early marriage have been located outside the health system, focusing largely on population planning, and in some instances, on non-discrimination and human rights or adolescent development.

The National Strategy Document on Prevention of Child Marriage (2013)... provides broad guidance to state and district governments to help them shape their interventions to end child marriage. The strategy specifies six areas of action: (i) law enforcement, (ii) access to quality education and health care, (iii) changing mindsets and social norms, (iv) empowerment of adolescents, (v) knowledge and data and (vi) development of monitoring indicators. [p. 35]

The National Youth Policy (2014) supports youth at risk and strives to create equitable opportunities for all disadvantaged and marginalized groups. The policy suggests the need for greater monitoring and media attention to prevent illegal social practices, such as child marriage, dowry, honor killings and caste-based discrimination and stigmatization of lesbian, gay, bisexual and transgender youth. [p. 28]

The National Policy for Empowerment of Women (2001) addresses discrimination against the girls and violation of their rights within and outside the family, particularly the implementation of laws against child marriage and also sex selection, child abuse and child prostitution. [p. 27]

The National Policy for Children (2013) does not talk about early and child marriage but includes 'married children' as a vulnerable group, along with children of manual scavengers, children of sex workers and children of prisoners and mandates that they should be tracked, rescued, rehabilitated and have access to their right to education (MWCD, 2013). Thus, the policy adopts a 'protectionist' approach that encourages tracking, rescue and rehabilitation. [p. 28]

Gaps and limitations in the data

The following are some areas that emerged as major gaps in the review and analysis of the data on early marriage and health. The primary source of data was the NFHS, supplemented by the DLHS wherever relevant. Although the NFHS is a national health survey, it involves representational sampling and, despite attempts to capture variations, it is quite limited. For example, interviews for the NFHS 3 were conducted with about 230,000 women aged 15–49 years and with men aged 15–54 years across India.

Absence of data collection and analysis on early and forced marriage

Data from the NFHS and DLHS primarily refer to prevalence of early marriage rather than to the related consequences. No data were collected or analyzed specifically from

the perspective of early and child marriage. The NFHS 3, for example, did not ask specific questions with regard to the consequences for health resulting from early and child marriage. The correlations have been made based on the available data.

> **The NFHS 3 data reflects the universal and early nature of marriage in India. There has been a gradual decline (from 54.2 percent in 1992 to 45.6 percent in 2006) in the total number of women were married before they were 18 years old. Urban areas show an exception, with a marginal increase in the percentage of women marrying before they are 18 years. In the NFHS 3, 19 percent of women aged 15–17 years and 7 percent of men aged 15–20 years were married at the time of the survey. [p. 43]**
>
> **In the NFHS 3, 8 percent of women who were 15 years old had already started living with their husbands and an additional 4 percent were married but had not started living with their husbands yet. [p. 44]**
>
> **In the NFHS 3, the median age at first marriage for women was well below the legal age of 18 years, while the median age at first marriage among men was above the legal age of 21 years. A slight increase in median age at first marriage for all women (urban and rural) was also reflected in the data, from 16.4 years in NFHS 1 to 16.7 years in NFHS 2 to 17.2 years in NFHS 3. [p. 44]**

Absence of early marriage data by sex, age and other factors

Capturing distinct data, such as by age or marital status, enables a nuanced understanding of issues, which in turn supports the development of well-targeted programs and policies. Data analysis regarding early marriage requires, at a minimum, that information be specified (disaggregated) by sex, age and marital status. The research found that even when age- and marital status-disaggregated information is available, many important additional indicators are absent, such as related rates of nutrition and anemia, access to and use of antenatal and post-natal care and knowledge of disease transmission and prevention.

Age and marital status data: Certain indicators were not available for age or marital status:

- Age-specific information related to religion, caste, education and wealth status was not available. For example, age at first birth, teenage pregnancy and motherhood.
- Data on age at first birth and median age at first birth was not found. Such information would provide clarity on the timing of beginning of childbearing among young married women.

- Age-specific information on sexual violence and physical violence experienced by married women was not found.
- Data on self-reported prevalence of sexually transmitted infections did not include information on marital status in the different age categories.
- Data on health problems during pregnancy was not specified by age; data on initiation of breast feeding was not specified by the age of the mother.
- Data on prevalence of anemia in children was not specified by the age of the mother at the time of birth. This would be useful in drawing correlations between the nutrition status of the mother and that of the child.

Nutrition and anemia: Although information broken down by age was available on the nutritional status and prevalence of anemia among women, such information was not available for specific age groups among married women only. Some data sets are available for women in general (married and unmarried) but there is need for age-disaggregated information to be separated by married and not married status. Age-specific information was also unavailable for married women across religious communities, social groups, education levels and wealth index.

> **By marital status, anemia was lowest for women who had never been married and highest for women who were widowed, divorced, separated or deserted at the time of the NFHS interview. Anemia tended to decrease with education and the household's wealth or economic status. [p. 56]**

This information would be useful in highlighting the extent of vulnerability of young married women to health risks associated with poor nutritional status. The DLHS does not have the data for nutrition and anemia, neither for children nor for ever-married women.

> **The data showed that early marriage clearly impacts the nutritional status of women while the data reflect quite the reverse among men. This may be due to the extremely patriarchal and gendered nature of marriage and therefore the disproportionately negative impact it may have on women. Anemia, body mass index and height were some of the common indicators used to ascertain the nutritional status of a person. [p. 55]**

Prevalence of disease and morbidities: There was no age-specific information on the prevalence of tuberculosis, diabetes, asthma or thyroid disorders or tobacco and alcohol use among married women. The data sources either provided information for all married women aged 15–49 or for all women (married and unmarried) aged 15–19 and 20–24 years.

Data on the prevalence of morbidities among married women of different age categories would help in providing a clearer picture of the extent of health risks faced by the women in the different age cohorts.

Contraception use: There are a number of constraining factors that prevent women from exercising their choice to safe, quality contraception. These factors may become stronger and more coercive within the arrangement of marriage. No age-specific data on informed choice about use of contraceptive methods was found for married women. Clearer data on married women's ability to access information or make informed choices in the use of contraceptive methods help clarify the social and gender dynamics that determine ability to access and negotiate the use of contraception.

> **Overall, 23 percent of currently married young women, including over one fourth of women aged 15–19 years and one fifth of women aged 20–24 years, stated the need for contraception—that they wanted to wait for at least two years for their next childbirth or wanted no more children but were not using any method of contraception. [p.66]**
>
> **In the NFHS 3, 11 percent of births occurred within 18 months of a previous birth and 28 percent occurred within 24 months. Young women from poorer socioeconomic backgrounds are particularly vulnerable to health problems and have restricted access to health care, often preferring to achieve their ideal family size at the risk of no spacing between births. [p. 49]**

Data by geographical state: The incidence of early marriage and issues arising out of it varies greatly across geographical locations. But variations need to be charted and chronicled in data to showcase the ways in which contemporary practices and regional cultures may or may not have a bearing on early marriage. By geographical state, age-specific information would be useful to make interventions in each state as per the specific context and need.

Violence against women: While the NFHS 3 provides some information on spousal violence and sexual violence, data on gender-based violence is a fraught terrain, with barriers to reporting and documentation. The Protection of Women from Domestic Violence Act, 2006 recognizes sexual violence within marriage, but the Indian Penal Code only criminalizes sexual relations in a marriage of girls younger than 15 years. It is silent in situations involving girls aged 15–18 years. This provides impunity for violence against young women in marital relationships. It also highlights serious issues regarding consent and age of consent. Early marriage is therefore potentially imbued with violence, particularly sexual violence, given the 'obligations' that a young woman is expected to fulfill as a spouse.

Like other aspects of data on marriage and women, this form of exclusion exhibits the sacrosanct status that marriage occupies within the social and policy discourse—where the complete picture is not sufficiently discussed. In the available government data sources, no data were found on other forms of violence, such as child sexual abuse and caste-based violence. The lack of adequate data on the various forms of violence provides an incomplete picture of the extent of abuse faced by young women within marriage.

> **The data showed that domestic violence, particularly spousal violence, was highly prevalent among young women and that there was urgent need for programs to address it. Recognition of certain forms of violence, such as sexual violence in marriage, is limited to the Protection of Women from Domestic Violence Act. Under the Indian Penal Code, however, sexual intercourse or sexual acts by a man with his wife, provided she is not younger than 15 years, is not recognized as rape, revealing the extremely patriarchal bias in the understanding of violence in the context of marriage. This reinforces inequality between men and women in marriages as well as provides impunity for violence against young women in marital relationships. [p. 59]**

Absence of data regarding accessibility to and use of health care facilities and services

Data by age and marital status was not collected in the NFHS with regard to access to health care facilities and services, such as reasons for visiting a health care facility, reasons for not accessing or problems faced while accessing it. The data also did not indicate what services were available at the facilities.

The absence of this information creates difficulties in understanding the experiences of married women, in particular women in early marriages, within the health care system. Services such as supplementary nutrition, immunization, health check-ups, referrals, nutrition supplements and health education are available for pregnant and lactating mothers, but age-specific information on the use of those services was not found in any of the data sources. Such data would be useful, first, in determining the problems that young married women experience in accessing those services and then, second, advocating the necessary steps to ensure improved access.

Health-seeking behavior: The NFHS and DLHS do not capture health-seeking behavior of young persons who are married. This would enable a clearer picture of ailments and the sources of health care that women and men use.

In the NFHS 3, young women were equally likely to report health problems as women of age 25–49 years, even though the latter were more likely to have health problems common to women at older ages not related to pregnancy but could complicate their pregnancy. By contrast, women aged 20–24 years were somewhat less likely than women aged 25–49 years to report each of the problems. [p. 51]

In the NFHS 3, only 38 percent of all women younger than 20 years gave birth in a health facility, whereas 46 percent did so at their 'own home' and 15 percent in their 'parents' home'. A large number of births (60 percent) to women aged 15–24 years took place at home, and only 16 percent were assisted by health personnel. [p. 53]

Urgent need for more data on critical groups

There is a considerable and concerning absence of data on several particularly vulnerable groups, such as children younger than 15 years, boys, young people with disabilities and other socially marginalized groups.

Children younger than 15 years: The NFHS and the DLHS data do not collect data on or about people younger than 15 years, resulting in a significant dearth in the available empirical information on child marriage. According to the NFHS 3, however, 27 per cent of Indian women aged 20–49 years were married before the age of 15. Systematic data collection and analysis for this age cohort could inform policy formulation and program implementation.

Boys and young men: There is a conspicuous absence of reference to boys in programs and policies concerning early marriage. While girls are more vulnerable to the consequences of early and child marriage than boys, it is important to develop action plans that address the issue of documenting the problems faced by boys who are married at an early age in order to create evidence and take necessary action.

The absence of a focus on boys in the National Strategy on Child Marriage (2013) is carried forward in the draft National Plan of Action to Prevent Child Marriage. It contains an array of proposed actions relating to implementation of law, capacity building of functionaries, creating a knowledge base, generating awareness at all levels, including reaching out to children through the education system. But there is nothing in the draft to address early marriage of boys. [p. 36]

Data across religious communities and social groups: No data by age was available for the different religious and social groups for such important indicators as pregnancy, knowledge, use of and unmet need for contraception, antenatal and post-natal care and services, knowledge of diarrhea and acute respiratory infection management, and spousal violence. Information with regard to religious and social groups would be useful to enable informing of future policy and program formulation as well as more equitable processes to address the issues and concerns of vulnerable populations. Such information, however, must be presented in a nuanced manner to ensure that it does not lead to profiling and stereotyping of communities and groups.

> **The NFHS data indicate that there are certain pockets, regions (urban and rural) and communities in the country where incidence of early and child marriage is much higher for various reasons; this may be related to economics, ethnicity, caste and religion, vulnerability and risk, sex ratios and gender, sexuality norms and attitudes. The median age at marriage for Scheduled Castes, Scheduled Tribes and Other Backward Castes was also younger than 18 years. [p. 44]**

The health implications of early marriage

While the implications of early marriage for health are well acknowledged, they are limited to only some aspects related to early pregnancy and childbearing. A range of other health issues that are likely connected to early marriage do not feature in the discourse of health and early marriage in India, such as nutritional status, vulnerability to sexually transmitted diseases, abortion, sterilization, hysterectomies and mental health issues. This is likely due to the manner in which the discourse of early marriage and health has emerged. For example, the analysis of maternal health outcomes discusses how women who experience early pregnancy and childbirth and have compromised nutrition levels are particularly vulnerable.

The implications for health as a result of marrying early necessitate a different lens of inquiry and analysis in the future toward building substantive scholarship in this important area.

> **Looking at the NFHS 3 data, the causes of malnutrition and anemia cannot be inferred, thus more information or data on other background characteristics, such as residential, marital, educational and wealth status disaggregated by age would be beneficial. However, the root causes of under nutrition or the poor nutritional status of a large number of women, including those from higher wealth quintiles points to other, more deep-**

seated gendered discrimination that has been known to be prevalent right from birth for girls and women. [p. 57]

Implications for health in the context of marriage also pose complexities in identification and measurement. That poverty, gender, caste, disability, sexuality and other axes of marginalization impact health status, including access to health care, is well recognized. This impact on women's health begins early for women and girls, while in their natal homes. The implications of early marriage for health, for example, on nutrition would therefore need to be cognizant of the continuum of impact that may have longer-term impact. Future inquiry of implications for the health of women in early marriage would need to contextualize the consequences while attempting to identify health issues that are specific to or exacerbated by early marriage.

A woman 'eats least and eats last' is a well understood reflection of the reality that most women in India find themselves in. Thus, the nutritional status of women may well be compromised even in their natal homes prior to marriage and is further compounded by socioeconomic factors, such as poverty, caste, residence, etc. While early marriage may further compromise the nutritional status, there is need to further understand these links.[p.57]

Early pregnancy affects both mother and child

Early childbearing has multiple adverse consequences for the health of young mothers who are physically and mentally unprepared to carry out the responsibilities of childbearing. Interventions need to be aimed at promoting awareness about the consequences of early marriage among women and among other community actors while strengthening the agency of women in making informed decisions pertaining to marriage, health and their lives.

By age 25 years, 85 percent of all women, regardless of their marital status, in the age group of 25–49 years (at the time of the NFHS 3 interview) had given birth. The percentage of all women who had begun childbearing increased sharply with age, from 3 percent at age 15 years to 36 percent at age 19 years. More than half of the married women aged 15–19 years (58.2 percent, or one in six women at that age) had begun childbearing at the time of the survey; 12 percent of women aged 15–19 years were mothers; and 4 percent of the women in the same age group were pregnant with their first child. [p. 49]

> **In the NFHS 3, the percentage of women aged 15–19 years who had begun childbearing was about three times higher among women who had no education than women who had 10 or more years of education. Early initiation of childbearing was much more common in rural than in urban areas and declined sharply with wealth. [p. 80]**

The data highlighted that early pregnancy, in addition to having adverse consequences for the health of the mother, had far-reaching consequences for the health of infants and children. The infant mortality rate was higher for children born to very young mothers than for children born to older mothers. The high rate was due to the young mothers' poor nutrition, lack of physical and emotional maturity, lack of access to or use of health care services and higher risk of infectious diseases. The mortality rates for all the indicators were lowest, at 50 percent, when the mother's age at childbirth was 20–29 years. The mortality rates were higher, at 77 percent, when the woman's age at childbirth was younger than 20 years (NFHS 3).

Links between early marriage and mental health is an area for further research

That early marriage has implications for the mental health of young married women is acknowledged. However, the nature and extent of the impact on mental well-being, particularly when an early marriage is a 'forced' marriage, needs in-depth study and understanding. The Mental Health Program, for instance, is oriented toward early detection and treatment, professional training and public awareness on issues of mental ill-health rather than on a more sociological understanding mental well-being.

The NFHS and DLHS data do not provide any information on the impact of early marriage on women's mental health. This is an important aspect of health that should be covered in future surveys. A UNICEF report from 2001 on early marriage stated that the abrupt end of adolescence, forced sexual relations, early pregnancies and the denial of freedom and personal development have profound psychological and emotional consequences. Young brides often feel isolated, rejected and depressed in the marital home. Loss of childhood and adolescence, the opportunity to play, develop friendships and be educated affects the development of girls. Data on the mental health consequences of early marriage would be helpful in formulating appropriate programs to address these consequences.[iii]

> **Most mental disorders begin during youth (12–24 years of age), although they are often first detected later in life. Young people have a high rate**

[iii] Sama is conducting exploratory qualitative research to explore the factors that affect mental health among young women, including in the context of early marriage.

> **of self-harm, and suicide is a leading cause of death in young people. A strong relation exists between poor mental health and many other health and development concerns for young people, notably with educational achievements, substance use and abuse, violence and reproductive and sexual health. Yet mental health remains a neglected issue in India, and there is not much attention paid in NFHS, DLHS and other data sources. There is a dearth of population or youth-based data and in the context of early and child marriage that could inform interventions to prevent mental ill-health and promote mental well-being. [p. 68]**

Early marriage has implications on women's and girls' agency

The data on decision making and mobility for women clearly indicate power hierarchies and demonstrate that younger women are particularly marginalized from decision making in both their natal and marital homes. The extent to which early marriage impacts decision making and the mobility of women is an important area to explore and understand.

> **The data also reflect other factors that need serious consideration in the analysis of early marriage and health. For example, the data on decision making shows that nearly half (46 percent) of the currently married women aged 15–19 years did not participate in decision making in their households, compared with 13 percent of women aged 40–49 years. Women's participation in specific decisions did not vary greatly by their education level, although the percent of women participating in each decision was higher for women who had 12 or more years of education, compared with women with no education (NFHS 3). [p. 46]**

Decision making and mobility are extremely gendered and, in addition to age at marriage, are important determining factors to be considered in the context of understanding health-seeking behavior, access to health care and other health determinants.

Need for research and analysis on age at marriage and associated health consequences

Should health consequences be explored not only for early but also for forced marriage? And what could be possible ways of understanding them? In the literature reviewed, marriage and marital status in relation to whether it was an early or child marriage (and therefore its consequences) was never articulated as such. The silence on the links between marriage and age is reflective of social fears surrounding women in their reproductive roles. Akin to the kind of anxiety teenage pregnancies have generated,

more in relation to a pointed socio-medical discourse on adolescent reproductive health that positions young adolescent mothers as 'social rejects' (rather than focusing on their health and reproductive rights), in India the stifling of data on the age of the young mother is to bring her in to the ‘legitimate’ category of the 'ever-married'. The lack of data on the variables that link age with marriage and the associated health consequences for women are seemingly subsumed under larger approval accorded to the ‘married’ status as a legal, absolute category.

AREAS FOR FUTURE RESEARCH

Based on the data and the many gaps in data that emerged through the review, and considering that such primary sources as the NFHS do not comprehensively capture particular qualitative aspects of the links between early marriage and health, Sama's analysis led to the following issues as suggestions for future research.

- The prevalent vulnerability of young girls in marital relationships resulting from gendered norms and unequal power relationships and poor availability and access to information, health care and support are bound to deeply affect young women in early marriages. Links between early marriage and gender-based violence (domestic and sexual violence) and the impact on mental health is an area for future study. Equally critical would be research to deepen a more broad understanding of implications of early marriage on the mental health of women and girls, including coping mechanisms, support and health care accessible to them at different levels.
- The National Adolescent Health Strategy includes enhancing access to information to 'influence cultural norms to reduce early marriage'. This provides an important opportunity to study the following:
  - Scope of understanding and addressing of early marriage as a health issue.
  - Health system strategies and interventions to address early marriage.
  - Impact of the strategies, interventions in (i) prevention of early marriage and (ii) improving access to reproductive and sexual health information and health care for women and men who are in early marriage situations.
  - Such research would provide critical insights toward assessing strategic interventions in the context of early marriage as a public health issue and engagement of the health system in addressing it.
- A review of the Annual Health Survey (2010–2011) data across nine high-focus states of Uttar Pradesh, Chhattisgarh, Madhya Pradesh, Uttarakhand, Jharkhand, Orissa, Bihar, Assam and Rajasthan revealed that the proportion of women aged 15–19 years who had begun childbearing was significantly high. Across all the nine states, a large percentage of married women aged 20–24 years had two or more children. Women and girls in early marriages had limited access to information and safe, quality health care, including contraceptive methods. Primary research to build an in-depth understanding of the reproductive health issues, including access to health care, by documenting perceptions and experiences of women in early marriage is another potential area of inquiry.

- Exploring the implications of early marriage in the context of vulnerable groups is important. The motivations and implications of early marriage due to vulnerabilities necessitate nuanced understanding. Such inquiry will provide insights on continuing social and normative perspectives on marriage toward informing future strategies.
- Assessing the impact of convergence and overlaps of diverse schemes to address early marriage is pertinent. Exploring the efficacy of the diverse initiatives to address early marriage and their impact as well as their limitations are also important areas to explore.

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