

Social Determinants of Child Marriage in Rural India

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Background: Child marriage represents a grave violence against children and deprives them of their rights to health, education, and a livelihood. Because child marriage should be recognized as a social and medical emergency, the social determinants of child marriage in India need to be mapped. The aim of this qualitative case study was to document social determinants of child marriage identified by the authors while providing community mobile health services in rural Mewat District, India.

Case Report: We present qualitative participatory medical histories and assessments of two clinical cases: an adolescent who is waiting to get married and a young woman who was married as an adolescent but developed multiple health complications after her husband abandoned her.

Conclusion: Patriarchy, coercion, social customs, and norms were identified as major social determinants. The two cases demonstrate that social norms influence intergenerational norms and lead to uninformed decision-making and child marriage. In low- and middle-income countries, medical professionals should urgently address child marriage as a major public health problem. Primary care physicians and medical professionals should implement preventive measures and provide anticipatory guidance to prevent child marriage.

Keywords: Child abuse, pregnancy in adolescence, public health, social conformity, social determinants of health, social norms

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INTRODUCTION

Child marriage represents a grave violation of the United Nations Convention on the Rights of the Child.¹ Worldwide, more than 60 million women are estimated to be married before they reach the age of 18 years, and more than one-third of these women live in South Asia.^{2,3} Despite the Prohibition of Child Marriage Act of 2006 that established marriage of females under 18 years and of males under 21 years as a cognizable offence, child marriage remains widespread in India.⁴ Evidence suggests that approximately 30% of all women aged 20–24 years are married before they attain legal age.⁵ The 2011 Indian census estimated that 17 million children in the age group of 10–19 years are married.⁵ A United Nations International Children’s Emergency Fund (UNICEF) study on reducing child marriage identifies the trajectory of associated adverse consequences: curtailment of freedom of choices and opportunities, early marriage, and early child-bearing.⁵ The study also partially attributes domestic violence and harmful health outcomes such as high infant, child, and maternal mortality rates to child marriage.

Children who marry early are subject to a growing problem of violence and abuse. They experience trauma, early life toxic stress, and related adverse childhood experiences. According to the Adverse Childhood Experiences study, a major American epidemiological research project, a powerful relationship has been established between maltreatment

and violence in childhood and adverse health effects in adult life.^{6,7} Development of high-risk health behaviors such as smoking, alcohol and drug abuse, and severe obesity are correlated with depression, heart disease, cancer, chronic lung disease, and shortened lifespan.⁶ Underage marriage puts children at risk of long-term adverse health effects that may not manifest until adulthood.⁸ A study published in *Lancet* reported that medical practitioners in Andhra Pradesh (a state in South India) saw adolescents who came in for checkups but lacked information, indicative of the low priority accorded to girls’ health.⁹

Although child marriage is a major public health problem, its social determinants in different regions have not yet been mapped. Social determinants of health are the conditions in which people are born, grow, work, live, and age.¹⁰

Bal Umang Drishya Sanstha (BUDS)¹¹ is an Indian-registered nonprofit organization that operates according to the Three Principles (3Ps): prevention of disease, prompt treatment, and promotion of health. BUDS facilitates access to healthcare in the marginalized rural community in the Mewat District in the state of Haryana, India, via a fully equipped mobile health van.¹²

Of the 644 districts in the 29 states in India, Mewat is currently ranked the lowest among the districts. In its composite ranking of all five development sectors—health and nutrition, education, agriculture and water resources, financial inclusion

and skill development, and basic infrastructure—the National Institution for Transforming India, Government of India, placed Mewat at the bottom.¹³ Mewat District household- and facility-level data revealed that the majority of adolescents suffer from high levels of malnutrition, anemia, and sexual and reproductive health issues. The percentage of married women who wed before they are 18 years of age in rural Mewat is 16.9%.¹⁴ Only 9% of married women in rural Mewat have had more than 10 years of schooling.¹⁴ Most of the families in Mewat have many children. Children either do not go to school or drop out of school after the primary level. They also get married at ages well below the legal age of marriage.⁴ This family life cycle repeats generation after generation.

The BUDS van provides healthcare access to many adolescents and young women who are undernourished and anemic, as well as to infants who are low birth weight and children suffering from various early-onset childhood illnesses who are brought to the clinic by adolescent mothers.

The aim of this case study was to identify the social determinants related to child marriage that were elicited from two patients seen by the authors as they provided community mobile health services in rural Mewat, India. These case studies will be used to develop a public health strategy to help prevent child marriage in this community.

METHODS

Knowing that direct questions get evasive answers, women in the region are conditioned to give socially desirable responses, and quantitative data need to be supplemented by qualitative responses reflective of social norms, the authors designed a qualitative participative case study approach to test whether one-on-one interviews would lead to greater disclosure. Because the BUDS team is accepted by the villagers, we conducted a participative, exploratory case analysis to gain a better understanding of the social determinants of child marriage.

Consent forms were translated into Hindi (the local language) and signed by the case study respondents. Consistent with the norms of the society, a woman was present throughout the interview because the interviewer (R.S.) is a US-trained male pediatrician from Delhi who volunteers with the BUDS mobile health van in underserved villages in Mewat District. Rapport building was facilitated by a senior woman social worker and female pediatrician from the BUDS team.

In conjunction with the BUDS team, the author visited two family homes to observe first-hand the social determinants related to child marriage. The names of the respondents have been changed to protect their identities.

CASE STUDY 1

Salma is a 14-year-old girl who lives with her family in Ghasera village, Mewat District, Haryana, India. The family is large, and the father, an itinerant seller of clothes, is the only wage earner. Salma has two sisters aged 12 and 7 years and three brothers who are approximately 10, 5, and 3 years old. Salma's 12-year-old sister attends a government school. None of the other children is in school.

During the prior 6 months, the family faced several health challenges, including respiratory and gastrointestinal infections, scabies, and eye and dental problems. They ac-

cessed the BUDS mobile health van facility twice to receive treatment.

Salma approached the primary care physician in the health van with symptoms of common cold and fatigue. While diagnosing her upper respiratory tract infection and anemia, the doctor asked Salma why she wasn't in school. Salma stated that she had dropped out of school after standard five (10 years of age) because her mother became ill with pulmonary tuberculosis.¹⁵ The disease is currently in remission, but the mother's left lung is fibrotic and nonfunctional. Salma's mother has a history of frequent admissions to the National Institute of Tuberculosis and Respiratory Diseases, Mehrauli, New Delhi, when she has an attack of asthmatic bronchitis.

When asked how she feels about early marriage, Salma said she has no views. She knows that early marriage is the custom in her community; girls get married as soon as they attain puberty. Salma said that the practice of marrying daughters at the age of 15-16 years is a "very common social norm in this village." If girls do not marry early, they are subject to taunts; people in the community suspect them of having illicit affairs or of having some kind of disability. The parents of adolescent unmarried girls are also criticized, and the community accuses them of being negligent or not having enough money to marry off their daughters.

Although Salma's reason for not continuing her education was her mother's ill health, her peers frequently either did not go to school or dropped out because the "environment is not conducive." Gender-based violence seems to be a threat for most young girls in the community. Adolescent girls cover their heads and faces in public and in the presence of males. They are not encouraged to leave home unescorted. The authors asked whether molestation had occurred. Salma and her mother were emphatic in their denial. Salma mentioned that the "media reportage and portrayal of gender violence" also add to the latent fears of the community.

CASE STUDY 2

Sahuni is 25 years old. Her house is well built and has three rooms and a toilet, indicating that the family is not very poor. The family has approximately one-half acre of land that provides food year-round. In addition to the parents, the household consists of five other siblings. One of the boys born to this family died early, possibly of blood cancer. The family members said that they had visited the BUDS mobile health van three times.

Sahuni and her 23-year-old sister participated in the interview; their mother provided intermittent comments. Like some of her peers, Sahuni received Quran-based religious education in a *madrassa* (a local center for Islamic religious studies); however, none of the other children in the family has ever set foot inside a school. From a medical perspective, Sahuni, her mother, and her sister looked tired and weak and showed signs of anemia and malnourishment. Sahuni's estimated weight is <35 kg. The mother's grueling daily routine and lack of proper nutrition likely contribute to her pallor and weakness. A homemaker, her day begins at 5:00 am. Following ablutions, she reads the Quran and begins her daily chores. After her husband leaves for work, she sews to augment the family income. She is worried about Sahuni's sister's marriage because the family is too poor to afford a dowry (which usually consists of a motorcycle).

Sahuni's medical condition—complaints of headache, body ache, depression, and fatigue—likely results from her poor physical and mental health status. Gradually, as rapport was built, including a visit to the health van parked nearby, Sahuni told her story. She was married at age 15 or 16 years to a man who worked as a driver. Sahuni had 8 successive miscarriages with heavy bleeding in her attempts to provide her husband with children. All attempts failed. After she was hospitalized for a blood transfusion, Sahuni's husband abandoned her at her maternal home. She described the cycle of poverty, ignorance, and illiteracy that is the lot of young women in her community and the threat of gender violence that drives *jawanladkis* (sexually mature adolescent girls) to be married at an early age.

Sahuni has no views of her own about being married early. During a revisit to question further, the authors were given an answer that they had heard repeatedly in the community: "*Izzat ka sawal hai*" (it is a question of honor). Sahuni conformed to what her parents had asked her to do. Now she has nowhere to go and nothing to do. "Society makes it more of an issue than our parents," she said.

Sahuni has no aspirations. Unschooling and confined to the house, she hopes that her husband will give her a new set of clothes for Eid (a major Muslim festival that was just a few days away when the interview was conducted) as he has given his sisters. Despite having cultivable land and a *pukka* (cemented) house, the woman of the house and her adolescent children are neglected, resulting in a chronic cycle of disease that could be corrected by medication/supplementation and a good diet.

DISCUSSION

Child marriage is associated with major health complications in teenage mothers and their children. Most underage mothers are at risk of reproductive health challenges, impaired mental health, malnutrition, anemia, vaccine-preventable infectious diseases, and exposure to sexually transmitted diseases. The children of underage mothers are at increased risk of prematurity, intrauterine growth retardation, being small for gestational age, birth asphyxia, perinatal complications, and even death.⁹ Teenage mothers risk hypertensive disorder, eclampsia, preeclampsia, and postpartum hemorrhage.

The onset of menarche indicates to the elders and community that a girl is of marriageable age, irrespective of her chronological age. *Ladki jawan ho gayi hai* means that the girl has become sexually mature. According to the two interviewees, the threat to family honour and adherence to social customs are determinants of early/child marriage. These factors may influence decision-making at the family level; however, at the community and societal level, social norms may be used to camouflage the actual causes such as structural inequalities and patriarchy.¹⁶ Some sexual reproductive factors—such as the onset of menarche—contribute to the gating of women; Salma said that adolescent girls never leave the house unaccompanied. Therefore, gender norms play out in the overemphasis of the connection between girls' virginity and chastity and family honor.¹⁶ Child marriage is used as a strategy to preserve such customs and traditions that are an extension of the normative conditioning that adolescents are subject to from infancy.^{2,17} As a number of studies in India have shown, these societal

threats coerce adolescents to conform to norms.^{16,17} Consequently, the control of the patriarchy, endorsed by community support, is perpetuated from one generation to the next.

These social, cultural, and patriarchal mindsets and gender norms discourage girls aged 10-12 years (or more) from going to school. Most young children are educated in the Urdu language at *madrassas* and are not sent to formal schools at all. Children who receive minimal education become home-bound, and the lack of livelihood opportunities perpetuates poverty in the family. Lack of knowledge about government programs also adds to disempowerment and isolation of families within communities (Table).¹⁸ These are the drivers behind low knowledge among adolescents about the negative health outcomes of early marriage (eg, multiple miscarriages, infections, anemia). The BUDS team found that social norms and neglect influence structural norms that contribute to the collective community experiences and uninformed decision-making. Illiteracy, lack of mobility, and early marriage influence the macroenvironment (disempowerment of women, apathy, inability to earn) that in turn strengthens social norms and neglect of adolescents (Figure).

Resources are available; the villages in Mewat District have mainstream schools in the vicinity, a primary health center, and a district hospital. The low access to these facilities may be explained by adolescent girls conforming to prevalent social norms, vested interest groups, and gender prescriptions and by inefficient implementation of the Prohibition of Child Marriage Act.⁵

The persistence of child marriage is a social and medical emergency, and its symptoms may already be overburdening India's already-overburdened health systems.⁵ Incorporating child rights and protection training into the medical school curriculum and continuing medical education of physicians is an urgent need. Physicians need to be aware of and involved with cases of child marriage because of its effects on two generations of children: the underage parent and her infant.

In rural and marginalized social environments, the roles of physicians should not be confined to clinical activities alone, but they should also provide comprehensive health services, prevention, and anticipatory guidance. Primary care physicians and healthcare providers are often the first point of contact outside of the family with abused and neglected children. They may come across various forms of exploitation, including child marriage, in their practices. Trained primary care physicians—pediatricians in particular—should be taught to engage with issues of violence and child marriage. Medical providers should ask questions about potential areas of child neglect, such as lack of education and poor nutrition. They should probe for the underlying etiology in all children with functional symptoms such as chronic fatigue. Practitioners who work in hospitals can order behavioral, counseling, or mental health/psychiatric consultations. This approach involves shifting from the diagnostic-prescriptive mode and into the realm of participative inquiry.

Globally, progress in understanding and preventing violence against children from birth 0-18 years is advancing rapidly. In 2016, the World Health Organization released INSPIRE, a package of seven evidence-based strategies to prevent violence against children.¹⁹ INSPIRE is an essential tool to help achieve Sustainable Development Goal (SDG)

Table. Planned Strategies and Existing Programs to Address Case Study Findings

Findings	Preventive Strategies	Selected Health and Welfare Programs ¹⁸
Social, health, and environmental determinants	<ul style="list-style-type: none"> • Contact women through local <i>mahila</i>/women's meetings to assess the enabling factors that can be strengthened • Link with government systems and programs • Include case study findings in BUDS strategy for prevention of early/child marriage • Conduct a larger scale survey that involves several villages to assess the situation of early/child marriage • Provide life skills education for informed decision-making among adolescents • Provide health education through the mobile health van to create awareness about physical and mental well-being • Motivate parents to invest in girls' education and health • Put every child in school; promote girls' education because investment in education prevents early marriage • Promote early childhood care and development • Empower adolescents through education, health, and vocational skill building • Use information technology to reach out to vulnerable children and adolescents 	<ul style="list-style-type: none"> • Pradhan Mantri Surakshit Matritva Abhiyan (free health services for mothers) • Adolescent-friendly health clinics • Beti Bachao Beti Padhao (Ministry of Women and Child Development) • CHILDLINE helpline (tel 1098) • Sukanya Samridhi Yojana (financial savings program for daughters) • Nai Roshni (leadership development program for minority women) • National Rural Livelihood Mission (poverty alleviation project) • Kishori Shakti Yojana (health, nutrition, and education program for adolescent girls) • Rashtriya Kishor Swasthya Karyakram (health program for adolescents) • Adolescence Education Programme (program to ensure adolescents have accurate knowledge about HIV) • Sabla (health, nutrition, and education program for out-of-school adolescent girls) • Weekly Iron and Folic Acid Supplementation Programme (program to combat adolescent anemia) • Ayushman Bharat (National Health Protection Scheme that will provide hospitalization coverage to more than 100 million persons)

BUDS, Bal Umang Drishya Sanstha; HIV, human immunodeficiency virus.



Figure. Determinants of child marriage.

Target 16.2 (End abuse, exploitation, trafficking, and all forms of violence and torture against children) and also for achieving SDGs 1, 3, 4, 5, 10, 11, and 16 that target poverty, health, education, gender equality, reduced inequalities, safe environment, and justice.²⁰ Some of the well-known strategies to prevent child marriage include (1) empowering girls with information, skills, and support; (2) educating and mobilizing parents and community members to restrict harmful gender and social norms; (3) enhancing the accessibility and quality of formal schooling; (4) providing economic support and incentives for girls; and (5) fostering an enabling legal and policy framework. Implementation of preventive programs faces challenges such as lack of convergence of various sectors, engagement of medical and multidisciplinary professionals, government policies, and gaps in implementation of the law.²

Nongovernmental organizations (NGOs) and medical professional societies such as Indian Child Abuse, Neglect and Child Labour, the Indian Academy of Pediatrics, and the Federation of Obstetric and Gynaecological Societies of India have huge numbers of pediatrician and gynecologist members who can be trained in identifying child abuse, neglect, and exploitation.

Physicians can be trained in the principles of trauma-informed care and in how to take a proper history, as well as how to properly document and record all cases. They should be able to work effectively with multidisciplinary

child protection professionals such as forensic and law enforcement agencies, the National Commission for Protection of Child Rights, child welfare committees, the CHILDLINE India Foundation (1098 tele helpline), child rights activists, and NGOs. Primary care physicians can give adolescents access to therapeutic treatment and justice. Clinical evidence, data, and strategic interventions by large numbers of practitioners can lead to social and policy change.

CONCLUSION

The social determinants of child marriage identified in these case studies are indicative of a patriarchal system that prevents women from obtaining an education, earning a livelihood, and becoming productive citizens. Child marriage is a violation of the basic rights of the child and a major public health problem. The need is urgent to provide an enabling environment for all adolescents, including those who have never been to school or who have dropped out of school. Preventive measures and anticipatory guidance to prevent child neglect, abuse, and child marriage should become a part of routine medical management. Social pediatrics, community medicine twinned with social/mixed methods research outcomes, and documentation of good practices are powerful enablers. Proactive and sustained evidence-based advocacy with government, civil societies, and professional societies can bring about changes in the macroenvironment, help ensure that laws are enforced, and eventually help adolescents find their rightful place in society. Physicians have an important role as influencers of public health policy and as advocates in the community for prevention of child marriage.

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