

MEMORANDUM FOR TASK FORCE
examining matters pertaining to age of motherhood, imperatives of lowering MMR,
improvement of nutritional levels and related issues

I. INTRODUCTION

The Centre for Health Equity, Law and Policy (C-HELP), an initiative of the Indian Law Society, Pune, aims to advance and improve health delivery, access and outcomes through the creation, sharing and use of knowledge on health-related law and policy.

The Task Force's objective of improving maternal and child health and nutrition levels is an urgent, necessary and commendable one. Though the maternal mortality ratio is decreasing in India, it is still unconscionably high at 113 per 1,00,000 live births¹, and India has the highest number of under-five child deaths in the world.² We are however concerned with media reports which suggest that the Task Force is considering revising the legal age of marriage (and as a consequence the age of motherhood) for women to 21 years in order to address these problems.³ The Hon'ble Finance Minister's Budget Speech in the Parliament, consequent to which the Task Force has been set up, also suggests that an increase in the age of marriage for women is on the agenda.

Raising the age of marriage for women with the aim of advancing their educational achievements and improving their health and nutrition status will not have the desired effect, and in fact, may be counterproductive. While child marriages have a deleterious impact on child brides' health, safety and well-being, and must be regulated, persons who have attained majority do not experience vulnerability in the same ways. Raising the age of marriage to 21 years, even as one policy intervention among others, would have negative repercussions and impacts on the agency, rights and entitlements that the law recognises are central to the life of adults. What is needed instead is the creation and promotion of an enabling socio-economic and cultural environment for all persons to look after their health, educate themselves and pursue livelihoods, and choose if and when to marry and start a family.

¹ Office of the Registrar General, India. (2020). *Special Bulletin on Maternal Mortality in India 2016-18*. Delhi

² Unicef. (2019). The State of the World's Children 2019. Children. *Food and Nutrition--Growing Well in a Changing World*

³ The Economic Times (2nd February 2020) *Panel to review age of marriage for women*, <https://economictimes.indiatimes.com/news/politics-and-nation/sc-17-ruling-behind-move-on-age-of-marriage/articleshow/73949040.cms>; India TV News (14th June 2020) *Government mulls to revise women's legal age for marriage from 18 to 21*, <https://www.indiatvnews.com/news/india/women-legal-age-for-marriage-india-2020-revise-sharda-act-women-and-child-development-626094>

II. OVERVIEW

Early marriages and low educational attainment of women are outcomes in a society riven with poverty, pervasive gender discrimination and violence, and low status of women, where conditions do not always exist for women to take decisions best suited for their well-being. Empowerment of women, through legally recognised and enforced rights, and investments in education, livelihood opportunities and safe and confidential health services, is key for advancing women's status in society and making them equal partners in families and communities.

Any law that circumscribes their agency, even though intended to protect and improve the quality of women's lives, reinforces the powerlessness. **Raising the age of marriage for women over the current legal age of majority will impact women's fundamental rights and deprive them of the capacity to take decisions in the personal and intimate spheres of their lives.**

The submissions describe the impact of such a law on women's right to health, right to found a family and right to marry. Ultimately, the law would have a negative impact on women's right to life, personal liberty and privacy, which are Constitutionally guaranteed and protected rights. Suggestions for alternative interventions are provided.

III. RIGHT TO MATERNAL HEALTH

a. Maternal health is a human rights issue

Maternal and child health indicators in India have slowly improved over the years, yet an extremely high number of women succumb to pregnancy related complications every year, many more suffer from debilitating injuries and disabilities as a result of pregnancy and childbirth, and India accounts for the most number of deaths of children under 5 years in the world. Maternal and child health is a pressing public health problem and is internationally⁴ and nationally recognised as a human rights issue. The Delhi High Court has recognised right to maternal health and the right to nutrition and medical care of children as a part of the fundamental right to health under Article 21 of the Constitution.⁵ The State has corresponding obligations to prevent maternal deaths and provide maternal and child health services. The right to health is to be understood as more than a right to medical care or treatment; it also encompasses equitable access to the social determinants of health such as nutrition, sanitation and hygiene.

⁴ United Nations Human Rights Council (2009). *Resolution 11/8. Preventable maternal mortality and morbidity and human right*. New York: UN Human Rights Council

⁵ *Laxmi Mandal v Deen Dayal Harinagar Hospital and Ors* (2010) 172 DLT 9

b. Largely medical and preventable causes of maternal and child deaths

A majority of maternal and child deaths in India are preventable and are attributable to a lack of access to good quality maternal care. Almost a third of maternal deaths occur in the 20-24 age group.⁶ As per data captured by the Sample Registration System, most maternal deaths (81 per cent) are due to preventable and treatable obstetric causes such as haemorrhage, sepsis, prolonged or obstructed labour, and unsafe abortions, with rural areas of poorer states having three quarters of all maternal deaths.⁷ The Government of India identifies delays in deciding to seek care, delay in reaching the appropriate health facility and delay in receiving quality care once inside an institution as the reasons for a large number of child and maternal deaths.⁸ Sixty eight percent of under-five deaths in India are attributable to child and maternal malnutrition.⁹

Gaps in continuity of care in the antenatal and postnatal periods are responsible for a proportion of preventable maternal deaths. While 79 percent of women aged 15-49 who had a live birth in the preceding five years had received antenatal care from a skilled provider,¹⁰ the number declines in the postnatal period. The postnatal period is a very crucial period for both mothers and newborns, as complications may arise in the first 24 hours, and many maternal and neonatal deaths occur in this period. Mothers and newborns are recommended health checks during this time. However, only 65 percent of mothers reported postnatal checks within two days of birth, and 30 percent of mothers did not receive any postnatal checks.¹¹ Only 27 percent of newborns had a first postnatal check within the first 2 days after birth and 64 percent of new-borns did not receive any postnatal health check.¹² Problems in poor access to emergency obstetric care, poor referral systems which leave women to be referred from one facility to another and without means of emergency transport, and financial barriers to care are some of the documented problems causing maternal deaths and morbidities.¹³

These figures point to the need and centrality of a well resourced and equitable health care system in addressing maternal and child health and well-being. Age of marriage and motherhood are not the leading predictors for the deaths of mothers and infants. The policy focus instead must be on improving the health system and strengthening accountability.

⁶ Office of the Registrar General, India. (2020). *Special Bulletin on Maternal Mortality in India 2016-18*. Delhi

⁷ Montgomery, A. L., Ram, U., Kumar, R., Jha, P., & Million Death Study Collaborators (2014). *Maternal mortality in India: causes and healthcare service use based on a nationally representative survey*. PloS one, 9(1), e83331. <https://doi.org/10.1371/journal.pone.0083331>

⁸ Ministry of Health and Family Welfare, Government of India. (2013). *A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India*. Pg 7

⁹ Perapadan, B.S. (2020). *68% of under-5 deaths in India due to child, maternal malnutrition*. The Hindu. At <https://www.thehindu.com/news/national/68-of-under-5-deaths-in-india-due-to-child-maternal-malnutrition/article31570050.ece>

¹⁰ International Institute for Population Sciences (IIPS) and ICF. (2017). *National Family Health Survey (NFHS-4), 2015-16: India*. Mumbai: IIPS. Pg. 202

¹¹ NHFS-4. Pg 209

¹² NHFS-4. Pg 210

¹³ Human Rights Watch (2009). *No tally of the anguish: Accountability in Maternal Health Care in India*. United States of America: HRW

c. Investing in healthcare infrastructure

In order to prevent maternal and child mortality and ensure the survival of mothers and their children, access to a robust health system, and education and information on reproductive and sexual health is necessary. Improving access to the social determinants of health, such as sanitation and nutrition, is also essential for ensuring the health and well-being of women and children. Access to health services and information must not be confined to the pregnancy and post-partum stage, but be available throughout the life cycle of girls and women and at all relevant stages of the health system. The RMNCH+A framework acknowledges that reproductive, maternal and child health cannot be looked at in isolation and that it is inextricably linked with the health of the population, and must be addressed in a 'continuum of care' approach.¹⁴ Some of the specific RMNCHA+A interventions for improving maternal and child health include improving the nutritional status of young girls and pregnant women, promoting menstrual hygiene, improving knowledge of and access to family planning methods and services, safe abortion services, provision of skilled obstetric services, and strengthening of provision and maintenance of sanitation, water, hygiene, nutrition and education in communities.

Several programmes have been launched for improving child and maternal health outcomes. Programmes such as Janani Suraksha Yojana, Janani-Shishu Suraksha Karyakram and POSHAN Abhiyaan which encourage institutional deliveries, seek to eliminate out-of-pocket expenses for pregnant women and sick infants, and aim to improve nutritional outcomes for children, adolescents, pregnant and lactating mothers respectively. These are important steps towards securing the health and well-being of the population and must be effectively implemented with strong accountability mechanisms. Ensuring adequate nutrition through implementation of the *National Food Security Act 2013* is another measure for improving the health of mothers and children. Other interventions, such as increasing the pool of skilled obstetric care providers and health education on recognising early signs of antenatal complications can go a long way towards reducing maternal mortality.¹⁵

d. Illegality hinders realisation of the right to health

The exact form and content of amendments to the age of marriage, if made, are not known. But raising the age of marriage to 21 years in a society where a large proportion of marriages that take place involve women below 21 years, will effectively legalise such marriages. Laws do not always immediately stamp out widely prevalent social practices, as can be seen by the continuing incidence of child marriages, and it can reasonably be expected that marriages by women below 21 years will continue to take place. But by making such marriages illegal, the law would endanger access to health services for women.

A cautionary tale of the dangers of illegality can be found in case studies of adolescents seeking abortion or reproductive health care under the shadow of the stringent *Protection of Children from Sexual Offences Act 2012* (POCSO) and mandatory reporting by healthcare

¹⁴ Ministry of Health and Family Welfare, Government of India. (2013). *A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India*. Pg 1

¹⁵ Montgomery, A. L., Ram, U., Kumar, R., Jha, P., & Million Death Study Collaborators (2014). Maternal mortality in India: causes and healthcare service use based on a nationally representative survey. *PloS one*, 9(1), e83331. <https://doi.org/10.1371/journal.pone.0083331>

providers. While the *Medical Termination of Pregnancy Act 1971* permits girls under 18 years of age to seek abortions, POCSO requires health providers to mandatorily report all cases that fall under its ambit. There has been documentation of girls under the age of 18 years who sought abortion but confronted with mandatory reporting requirements in hospitals were forced to leave. This is because either the pregnancy was a result of a consensual sexual relationship and they did not wish to see their partner in jail, or that they had become pregnant due to sexual violence by a family member and they did not wish to risk disclosure or reprisal by reporting the crime.¹⁶ Such illegality has pushed adolescent girls into unsafe abortions. The fear of POCSO also discourages girls from accessing other sexual and reproductive health services such as contraception, thus endangering their health.

Raising the age of marriage to 21 years would effectively cause marriages of women under 21 years to be seen through the lens of illegality. Similar to the unintended effects of POCSO, it would hamper their access to reproductive and sexual health services and would in effect worsen maternal and child health in India.

IV. CHOOSING WHEN TO START A FAMILY

a. Reproductive autonomy and childbearing

The decision of if and when to start a family is at the core of reproductive autonomy which is a dimension of personal liberty¹⁷ and privacy under Article 21 of the Constitution¹⁸ and is an internationally recognised human right. Since almost all of childbearing in India happens within marriage, by raising the age of marriage, the age of motherhood will also effectively be regulated. This would impact on adult persons' ability to choose when to start their families. As data shows, **majority of Indian families choose to have children in their early 20s.**

The median age at first birth among women in the age group of 25-49 years is 21 years.¹⁹ Further, a majority of the births in India are wanted births. As per the National Family Health Survey-4 data, 91 percent of the births in the five years preceding the survey were wanted at the time of conception, with the highest percentage of wanted births (94 percent) among women who were less than 20 years at the time of delivery. For women who were 20-24 years of age at the time of delivery, a similarly high percentage (almost 93 percent) of births were wanted.²⁰ The percentage of births that were wanted at the time has *increased* from 79 percent in 2005-06, to the present level of 91 percent.²¹ As these figures show, **women in the 18-21 years of age want to have children.** The percentage of unwanted births increase with the mother's age, with almost a third of births to women aged 45-49 years reported unwanted.

¹⁶ N, J., Bhate-Deosthali, P., Rege, S. (2016). *Ethical concerns related to mandatory reporting of sexual violence*. Indian Journal of Medical Ethics, 2 (2 (NS)), 116. At <https://ijme.in/articles/ethical-concerns-related-to-mandatory-reporting-of-sexual-violence/>; Jain D, Tronic B. (2019) *Conflicting abortion laws in India: Unintended barriers to safe abortion for adolescent girls*. Indian Journal of Medical Ethics, 4 (4 (NS)), 310

¹⁷ *Suchita Srivastava and Anr v Chandigarh Administration* (2009) 9 SCC 1

¹⁸ *Justice KS Puttaswamy v Union of India* (2017) 10 SCC 1

¹⁹ NFHS-4. Pg 82

²⁰ NFHS-4. Pg 107

²¹ NFHS-4. Pg 86

It is also important to note that the **level of teenage childbearing has declined by half within a decade**. As of 2015-16, 8 percent of women aged 15-19 years had begun childbearing, a marked decrease from 16 percent in the preceding decade (2005-06).²² Seen in conjunction with the data on wanted births and the trend in decline in child marriages, this suggests that women are increasingly able to delay teenage marriages and pregnancies, and are choosing to give birth between 19-24 years of age.

b. Access to contraception and family planning services

Raising the age of marriage is perhaps with the intention that older women will be in a better position to make reproductive decisions. However, by ensuring access to a wide range of contraceptive methods and family planning services, women of all ages can be empowered to take control over their bodies and fertility. Access to contraception and family planning services is an important method of ensuring maternal health. Knowledge of and access to a wide range of safe and modern contraceptive and family planning methods is integral to the realisation of reproductive health and rights, and enables women and their families to avoid unplanned pregnancies, decide the number and spacing of children, complete their education and remain in the workforce. Successive childbirths in a short time span is associated with greater costs to maternal and child health and higher under-five mortality.²³

However, women in India are disempowered from controlling their reproduction and protecting their health for various reasons. While almost all (99 percent) currently married women report knowing about at least one contraceptive method, only about half of them (48 percent) report modern contraceptive use.²⁴ By far the most prevalent form of contraception is a permanent one, with more than a third (36 percent) opting for female sterilisation. It is a sobering fact that almost 60 percent of users of female sterilisation were not informed about possible side effects of the method, and more than half of them had received no information on other methods from health or family workers.²⁵ Women usually undergo sterilisation after having two or more children, and it is evident that they are unable to access temporary or reversible modern contraceptive methods, thus affecting their ability to time their childbirths or determine spacing. There is also a high unmet need (22 percent) for contraception among women aged 15-24 years.²⁶

There is an urgent need to **expand the choices and availability of modern and safe contraceptive methods for both men and women, and promote rights-based reproductive healthcare that respects informed consent and patient safety and privacy**. Adolescents and unmarried women also need to be made the beneficiaries of family planning and contraceptive use programmes. Special focus should be on women belonging to Scheduled Castes and Scheduled Tribes and those residing in remote areas. There also needs to be greater engagement of men in family planning programme communication and implementation. Women are both expected to use contraception and are viewed with

²² NFHS-4. Pg 83

²³ NFHS-4. Pg. 187

²⁴ NFHS-4. Pg 111-112

²⁵ NFHS-4. Pg 141

²⁶ NFHS-4. 117

suspicion for doing so. Thirty seven percent of men think contraception is a woman's business and men have no role to play, and one-fifth of men think contraception may lead to a woman becoming promiscuous.²⁷ Such negative beliefs hinder women's realisation of their reproductive rights and health. Men need to be made equal partners in family planning through creation and deployment of male contraceptive options, and education.

Investing in such interventions would advance the realisation of maternal health, empower women and improve child survival and health. Increasing the marriageable age of women will have little bearing in addressing these concerns.

V. CHOOSING WHEN TO MARRY

a. Marriage and the right to personal liberty and privacy

Raising the age of marriage for women would have the effect of curtailing their decision of when to marry and would impinge on the right to privacy and personal liberty. Autonomy, in its many dimensions, is a Constitutionally protected value; the Supreme Court has held that attaining the age of majority entitles a person to make her own choice and exercise her freedom²⁸ and has also cautioned against well-meaning protectionist impulses of the State that restrict individual autonomy and liberty in personal matters such as marriage.²⁹ The State can legislate and change the conditions for a valid marriage, but such a law must be procedurally and substantively fair, just and reasonable.

b. Marriage before the age of 21 years is very common

While it is not clear whether amendments to the age of marriage would render marriages by women below the age of 21 years as void or voidable, what is certain is that such a law would cast a pall of uncertainty and illegality over a widely prevalent social practice. As per the NFHS-4, the median age at first marriage for women in the age 20-49 is 19 years and almost 60 percent of women in the age group 20-49 were first married by the age of 20 years.³⁰ A majority of women in India are thus married before they reach the age of 21 years. This is for a variety of entrenched reasons: poverty that causes girls to be seen as an economic burden, the centrality and inevitability of marriage in Indian life, perceived and real lack of social and financial alternatives to marriage for women, the social norms which view girls as burdens (*paraya dhan*) of their natal family, viewing girls only as wives and mothers, social expectations that husbands should be better educated than their wives, and fears of female sexuality.³¹ These reasons are true for child marriage, and remain true for early marriage of women in India. **Raising the age of marriage above 18 years for women would do little to address the causes and factors leading to early marriage in India, and would instead disrupt families and community life, thus calling into question such an amendment's reasonableness and proportionality.** As we have described in the preceding paragraphs, the objective of improving maternal and child health is better met through other interventions in

²⁷ NHFS-4, Pg. 147

²⁸ *Soni Gerry v Gerry Douglas* (2018) 2 SCC 197

²⁹ *Shafin Jahan v Asokan K.M.* (2018) 16 SCC 368

³⁰ NHFS-4, Pg 165

³¹ Mathur, S., Greene, M., & Malhotra, A. (2003). *Too young to wed: The lives, rights and health of young married girls*

the areas of health and education. Raising the age of marriage would negatively affect a large proportion of society doing little of benefit to offset the harm.

c. Marriage as a means to a better life

Recent research has also revealed the reality of self-arranged marriages among adolescent girls. Girls, faced with an unmet need for care and affection from their families, familial disapproval and violence against their choice of partners, taboos against premarital sex, and lack of educational or livelihood opportunities, chose to elope and marry their partners.³² **In such limiting and disempowering circumstances, marriage is an exercise of agency and choice by girls and women for better social and financial security.** By making marriage legally inaccessible till the age of 21 years, the law would make it even more difficult for women to choose their partners and escape the stranglehold of poverty, familial control and surveillance, and rigid norms around female sexuality.

d. Delaying marriages through investments in education

Instead of forcing women to marry later by raising the marriageable age, efforts should be geared towards encouraging girls to finish their schooling and pursue graduate education or technical skills training. This would **enable women to be financially secure, gain life skills and confidence, and delay marriages and childbirth by their own volition and choice.**

Research suggests that early marriage is not the reason why girls drop out of school, but rather, lack of good quality, affordable, accessible and safe educational institutions lead to families forcing girls to leave their schooling.³³ Pervasive gender norms which devalue girls also contribute to women and girls receiving lesser education than men and boys. Girls shoulder the burden of household work.

VI. CONCLUSION

Women's equal personhood, agency and empowerment must be kept at the front and centre of all laws and policies impacting their lives. Instead of raising the age of marriage, which restricts the exercise of women's right to autonomy and endangers their right to health, the State can and must direct its attention to creating an enabling environment for women to realise their right to health, education and livelihood. It is essential that public health interventions for addressing maternal and child health be strengthened, with programme planning and implementation that takes into account the continuum of care approach of the RMNCH+A. Preventable maternal and child deaths, which account for the majority of deaths, needs to be dealt with urgency.

In order for women to be able to fully realise their right to maternal health, both men and women should be able to access information on and avail of a wide range of safe and modern contraceptive methods. Their rights to informed consent, safety, confidentiality and privacy

³² Partners for Law in Development (2019). *Why Girls Run Away to Marry: Adolescent Realities and Socio-Legal Responses in India*. New Delhi: Partners for Law in Development

³³ Ibid.

must be respected at all times during the provisioning of contraception and family planning services.

Young girls must be encouraged to finish their schooling by providing them with safe, accessible and good quality educational institutions, and tackling the societal and gender norms that interfere with their right to education. Their education should build a sense of confidence and self-esteem and equip them with critical life skills which will enable them to take decisions that are best suited for their well-being.

These suggestions are not comprehensive, but are indicative of the range of interventions that are needed for responding to the problems that are on the Task Force's agenda. Girls and women in India live in circumstances which severely restrict their choices and autonomy, and any proposed solution must not be part of the problem.