Taking action to address child marriage:
the role of different sectors

Health

Child marriage can have tremendous effects on the health of girls and their children. Compared to women who marry later in life, child brides experience higher rates of adverse sexual and reproductive health outcomes (not only during their youth but also throughout their life course), gender-based violence, malnutrition, and increased maternal morbidity and mortality. Child marriage can also be associated with poor mental health, including feelings of isolation, depression, and suicidal thoughts and behaviours, and can also contribute to poor health outcomes for future generations.

Child marriage leads to the early onset of sexual activity, often without consent. Particularly in sub-Saharan Africa, the burden of HIV has fallen largely on adolescents, particularly adolescent girls. Adolescents and young adults face the highest concentration of new HIV infections, and this age group has not benefited from recent declines in HIV and AIDS-related mortality evident among other age groups. Because husbands are often significantly older, married girls have less power and ability to exercise their rights when it comes to negotiating sexual activities within their relationships. Combined with the fact that husbands of child brides often have had more sexual partners, these marriages can put child brides at high risk for sexually transmitted infections, including HIV. In some countries, such as Kenya and Uganda, for example, married girls are more likely to be HIV-positive than their unmarried peers.

Being married early, without consent, and to older men, can also impact girls' ability to negotiate their sexual and reproductive health needs, including whether and when to have sex and whether and when to use contraceptive methods. This lack of agency and voice in reproductive decision-making places child brides at high risk of early, unintended, and frequent pregnancy. Ninety per cent of adolescents in the developing world who give birth do so within marriage. Married girls often experience pregnancies before they are physiologically and emotionally ready, and they face significant barriers to accessing comprehensive and respectful medical care during pregnancy and childbirth, which puts adolescent girls at great risk for complications during gestation and delivery, including anaemia and malnutrition, prolonged or obstructed labour, obstetric fistula, and death. Where safe and legal abortion is not available, unsafe abortions and barriers to accessing adequate and respectful post-abortion care place both married and unmarried girls at risk of haemorrhage, infection, genital trauma, long-term health complications, and death. Health risks from malaria are also higher among pregnant adolescent girls than pregnant women. As a result, girls aged 15 to 19 experience rates of maternal mortality globally that are significantly higher than young women aged 20 to 24, with an estimated 70,000 adolescent girls dying of complications from pregnancy and childbirth annually. Preventing child marriage and empowering adolescent girls to negotiate sex, condom use, and contraception are all crucial elements of achieving an AIDS-free generation and reducing early and unintended pregnancy.

In some settings, child marriage is associated with female genital mutilation or cutting, which can have severe health consequences for girls. Each year 3.6 million girls undergo female genital mutilation/cutting, most common in Africa and the Middle East, which is often practised as a coming-of-age ritual or to prepare girls for marriage, and is

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common in countries with high prevalence of child marriage. This harmful practice can cause pain, bleeding, infections, and even death. It can limit a woman's sexual pleasure and lead to increased risk of HIV, infertility, and complications during childbirth. Like child marriage, female genital mutilation/cutting is a form of violence against women and girls and a manifestation of gender inequality. But it is not the only form of violence to which child brides are subject. In many instances, child brides face higher levels of gender-based violence, including intimate partner violence, marital rape, violence during pregnancy, and domestic abuse from in-laws and other family members, which can lead to poor physical and mental health outcomes.

The negative health effects of child marriage can carry on to the children of child brides, who have higher rates of infant and child mortality and stunting, and are more likely to experience malnutrition and poor physical health as compared to children of mothers over 18. Adolescent girls who give birth are 35-55 per cent more likely to deliver a preterm or low birth-weight baby than are those who give birth after 19 (the effects of child marriage on the nutrition status of girls and their children are discussed further in the *Food security and nutrition* brief).

Preventing and responding to child marriage is directly connected to achieving many health sector goals. Delaying marriage can lead to delayed sexual initiation and first birth, reduced incidence of gender-based violence, increased spacing between births, reduced maternal morbidity, lower HIV infection rates, and can contribute to ending preventable maternal and child deaths. These important connections and similar target populations make health programming a critical point of access and intervention to prevent child marriage and address the sexual and reproductive health needs of young married girls and couples.

Integrating child marriage prevention and response into health programmes

Health programming should target the unique needs of adolescents—married and unmarried—to ensure they have the information and resources to make informed decisions about their sexual and reproductive health and rights. This information often starts with basic facts about puberty, menstruation, pregnancy, and sex, through fertility awareness or body-literacy programmes.

Programmes should address gender- and age-related biases among providers so that they fully respect the reproductive desires of married girls, rather than reinforce the societal pressures often faced by young brides to prove fertility. Programmes should assess how providers dispense information and contraception and, to the

Strategies for integrating child marriage

- Build adolescents' communication and negotiation skills related to sexual and reproductive health
- Comprehensive sexual and reproductive health education for married and unmarried adolescents
- Mass media and behaviour change communication campaigns to influence and promote healthy sexual and reproductive health practices, including through the use of new technologies
- Education and mobilisation of community members on the harmful health impacts of child marriage
- Training of providers and equipping of facilities for the provision of youth-friendly services
- Psychosocial services
- Public-private partnerships for scaling
  - HIV services for married and unmarried adolescents
  - Appropriate maternal health services

greatest degree possible, ensure girls' full and free informed choice for family planning. This requires that providers impart useful, accurate, and unbiased knowledge about various contraceptive methods and how they work, and provide counselling on how to choose a method that best meets the needs and intentions of adolescent girls within the context of their particular relationship dynamics, throughout their life course. This includes age-appropriate, youth-friendly access to sexual and reproductive health information, and access to services, including safe abortion, where legal, and post-abortion care. Providers need to avoid creating additional barriers, such as impeding married girls' access to contraceptive methods by requiring the permission of their husbands. Girls married to HIV-positive husbands, as well as HIV-positive girls (including those who may be pregnant or parenting) will need special attention and care within HIV programming.

Programmes should sensitise providers to the fact that marriage does not reduce the health risks a girl faces, particularly when she becomes pregnant. Maternal and child health programmes must, in fact, address the often heightened health needs of pregnant girls, and ensure they receive the adequate and respectful health care they need during pregnancy and childbirth. Given the negative impacts of early pregnancy on the children of child brides, programmes should target pregnant adolescent girls, their husbands, and their families with information about proper infant care and the importance of breastfeeding and birth spacing, and should provide married girls with the services and support needed to achieve these aims.

In some settings, unintended pregnancies outside of marriage may drive child marriage. In such cases, the same information and services can help young sexually active unmarried couples to prevent pregnancy and thus prevent child marriage. Both married and unmarried girls often face stigma when seeking reproductive health services, causing them to be less likely to return for follow-ups or continued care and treatment. As this stigma may prevent service uptake, programmes should educate providers on girls' rights and sensitise them to the needs of adolescent girls, as well as promote a shared sense of responsibility for the prevention of unintended pregnancy, HIV, and sexually transmitted infections among boys and men.

Programmes that strengthen girls' rights to choose if, when, and whom to marry—as well as if, when, and with whom to engage in sexual activity—will enhance their agency and health outcomes. Providing girls with opportunities to access needed information and resources can improve their health knowledge and behaviours, as well as build resolve related to their health desires. Programmes can also work with men and boys to enhance couple communication and collaborative decision-making with regard to sexual and reproductive health.

Programmes that aim to change health behaviours often address social and cultural norms and expectations, many of which are also connected directly to child marriage. Health sector programmes are therefore in a position to address many health risks associated with child marriage. Further, targeting health systems and services to reach and serve married adolescents may improve quality, access, and uptake for married adolescents and girls at risk of child marriage.

Programme examples

Integrated Family Health Programme (IFHP+)
is a USAID-funded, Pathfinder International-implemented programme in Ethiopia that works to strengthen integrated family planning, maternal, newborn and child health, and HIV/AIDS as well as reproductive health services at the community level. Health practices at the household and community level are strengthened through improved availability and quality of health services, products, and information. IFHP+ also supports government initiatives to strengthen key elements of the health system and train health care workers. This programme included child marriage prevention and response in its programme design, implementation, and monitoring and evaluation. The programme reports 14,220 delayed marriages, more than 3,900 community and religious leaders sensitised on health and gender issues, and nearly 2.8 million visits to youth-friendly sites.

Programmes with a similar focus can incorporate child marriage during programme design by targeting family planning, maternal, newborn and child health, and HIV/AIDS services to married adolescents, as this population is at a heightened risk for reproductive health problems and often lacks access to needed health information. Programme implementation can include training healthcare workers to educate community members of the harms associated with child marriage, as well as how to respond to the unique needs of married adolescents. Integrating child marriage in programme monitoring and evaluation through measurement of child marriage-related outcomes, and at a minimum age, sex, and marital status of programme participants, can help implementers understand whether programme activities are impacting child marriage.

PROCOMIDA (MYAP), a USAID-funded, Mercy Corps-implemented programme in Guatemala, is an innovative mother and child nutrition programme that uses a preventive approach targeted to pregnant/lactating women and children aged 6–24 months. PROCOMIDA provides beneficiaries with a nutritionally-balanced ration that enables mothers and other caregivers to adopt healthier practices, including health-seeking behaviours. The programme also works with staff of government health facilities, as well as organised community structures, to improve the technical quality and cultural appropriateness of the services provided. Through these approaches, PROCOMIDA addresses both the demand-side and supply-side of health care provision in northern Guatemala. The programme has been particularly successful at reaching the poorest households.

To address the needs of child brides and their children, nutrition programmes should specifically target pregnant and lactating adolescents for nutritional programming, through programme design and implementation. Programme design and implementation should also focus on engaging young fathers in nutrition education and services so that the health of the young mother and her baby are not her responsibility alone. Through performance monitoring, nutrition programmes should track the age of their clients and learn and adapt to target services to address the specific needs of young mothers. Incorporating child marriage indicators into programme evaluation could also help these kinds of programmes to understand whether they are effectively reaching and meeting the needs of highly vulnerable populations who have experienced child marriage.

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Monitoring and evaluation: illustrative examples

An initial and powerful way to integrate child marriage prevention and response into programming is by measuring changes related to child marriage, learning how these changes impact other programme areas, and then adjusting programming accordingly. The following are sample indicators that can be used in health programmes to understand child marriage-related impacts. For a more complete list of indicators, please refer to the USAID Child, Early, and Forced Marriage Resource Guide or *Girls Not Brides'* Measuring Progress: recommended Indicators.

Monitoring and evaluation: illustrative indicators

Indicator	Data source and notes
Rate of condom use at last high-risk sex, males and females ages 15–24	Data are collected and made publicly available via UNICEF MICS and DHS. More localised data could be collected via community- or programme-level surveys.
Percentage of pregnant adolescents who had access to emergency contraception or safe abortion	The Guttmacher Institute and Marie Stopes International may have data to supplement DHS or government sources. More localised data could be collected via community- or programme-level surveys.
Percentage of girls (married and unmarried) who have accessed a health clinic in the last 12 months (e.g., sexual and reproductive health, HIV testing)	A survey of individuals in the target communities. Disaggregate by marital status.
Percentage of births attended by a skilled health professional	UNICEF collects data and makes it publicly available. Disaggregate by age.
Percentage of health service providers who have received training on child marriage laws, risk factors for child marriage, and how to report law violations	A survey of health service providers.
Percentage of health care providers who report that they would provide family planning to a sexually active youth client, including married and unmarried girls	A survey of health service providers.

Suggested further reading

The briefs in this series are based on the Child, Early, and Forced Marriage Resource Guide (2015), written for USAID by Allie Glinski, Magnolia Sexton and Lis Meyers on behalf ICRW and Banyan Global. References, programme examples, and further information can be found in that guide, located here: https://www.usaid.gov/documents/1865/child-early-and-forced-marriage-resource-guide. For additional information, see:

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