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22 REACHING CHILD BRIDES

KNOWLEDGE SUMMARY: WOMEN'S & CHILDREN'S HEALTH



Child marriage affects 10 million girls under the age of 18 every year. The negative health and social impact of child marriage include higher rates of maternal and infant mortality, sexually transmitted infection, social separation, and domestic abuse compared with older married women. The UN defines Child Marriage as a Human Rights violation and is working to end this practice globally, however many girls still fall victim each year. While the importance of ending the practice of child marriage cannot be overlooked, targeted interventions are also needed to mitigate the negative health and development impacts. Health services can serve as an entry point for health and social interventions to decrease the risks associated with pregnancy and improve reproductive and child health. Health services can also facilitate opportunities for multi-sectoral connections such as formal and informal education and income generation to mitigate the negative impact of child marriage.

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The challenge

Every year, 10 million girls marry before their 18th birthday; in the developing world one in seven girls is married before age 15.^{1,2} In South Asia and Sub-Saharan Africa more than 40% of girls are married by age 18.^{3,4} The UN recognizes child marriage as a serious human rights violation that threatens the achievement of nearly all the Millennium Development Goals.^{2,5,6} Many cultural, social, and economic pressures contribute to the continued practice of child marriage, making it a difficult issue to tackle.^{4,7}

Child marriage has numerous, and serious, consequences for the health and protection of girls. Married adolescents have poorer pregnancy outcomes, higher risk of HIV infection and unsafe abortion, and are more likely to suffer from domestic and sexual abuse, than non-married girls or older married women.^{1,3-6,8,9} Child brides also experience social isolation, and have limited contact with their birth family and social circles.^{5,10} Furthermore, child marriage is dramatically correlated with early termination of education; child brides are less likely to benefit from economic development programmes, or have access to income generating opportunities.^{3,8,10}

Negative health consequences associated with child marriage

Child marriage has a negative impact on reproductive health. One third of women in developing countries, and 55% in West Africa, give birth by age 20; 90% of these births are within wedlock.⁵ Young age, coupled with limited access to health services, a lack of reproductive health information,

Box 1 – Preventing child marriage

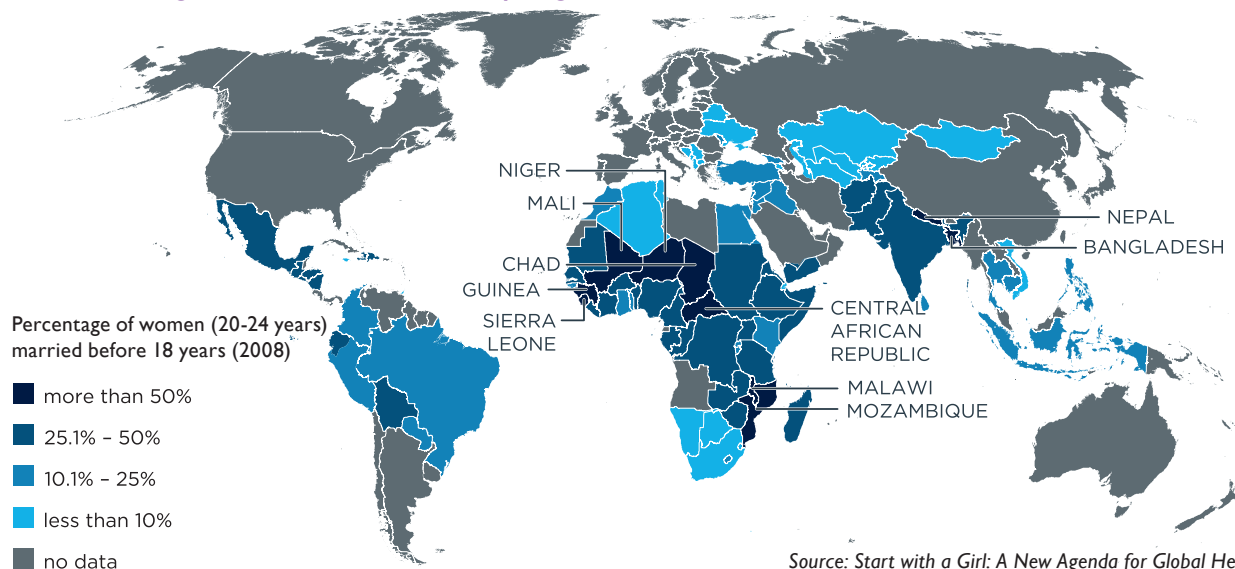
The emphasis of programming has been the prevention of child marriage, which is essential to end this harmful practice.^{1,2,7} Key steps (with illustrative examples) have been identified to effect change:

- **Prohibit Early Marriage:** There is an increased focus on political and institutional laws governing marriage.² WHO has called upon policy makers to enforce laws banning marriage before age 18.⁷
- **Promote Girls' Education and Empowerment:** One major priority in programming is girls' education and empowerment. In Benin, the Community Action for Girls' Education Project conducted community and family education on the effects of child marriage to decrease school drop out rates in girls.¹²
- **Address Cultural and Social Norms:** Many families feel pressure to follow cultural practices even when harmful.⁷ In Nepal, the Bhaktapur Adolescent Girls' Education Project works with families to find solutions to household problems that fuel child marriage.¹²

Many programmes address decreasing the incidence of child marriage as one of many intended outcomes, or as a secondary outcome within a programme addressing girls' education, empowerment, delayed pregnancy or health. Programmes with the greatest success often address multiple factors and have culturally relevant interventions.^{3,5} Multi-sectoral approaches to prevent child marriage are necessary to effect lasting change, with focuses on families, girls, communities, and policy.^{3,5}

Figure 1

Child marriage is still common in many regions of the world

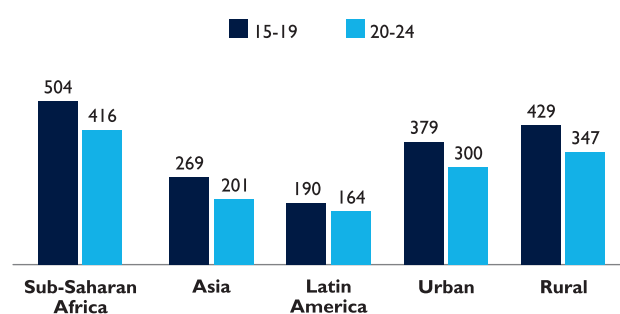


cultural pressures, and little control or autonomy for decision-making, leads to high-risk pregnancies.⁴ These pregnancies, especially first-time pregnancies, are associated with high rates of maternal mortality, obstructed labour, pregnancy-induced hypertension, and fistula.⁸ Girls between the ages of 10 and 14 have five times the risk of dying during pregnancy and birth compared to women aged 20 to 24.^{5,7} Early onset of childbearing is also associated with negative maternal health outcomes due to frequent childbirth, unplanned pregnancy, and abortion.¹¹ Adolescent first time mothers have the accumulated risks of both age and parity, making these pregnancies extremely vulnerable.^{7,8}

The young age of mothers also compromises the health of their babies, with a dramatically increased risk of neonatal and infant mortality.^{11,13} Adolescent mothers are also likely to exhibit poor feeding practices, less consistent well-baby care

Figure 2

Maternal Mortality Ratio by Age



Data source: A.K. Blanc, W. Winfrey, J. Ross, *New Findings for Maternal Mortality Age Patterns: Aggregated Results for 38 Countries, 2012.*

practices, such as vaccination, and are more likely to have stunted or wasted children, compared to older mothers.^{11, 13, 14}

What works

While ending child marriage is the ultimate goal, in countries where it is culturally engrained, efforts seeking to end this practice often have difficulty gaining political traction and social acceptance; this makes programmes to improve the health and well-being of married adolescent girls even more important.⁵

Support the most hard-to-reach young married girls through ANC services

Due to social isolation, poverty, and other pressures, many married girls have limited contact with formal health services before or after pregnancy. First contact prior to pregnancy is ideal to delay pregnancy, support family planning and child spacing, and impact general well-being. However, throughout the world, most women receive antenatal care services (ANC) of some kind at least once during pregnancy.^{8, 10} Even a brief encounter with health service can be used to identify adolescent first pregnancies, and provide support and services.

By identifying adolescent first-time mothers through ANC and providing services, often outside of health facilities, reproductive health, safe abortion and family planning needs can be met, impacting child spacing, improving maternal and child health outcomes, and creating positive effects on population growth and demographics.^{5, 7, 10} The Berhane Hewan Programme, in Ethiopia, identified girls through ANC services, and enrolled them in community based programmes, including girls' groups and home visits.¹⁰ The enrolled girls were 3 times more likely than non-enrolled girls to use contraceptives, to know about counseling and testing services, and to have stronger social networks.¹⁰ Targeted adolescent pregnancy interventions have also

proved vital in the utilization of safe delivery and postnatal care, improving feeding practices, immunization coverage, and the decrease of age related adverse outcomes for both mother and child.^{11, 17, 18}

Use health services as an entry to other services

Through the initial contact with ANC, married adolescent girls can connect with multi-sectoral services.¹⁰ Health services can serve as an entry point to broader development programmes, and provide access to other sources of care within the community that offer greater protection. Providing multi-sectoral services to married adolescent girls can empower them, and help them to develop greater autonomy.^{10, 17} Furthermore, through an initial contact with health services, girls can get involved in community programmes to improve partner communication and support, and participate in household decision making.^{10, 16} These programmes are essential to supporting girls to act in their own interests, become active within their households, develop stronger communication skills, engage in girls groups, and connect to their communities.¹⁰ Girls groups and community programs can also serve to bring girls back to health services as needed, to promote continued improvements in health.

Adolescent mothers can also engage in formal and informal education, skills building activities, and income generating opportunities.¹⁰ While adolescent mothers are far less likely to earn a salary or engage in economic activities, targeted interventions can help them gain some financial independence, become financial contributors to their household, or create savings for emergency medical needs, through skills development, income generation and financial planning strategies.^{5, 16}

Evaluations and expanded coverage are critical

Most programmes addressing child marriage need more rigorous evaluation. For programs that have not been evaluated, monitoring and evidence generation is needed to identify successful programmes and support continued implementation on a wide-scale. Promising initiatives could also serve as benchmarks for evaluation.^{10, 12}

Where there is evidence of success, programs should be

applied to scale. In many high prevalence countries, programs can be scaled to focus on regional hot-spots where there are much higher rates of child marriage. Coupled with evaluation and evidence generation, culturally specific targeted interventions need to be a priority. Visible partnerships with, and support from, government and policy makers cannot be overlooked as vital to the scalability, sustainability, and cultural acceptability of programs.

Box 2 – Case study: First Time Parents Project, India

The Population Council implemented a quasi-experimental pilot project to provide community-based services and ANC for married adolescent girls during their first pregnancy.^{15, 16} They enrolled over 1,800 married adolescent girls in the programme. Pregnant adolescents were identified through ANC and enrolled in community based interventions and girls groups. Girls participating in these interventions experienced dramatic increases in healthy behaviors such as contraceptive use, seeking ANC,

delivery planning, and newborn care, beyond those girls receiving health service only.^{10, 15} They also experienced measured improvements in social and personal well-being, compared to girls receiving health services alone.^{10, 15} While health center-based interventions were valuable for improving health outcomes, the social interventions of home visits and girls groups led to improvements in both health and social outcomes.^{10, 16}

Conclusion

Married adolescent girls have been an underserved population in the fight to end child marriage and protect children. While we cannot overlook the importance of ending the practice of child marriage, targeted interventions are also needed to mitigate the negative health and development impacts. These interventions can be developed

and provided through health services to improve the development and wellbeing of married adolescent girls. Partnerships with governments and enforcement of existing legislation, and taking a human rights approach, can serve as vital underpinnings to sustainable and scalable programs.

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