EDITORIALS

Adolescent girls and marriage decision-making in India: questions of competency, choice and consent

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In two recent Delhi High Court cases, judges recorded that girls below the age of 18 may willingly enter into marriage (1,2). The declaration that marriages involving girls below the legal age of marriage are "neither void nor illegal" has several implications for adolescent health as well as for health researchers and care providers. Is marriage involving a minor girl ethically acceptable under any circumstance? And of particular relevance to health researchers and care providers: do minor girls, particularly those below the age of 16 years, have the competency to make such decisions? To what extent can minor girls in the Indian context make "free, voluntary and informed decisions" regarding any issue including relationships, marriage, and health care?

The adverse health impact of early marriage

Attempts to curb early marriage were initiated by the British in the form of the Child Marriage Restraint Act, 1929 (3). According to this Act, marriages involving minors are illegal but not void, and relatively mild penalties are imposed on parents and male spouses who are 18 years and above. The Central Government's Prevention of Child Marriage Bill, introduced in the Rajya Sabha in 2004, attempts to impose stronger curbs by including a provision to declare child marriages void (4). A Parliamentary Standing Committee has recommended the following modifications to further strengthen this Bill: compulsory registration of all marriages within a stipulated period; careful scrutiny of age; and clear specification of accountability of government officials responsible for registration and scrutiny.

There are approximately 100 million girls between the ages of 10 and 19 years in India. More than half are married by the time they reach the legal age of marriage, 18 years (5). Young age at marriage is associated with a host of adverse individual and public health outcomes, including increased risk of malnutrition, anaemia, maternal and infant mortality, and high fertility (5, 6). For example, according to the 1998-99 National Family Health Survey, 39 per cent of currently married adolescents, ages 15-19 years, had chronic energy deficiency and 56 per cent had anaemia (7). Neonatal and infant mortality rates among infants born to adolescent girls are 60 per cent higher than among infants born to women ages 20-29 years (6). Moreover, young age at marriage goes hand in hand with curtailed education and economic opportunities, contributing to the perpetuation of gender inequities.

Thus, early marriage has an adverse impact on adolescent development and health and on the health of future generations. From a health and development perspective, early marriage poses greater risks than benefits for the adolescents involved. Therefore, we may conclude that this practice is unethical and warrants concerted and consistent social and legal interventions.

The reality of adolescents' competency, choice and consent

The recent Delhi High Court judgments raise two additional questions of relevance to health researchers and care providers. First, do minor girls, particularly those below the age of 16 years, have the competency to make such decisions? And, second, to what extent do minor girls in the Indian socio-cultural context have the opportunity to make "free, voluntary and informed decisions"?

Currently, according to Indian law, only those who have attained majority (above 18 years), can provide consent for medical procedures like medical termination of pregnancy and HIV testing (8). By extension, adolescent minors' participation in research is governed by their parents' or legal guardians' consent. Underlying these requirements are the presumptions that adolescents do not have the competency to make such decisions and that parents or legal guardians will act in the best interest of their children.

Ethicists have argued that demonstrating respect for persons and their autonomy also means recognising young people's limitations, their need for special protection, and their evolving rights and cognitive capacities (9). Within the Indian family context, adolescent girls are given few opportunities to make decisions, and social restrictions on mobility and limited education curtail their development. However, girls also tend to take on a range of household responsibilities from an early age, gaining maturity through these experiences. Thus, we cannot assume that adolescent minor girls do not have decision-making capacity. Research is needed to better understand adolescent minors' competencies in different settings in India.

Concurrently, researchers and care providers need to critically examine whether parents or legal guardians are in a position to act in the best interest of adolescents when their perspective is likely to be heavily coloured by socio-cultural and economic conditions. For example, in group discussions and interviews we conducted with parents and adolescent girls in North Karnataka, participants

noted that the fear of the social consequences of a girl's pre-marital sexual activity (whether real or perceived, consensual or otherwise) led parents and girls themselves to view early marriage as the only safe option. While social norms and choices are dynamic, the vast majority of parents and adolescent girls in India have few choices. They continue to make decisions under constrained circumstances. Parents' good intentions when enacted do not necessarily result in the promotion of adolescents' best interests. Child marriage is one example.

Health researchers and care providers may also not always be in a position to act in the best interest of adolescents. Our socio-economic background and personal experiences and values influence what information and choices we provide, our assessment of parents' and adolescents' competencies, and the extent to which we elicit participants' or patients' decisions.

In conclusion, researchers and care providers face serious ethical dilemmas related to choice, consent and competency when addressing the health needs of adolescent minor girls. An ethical practice would entail recognition of the diverse capacities of adolescent minors; assessment of these capacities; discussion with adolescents and parents about the choices available to them keeping in mind how socio-cultural and economic conditions shape those choices; and awareness of how one's own position and values influence these actions. In countries such as the United States, legal provisions such as the "mature" and "emancipated" minor enable the recognition of adolescents' capacities. The recent judgments in India suggest that this may become possible here as well. However, we must monitor whether such provisions will be used to normalise harmful practices such as child marriage, or to promote and protect adolescents' rights.

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