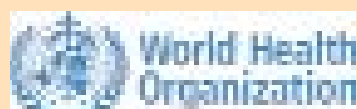


MARRIED ADOLESCENTS



Married Adolescents

NO PLACE OF SAFETY



WHO Library Cataloguing-in-Publication Data

Married adolescents : no place of safety.

1. Marriage. 2. Women's rights. 3. Child welfare. 4. Pregnancy in adolescence. 5. Pregnancy complications. 6. Adolescent health services. 7. Developing countries. I. World Health Organization. II. United Nations Population Fund.

ISBN 92 4 159377 6

(LC/NLM Classification: HQ799.2.M3)

© World Health Organization 2006

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 2476; fax: +41 22 791 4857; email: bookorders@who.int). Requests for permission to reproduce or translate WHO publications - whether for sale or for noncommercial distribution - should be addressed to WHO Press, at the above address (fax: +41 22 791 4806; email: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

The named authors alone are responsible for the views expressed in this publication.

Printed by the WHO Document Production Services, Geneva, Switzerland

Contents

Executive summary	4
What do we mean by early marriage?	6
Early marriage declining – but still far to go	9
Sexuality and health in early marriage	11
Early marriage often leads to unsafe sex	14
Early marriage may be driven by fear	17
Gap between marriage and first child is falling	19
The risks of early pregnancy	22
Married adolescents miss out on health care	26
Programmes to reach married adolescents:	
programmes to delay marriage	29

Married adolescents : no place of safety was written and produced for WHO
by Peter McIntyre, Oxford, UK.

Cover photo by Sandeep Saxena, Frontline Magazine, India, shows an adolescent bride at a temple
near Jaipur the day after her wedding.

Title page photo by © Adam Hinton/ PANOS PICTURES

Preparing a wedding day veil in Donetsk, Ukraine.

Much of the material for this document was provided or suggested by experts of the World Health Organization, the United Nations Population Fund, The Population Council and others who attended a Technical Consultation in Geneva in December 2003 to consider the evidence regarding married adolescent girls' reproductive health, vulnerability to HIV infection, social and economic disadvantage, and rights.

Executive summary

Marriage is widely regarded as a place of safety to shelter from the risks of adolescence. In many parts of the developing world, parents and policy makers see marriage as a walled garden where cultural and family values protect young girls from defilement and stigma. Particularly in poorer and rural areas, there is pressure on parents to marry off their daughters while they are very young before they become an economic liability. Millions of girls reluctantly enter into marriage while they are still children, just sexually mature but unready in every other way for this profound change in their lives. Typically, an adolescent bride knows little of her new husband or new life, has little control over her destiny and is unaware of the health risks that she faces.

When an adolescent girl starts a sexual relationship with a man 10 years older than she is, he may be sexually experienced. If he is infected with a sexually transmitted infection (STI) or with HIV, a marriage certificate offers no protection. In the context of the AIDS pandemic, it is a chilling fact that the majority of unprotected sex between an un-infected adolescent girl and an infected older man takes place within marriage with the blessing of parents and community. Neither AIDS nor STIs respect marriage as a place of safety.

Early marriage below the age of 18, and particularly very early marriage below the age of 16, distorts the life pattern of young girls. It often brings an end to their education and their hopes of an independent income. It places a young girl in a position of isolation, detached from her own family and friends and living within a household where she may not be val-

ued until she has proved her fertility.

The newly married couple must try to create a life-long relationship under conditions where they have little or no pre-existing knowledge of each other, there is no sense of equality and they have little support. They have unprotected sex, under pressure for the young bride to conceive within the first year of marriage. If sex is not freely given by the girl, it may be taken as a right by the man.

In sub-Saharan Africa the risk of HIV infection is very high, and everywhere there is a risk of sexually transmitted infection. Such infections may damage the fertility of a young woman, and cause the stigma that early marriage was supposed to avoid.

An adolescent bride who becomes pregnant receives new status as a mother-to-be, but also faces new dangers. Pregnancy and delivery carry increased risks for adolescent first time mothers, who may be neither physically nor psychologically ready for childbirth.

In the case of very young mothers risks may arise from becoming pregnant before the body is fully grown and prepared. In the case of older adolescents, the risks are mainly those associated with a first pregnancy. The young mother knows little about her own body or warning signs, and lacks sufficient money and status in her new household to access antenatal care or a skilled attendant at the birth. There is unlikely to be a system for her to receive obstetric care in an emergency. These circumstances lead to death in childbirth for too many young mothers, while for every girl who dies, another 30 suffer a pregnancy related illness, injury or disability. Some injuries cause a young married girl to be abandoned by her husband and new family and left with no means of support.

This picture of too early marriage is reflected in South Asia, parts of sub-Saharan Africa, and some parts of Western Asia¹ and Latin America.

1. In line with current UN usage, this document uses Western Asia for what was previously referred to in English as the Middle East, except when referring to data collected and cited as being for 'the Middle East'.

Mothers who were unable to make choices for themselves, are often under pressure to compel their daughters to repeat the cycle.

Early marriage often takes away a girl's human right to choose when to marry, to choose her husband or to consent to sex. It prevents her from making informed choices about protected sex based on an understanding of the risks and the options.

Even when legislation protects girls from early marriage and early childbirth, deep rooted cultural customs may slow the pace of change. However, in many places there are programmes designed to delay marriage, to encourage adolescent girls to stay in school and

to delay the birth of the first child. Programmes also seek to ensure that young married girls have a better chance of a healthy pregnancy, safe delivery and good quality postnatal care. The most promising programmes engage adolescent girls, parents, husbands and in-laws, as well as social and cultural issues, so that the rights of adolescent girls can be protected by the societies in which they grow and develop.

The Millennium Development Goals for international development cannot be achieved without tackling early marriage. This document explores these issues and outlines some promising programmes in countries where early marriage and early childbirth are common. ■

Millennium Development Goals

Tackling the ill-effects of early marriage has a direct bearing on six of the eight Millennium Development Goals agreed in September 2000 as development priorities until 2015.

Goal 1: Eradicate extreme poverty and hunger

Young brides are less likely to have the training and opportunity to earn, and less likely to be able to access resources.

Goal 2: Achieve universal primary education

Eliminating the worst examples of early marriage, below the age of 15, will allow girls to complete primary education, and acquire skills to increase their chance to earn an income.

Goal 3: Promote gender equality and empower women

Giving adolescent girls a choice in whether to marry and providing alternatives to early marriage will give girls greater self-confidence and choice. Girls who marry will have greater confidence to control their own fertility, and to seek treatment for infections or when pregnant.

Goal 4: Reduce child mortality

Delaying first births and improving antenatal, delivery and postnatal care for young first time mothers will have a significant impact on child mortality figures.

Goal 5: Improve maternal health

The target is to reduce by three-quarters the ratio of women dying in childbirth by 2015. Young first time mothers have double the chance of dying during or after childbirth. Very young mothers below the age of 15 have a five-fold chance of death.

Goal 6: Combat HIV/AIDS, malaria and other diseases

Adolescent girls who marry older men have a heightened risk of HIV. Reducing levels of adolescent marriage is an essential part of an overall programme to reduce the risks of HIV.

What do we mean by early marriage?

The UN Convention on the Rights of the Child (CRC) marks the age of 18 as the dividing line between childhood and adulthood. However, the legal framework for marriage varies between countries and can be different for males and females. In some cultures, religion or tradition permit marriage at the age of 12 or earlier.

The CRC promises children the right to education and the highest attainable standards of health, and the right to be protected from mental and physical violence, sexual abuse and sexual exploitation. Children have the right to have their views taken into account and not to be separated from their parents against their will. Anyone below the age of 18 is a child “unless under the law applicable to the child, majority is attained earlier”¹. In some countries marriage automatically confers adult status. Girls who marry below the age of 18 can lose the protection of the CRC.

International conventions have insisted for more than 50 years that marriages should be freely entered into. The Universal Declaration of Human Rights says marriage shall only be entered into “with the free and full consent of the intending spouses”. However, the legal framework in countries may lack sufficient power to offer this protection. As an example, in Ethiopia, the Civil Code says that consent obtained by force for marriage is invalid. However, the Code says that an agreement based on ‘reverential fear’ for a parent does not invalidate a marriage.²

The Committee that oversees the Convention on the Elimination of All Forms of

The Convention on the Rights of the Child (CRC) defines a child as anyone under the age of 18. The World Health Organization defines an adolescent as a person aged 10-19.

Young people are defined as persons aged 10-24, while youth are defined as 15-24-year-olds.

Discrimination against Women (CEDAW) has recommended that 18 should be the minimum legal age for marriage for both males and females. However, 20 countries are not parties to CEDAW and another 23 have made reservations, withholding support from Article 16 which guarantees equal rights in marriage.³

The legal age of marriage varies from 14 in Bolivia to 21 in Cameroon. Traditional marriages are often allowed at ages well below the legal age and there are still many marriages initiated as soon as the girl becomes sexually mature as defined by the onset of menarche, typically around 12 to 14 years of age. In Ghana, young people below the age of 18 can marry with the consent of a parent or guardian. In Colombia, the legal age of marriage is 18 for boys and girls, but boys over the age of 14 and girls over the age of 12 can marry with the consent of their parents. Turkey has a legal age of 15 for girls and 17 for boys, but religious marriages can take place at younger ages.²

Variations in marriage

There are social and cultural variations in marriage. Marriage is not always one fixed event and the processes are changing throughout the developing world. Even within arranged marriages there is a huge variation in practice. A girl may be betrothed at a very young age but not live with her husband until later.⁴

1. Convention on the Rights of the Child, Article 1.

2. Haberland N et al. 2003. *Married Adolescents an Overview*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

3. Figures for accession and reservations are as at August 2005. The status of accession to CEDAW by individual countries can be checked on the Office of the High Commissioner for Human Rights website. Go to <http://www.unhchr.ch/> and click on Treaties.

4. Brady M. 2003. *Differentiating risk perception and protection needs across the marital transition*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

"The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriage in an official registry compulsory."

Convention for the Elimination of All Forms of Discrimination Against Women, Article 16.2.

Some engaged couples live together before marriage. Other betrothed couples may 'date' before marriage and this may or may not include sexual relations. In other societies pre-marital sex is strictly forbidden.

Couples who cohabit may consider themselves as married, even if no formal marriage ceremony has taken place, and if asked for a survey or census would give their status as married. In some cultures, couples may have a baby together before marriage to demonstrate fertility. Other societies tolerate the taking of more than one wife by a man, although studies have found that women in polygamous unions strongly disapprove.¹

In some societies of Pakistan and South India cousin marriage systems are used to strengthen ties within families, and such marriage systems can have complex rules.² In other societies, for example in north India, there are strict rules preventing such marriages, and 'exogenous' marriages are arranged outside the family.

Combination of factors

Two factors can combine to raise concern over the circumstances of adolescent brides. One is the extreme young age at which marriage can take place; the other is lack of choice and autonomy, especially on the part of the adolescent girl, but also on the part of her husband.

The majority of adolescent brides in Gujarat

Married at 12 years of age to a man who is older than her own father

Maimuna was married at the age of 12 to a man older than her father whom she had never seen before their wedding. She is his fourth wife and has three children. She is lonely and desperate.

Maimuna says: "Forceful marriage brings about hatred and once you hate someone, you can do any evil act against him."

She thanks God that only one of her children is a girl. "I cannot give out my daughter for marriage at 12. I will educate them if I have the means."

Source: Mario V Bello, Adolescent Health and Information Project, Kano, Nigeria

and West Bengal, India, have not met their husbands before the marriage ceremony.³ This is also true in a broader range of countries for girls who are married below the age of 16. In Egypt, girls are more likely to have a say whom they marry if they have stayed longer in school, have literate parents and have worked before they marry.⁴

One study in Bangladesh found that almost all girls who married between the ages of 13 and 19, and their husbands, would have preferred later marriage.⁵ Some had pursued this with their parents but, in most cases, their requests were ignored. A father's death, a large number of daughters, and poor financial circumstances influenced family decisions to marry off their daughters at an early age.

Where young girls are perceived as an economic liability, their marriage may form part of a family's survival strategy. Families may even agree to dowry demands from the husband's

1. UNFPA. 1999. Interactive Population Center. *Sexual and reproductive self-determination. Voluntarism and marriage.*

2. Cleland J. 2005. Correspondence.

3. Santhya K et al. 2003. *The gendered experience of married adolescent girls in India: Baseline findings from the First-Time Parents Project*, presented at the Second Asia and Pacific Conference on Reproductive and Sexual Health, Bangkok.

4. El-Zanaty et al. 1996. *Egypt Demographic and Health Survey 1995*, National Population Council, Cairo.

5. Chowdhury S. 2003. *Pregnancy and postpartum experience among first time young parents in Bangladesh; preliminary observations*, in WHO 2003. *Towards adulthood, Exploring the sexual and reproductive health of adolescents in South Asia*, editors Bott S et al.

family, which they cannot meet.¹ A failure to meet dowry promises affects the position of a married girl within her new home, contributing to feelings of fear, shyness and shame.

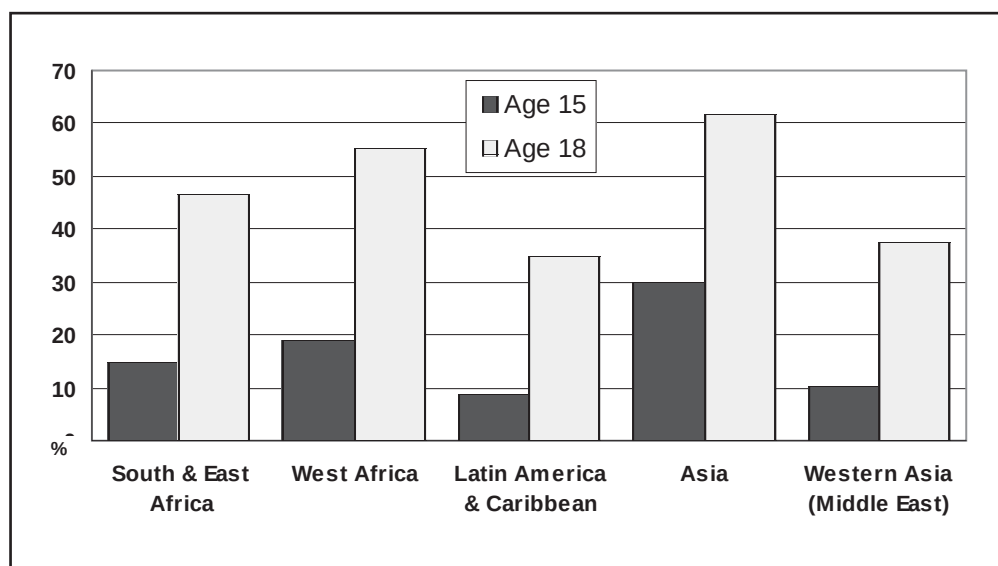
Although early marriages are often said to reflect traditional cultures, the pressures that lead to early marriage are present-day. An investigation in rural Jaipur by the Indian magazine, *Frontline*, found that poverty and rising marriage costs were the main reasons given by parents for early marriage and for marrying off more than one daughter at a time.¹ Custom and tradition were hardly mentioned as reasons. The report concludes that insecurity and rising expenses may be forcing mothers who themselves married after the age of 18 to marry off their daughters before they are 18.

In this document, most data is based on studies or surveys in which adolescent girls or women are asked about their own experience of marriage. Marriage is therefore largely self-defined, and may be formal or informal.

It should be acknowledged that many older adolescents freely choose to enter into cohabitation or marriage, and that many see it as a positive experience which releases them from the lack of autonomy, choices and access to services such as contraception, that can go along with being an unmarried adolescent. The main focus of concern in this document is on marriage at a very young age, on lack of autonomy and freedom to choose by adolescent girls, and on the risks this brings to their health and life chances. ■

Figure 1
Percentage of
adolescent girls
married by the
ages of 15 & 18

The proportion of girls married by 15 and 18 years was highest in Asia, followed by West Africa, South and East Africa and Western Asia (Middle East)



Source: DHS data. Calculated from surveys of women aged 25-49. Cited in Bruce J and Clark S. 2003. *Including Married Adolescents in Adolescent Reproductive Health and HIV/AIDS Policy*, presented at WHO/UNFPA/Population Council technical consultation on married adolescents, Geneva.

Early marriage declining – but still far to go

The age of marriage is rising in most parts of the world, but the number of early marriages is still substantial. Traditional or religious tolerance of early marriage can slow the trend to later marriage. Over the next ten years an estimated 100 million girls will marry before their 18th birthday. They represent one third of adolescent girls in developing countries excluding China.¹

- ◆ 60% or more of girls are married by 18 in Burkina Faso, Chad and Bangladesh,²
- ◆ 50% or more of girls are married by 18 in Mozambique and Nepal,
- ◆ 40% or more of girls are married by 18 in Nigeria, Ethiopia, Malawi, India and the Yemen,
- ◆ 30% or more of girls are married by 18 in Ghana, United Republic of Tanzania, Guatemala and Indonesia,

- ◆ 20% or more of girls are married by 18 in Zimbabwe, Brazil, Haiti and Egypt.

International Planned Parenthood Federation (IPPF) data from 55 countries shows that, between 1992 and 2001, the legal age of marriage was raised in 23 countries for women and in 20 countries for men.³

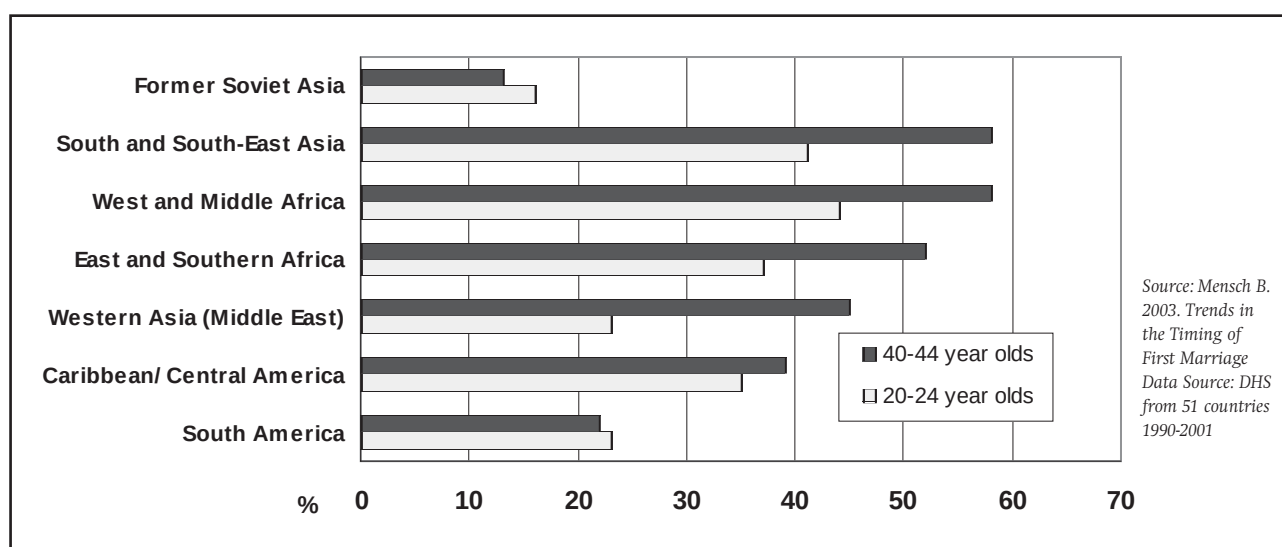
The largest falls in early marriage have been seen in West Africa, East and Southern Africa, South and South-East Asia and Western Asia (Middle East). There were smaller decreases in East Asia and in Central America and the Caribbean. When cohabitation is included there were small increases in South America and in the former Soviet Union.

In some countries the decline has been rapid. In Bangladesh the percentage of girls married by 18 years fell from almost 90% to 65% in 20 years. In Ethiopia it fell from 79% to 49%, in Nepal from 70% to 55% and in Nigeria from 55% to 40%. There were marginal decreases in Burkina Faso, Mali and the Dominican Republic.³

However, very early marriage is still common. The median age of marriage is 16.7 in Mali and

Figure 2
Women married by the age of 18

Comparing the histories of women in their 40s and women in their 20s shows a long-term decline in early marriage.



1. Bruce J and Clark S. 2003. *Including Married Adolescents in Adolescent Reproductive Health and HIV/AIDS Policy*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.
2. Figures from Haberland et al. 2003. *Married Adolescents: An Overview*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.
3. Mensch B. 2003. *Trends in the Timing of Marriage*. Analysis conducted for the National Academy of Sciences Report on Transitions to Adulthood in Developing Countries.

Early marriage

- Early marriage is declining but the number of girls married by the age of 18 is still large.
- Girls in rural areas and those who leave school early are the most likely to be married early.
- Many countries have laws to prevent early marriage. This does not always prevent many girls becoming married as soon as they are sexually mature.

Nepal: education ends when a girl marries young

30 years ago, marriage under the age of ten was common in Nepal. The legal age for marriage was raised and by 1991 the mean age of marriage had risen to 18.1 years. According to the 1996 Nepal Family Health Survey (NHFS), 44% of female adolescents were married and, of these, more than half were already mothers or pregnant. 32% of women who dropped out of school cited marriage as the reason. The NFHS also showed that 32% of illiterate adolescents had started childbearing, compared with only 10% of those who had gone on to secondary education.

Adhikari R. 2003. *Early Marriage and Childbearing: Risks and Consequences* published in WHO. 2003. *Towards Adulthood, Exploring the Sexual and Reproductive Health of Adolescents in South Asia*, editors Bott et al.

16.1 in Bangladesh.¹ In Amhara, Ethiopia, half of women aged 20-24 were married by the age of 15, and the figures were 38% in Bangladesh and 25% in Jinotega, Nicaragua.¹

- ◆ Boys are much less likely than girls to marry early. The highest rate of early marriage for young men is in Chad where about a quarter are married by their 20th birthday: 85% of girls in Chad are married by this age.¹
- ◆ There are large differences between urban and rural populations. In South and South-East Asia twice as many rural girls marry by the age of 18 compared with urban girls. In Mali 74% of rural girls are married by the age of 18, but only 46% of urban girls.¹
- ◆ There is a strong correlation between early marriage and leaving school. In West and Mid Africa, 70% of girls with three years of schooling or less marry by the age of 18.² For

girls with eight or more years of schooling this figure falls to 12%. The same trend is seen to a lesser extent in every region, with early marriage declining in girls who have had four or more years of education, and declining further in girls with eight or more years of education.² In Brazil, Kenya and Mozambique, married girls with no children are even more likely than unmarried mothers to leave school.¹

- ◆ Conflict can disrupt trends and patterns in marriage. In Rwanda and Burundi the usual age of marriage was about 25 for women. Following the war the age of marriage fell.³ In conflicts it can be safer for an adolescent to be married as she may receive more protection. However, conflicts have also made men less able to pay bride price, leading them to delay marriage. ■

1. Figures from Haberland et al. 2003. *Married Adolescents: An Overview*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

2. Mensch B. 2003. *Trends in the Timing of Marriage*. Analysis conducted for the National Academy of Sciences Report on Transitions to Adulthood in Developing Countries. Data Source. DHS tabulations.

3. WHO Regional Office for Africa. 2003. Contribution at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

Sexuality and health in early marriage

The isolation of young adolescent girls within marriage and their lack of education means that they are often the least well-informed group of young people about sexual and health issues.

In Bangladesh only a third of married girls in one study described themselves as well informed about sex before marriage.¹ In Northern Nigeria, another area with high rates of early marriage, married girls had about the same level of knowledge about fertility and contraception as unmarried girls, but knew significantly less about AIDS and RTIs. Fewer than half of the married girls in Northern Nigeria had heard of AIDS and only a quarter knew that they could get HIV through having sex with an infected man. Even those who had heard of AIDS seemed unconcerned. More than 60% felt that they were at no risk of AIDS.²

In Kenya younger married girls were less knowledgeable than older married girls about fertility, STIs and HIV. Younger married girls had significantly less knowledge about their fertile period, and were less likely to know that they could conceive even if the man withdrew before ejaculation.³

In Nepal a survey of 2000 households showed that young married women had access to the radio but less access than their unmarried peers to television or written information. They had the lowest level of awareness amongst young people about STIs, and only two thirds had heard of HIV/AIDS (as opposed to 95% of males and single females). Almost half of mar-

Isolated and less aware

- Married girls often lack knowledge about sex and the risks of STIs and HIV/AIDS.
- Younger wives may feel confused, ashamed or isolated.

ried girls knew that if a husband and wife are mutually faithful that is protective against HIV, and that they are at risk if a husband frequents sex workers. However, married girls were much less likely than unmarried girls to know that condoms can prevent the transmission of sexual infections as well as pregnancy.⁴

Many urban married women in India recall their first sexual experience within marriage as a time of confusion and shame.⁵ Women who had married before the age of puberty often felt they had been 'tricked' into sex by an older woman in her husband's family. Others described shyness and modesty ('sharam'), in circumstances where they were having their first sexual experience in the house of a stranger, where other members of the family were encouraging the couple to be sexually active. Others felt that they had been forced into sex without knowing exactly what it entailed. Others saw sex within marriage as part of a pragmatic arrangement.

Isolation and lack of awareness of their rights means that married adolescents may be more willing than older women to put up with gender violence within the marriage. Married girls are slightly more likely to say that it is acceptable for a man to beat his wife or to force a woman to have sex. There is some evidence that gender violence is more likely with younger

1. Khan M, Townsend J and D'Costa S. 2002. *Behind closed doors: a qualitative study of sexual behaviour of married women in Bangladesh*. Culture, Health and Sexuality, 4(2), April-June 2002.

2. Haberland N, et al. 2003. *Married Adolescents: An Overview*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

3. Erulkar A and Onoka C. 2003. Data from *Adolescent Reproductive Health Information and Services Survey*, Central Province, Kenya, 2001.

4. Neupane S, Nichols D and Thapa S. 2003. *Knowledge and Beliefs about HIV/AIDS among Youth in Urban Nepal*. Asia-Pacific Population Journal, Dec 2003.

5. George A. 2003. *Newly married adolescent women: experiences from case studies in urban India*, published in WHO. 2003. *Towards adulthood, exploring the sexual and reproductive health of adolescents in South Asia*, edited Bott S. et al.

wives. A DHS survey in Egypt found that 29% of married adolescents had been beaten by their husbands.¹ In Bangladesh married men under the age of 30 were more likely than older men to beat their wives.² The age difference between husband and wife within marriage suggests that younger wives are therefore more likely to be beaten. A study in China, Province of Taiwan also showed that girls under the age of 18 were more likely to experience domestic violence.²

"Efforts must be made to narrow the information gaps that exist between the sexes and marital status. Married females remain largely neglected. ... Current approaches to information and knowledge dissemination do not seem to be sufficiently gender or marital-status sensitive."

Asia-Pacific Population Journal. 2003. *Knowledge and Beliefs about HIV/AIDS among Youth in Urban Nepal*.

Age gap can lead to isolation for younger wives

The age gap between an adolescent bride and her husband tends to be bigger, the younger the adolescent girl. The mean age difference between a married girl aged 15-19 and her husband is 13.9 years in Guinea, 10.7 years in Burkina Faso, and 9.8 years in Bangladesh.¹ Age gaps tend to be smaller in Latin America and the Caribbean, but are greater than seven years in Haiti and the Dominican Republic. As the age of marriage increases, the age difference between a young bride and her spouse decreases.²

This age gap shapes the social context of the marriage. The greater the gap the less easy it is for the couple to talk. In Mali, a married girl under the age of 19 is twice as likely to discuss how to avoid AIDS with her husband if he is less than six years older than she is.³

The young married girl is consistently more isolated than an unmarried girl or older married woman. In Bangladesh, 80% of unmarried girls reported having many friends who lived close by while only just over 40% of married adolescents could say the same.⁴

In an Indian study only one in seven married girls aged 15-19 (13.8%) could go to market without her husband's permission and only one in ten (10.2%) could visit friends without permission.⁵ Twice as many older married women had the freedom to do these things. The age gap can also be a risk factor for STIs and HIV/AIDS. Among girls aged 15-19 in Uganda, the risk of HIV infection doubles for those whose partners are ten years or more older than they are.⁶ In Zimbabwe, the risk increases for each year of age difference between partners.⁷

1. Bruce J and Clark S. 2003. *Including Married Adolescents in Adolescent Reproductive Health and HIV/AIDS Policy*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.
2. Mensch B. 2003. *Early Marriage in a Demographic Context*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.
3. DHS data, Mali.
4. Amin S, Mahmud S and Huq L. 2002. *Baseline Survey Report on Rural Adolescents in Bangladesh*. Dhaka: Ministry of Women's Affairs, Government of Bangladesh.
5. Santhya K and Jejeebhoy S. 2003. *Sexual and Reproductive Health Needs of Married Adolescent Girls*. Economic and Political Weekly Vol XXXVIII, No 41.
6. Kelly R and Gray R, 2003. *Age Differences in Sexual Partners and Risk of HIV-1 Infection in Rural Uganda*. Journal of Acquired Immune Deficiency Syndromes, Vol 32, No 4, April 1, 2003;
7. Gregson S et al. 2002. *Sexual Mixing Patterns and sex-Differentials in Teenage Exposure to HIV infection in Rural Zimbabwe*, The Lancet, 359 1986-2003, (6&7 both cited in Luke N and Kurz K. 2002. *Cross-generational and Transactional Sexual Relations in Sub-Saharan Africa: Prevalence of Behavior and Implications for Negotiating Safer Sexual Practices* ICRW AIDSMark.)

1. Bruce J. cited in UNICEF. 2001. *Early Marriage, Child Spouses*. Innocenti Digest, No.7. Florence, Italy: Innocenti Research Centre.
2. Nurse J. 2003. *Gender Based Violence in Married and Partnered Adolescents*. presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

Secret hopes of the invisible married adolescents

In Senegal one in nine girls is married by the age of 15 and half are married by the age of 20. However, married girls of this age were not recorded as adolescents in a household survey in Dakar. Married girls, even those who marry at 15, are treated as adult women and known as *Sokhna* or *Diongoma*. Words in the Wolof language for adolescent — *Ndiankhe* and *Ndiangamar* — connote frivolity.

A Population Council research team conducted a qualitative study to find out about these invisible married adolescents. Some had been married as early as 12 and some were on their second marriage or in polygamous unions. In most cases parents had arranged the marriage. Some girls had not met their spouses before marriage, and a few had learned they were to be married only on the day of the wedding.

The Senegal HIV/AIDS national programme identified married adolescents as a sub group at high risk of HIV/AIDS because families tended to marry them to older migrant workers.

However, married adolescents perceive themselves as being at low risk of HIV and their families share this view.

Only 6% of married girls continued in school. Most dropped out because their husbands or parents asked them to do so. However, many would like to continue to learn, and about a third made an agreement with their husbands that they could continue in school.

They lamented how little they knew about their bodies, sex and reproductive health. They wanted to learn to read and write and wanted skills that would allow them to earn. Married adolescents are financially dependent on their husbands. They do more work and enjoy less freedom after marriage.

The girls' families expect a child soon after marriage, but girls prefer to delay. Girls under 15 wanted to delay childbirth 4-5 years; those aged 15-18 for 2-3 years.

Source: Diop N and Meyers C. 2003. *Married Adolescent Girls' Lives: A Perspective from Senegal*. Population Council. Data DHS 1997.

In Brazil a quarter of men in one study had physically abused their partners. Rates of violence were highest in the 20-24 age group whose partners were more likely to be adolescent girls.¹

Some very young brides have little or no say in their sexual initiation. A 1997 study in Calcutta found that 80% of girls who married before the age of 15 and who attempted to resist sex with their husband, were forced to do so against their will.² In many countries rape laws exclude forced or violent sex within marriage.

Bruce and Clark show that in many countries women are conditioned to accept that a hus-

band has a right to sex.³ Asked whether a husband was justified in beating his wife if she refused him sex, more than 40% of women agreed in Ethiopia and Zambia and more than 60% agreed in Mali. In Turkey, 13% of women agreed and in Haiti, more than 10% agreed.

In a survey by the Navrongo Health Research Centre, Ghana, of 3,220 adolescent girls, one third agreed that a man sometimes has to force a girl to have sex, and 38% agreed that a boy is sometimes justified in beating his girlfriend. Married adolescents, made up only 15% of this sample, but were slightly more likely to accept and justify male violence against women.⁴ ■

1. Instituto PROMUNDO and Instituto NOOS. 2003. *Men, gender-based violence and sexual and reproductive health: A study with men in Rio de Janeiro, Brazil*.
2. UNICEF. 2001. *Early Marriage, Child Spouses*. Innocenti Digest, No.7. Florence, Italy: Innocenti Research Centre.
3. Bruce J and Clark S. 2003. *Including Married Adolescents in Adolescent Reproductive Health and HIV/AIDS Policy*. Table 5.
4. Debpuur C. 2003. *Married Adolescents in the Kassena-Nankana District, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents*, Geneva.

Early marriage often leads to unsafe sex

Marriage is often seen as a state where women are protected against sexually transmitted infections and against HIV/AIDS, but it is not. A monogamous marriage between two uninfected people is indeed protective. But marriage can also institutionalise the transfer of infection and allow society to drop its guard. The idea of marriage as a fortress against HIV is a myth.

The most common route to risky sexual intercourse for adolescent girls in developing countries is through marriage. This is because, in most countries, more married adolescent girls than unmarried adolescent girls are having unprotected sex, they have sex more frequently and they are less likely to protect themselves. In many countries the use of condoms is almost exclusively confined to non-married sexual relationships.¹ In this context, marriage can include stable relationships that have not been formalised. In the Dominican Republic, 22.4% of 15-19-year-old girls in 1996 considered themselves to be married, even though the vast majority of marriages at this age are 'without papers'.² Of sexually active girls in this age group, 87% were married and only 1.5% of married girls used a condom the last time they had sex.

In many cultures, parents encourage their daughters to marry young because they regard marriage as a place of safety that will protect them from harm and disgrace. In fact, married adolescent girls tend to have higher rates of HIV than their sexually active unmarried counterparts. Young married women have little knowledge of the risks of sex or what they can

No hiding place

- Marriage is no protection against STIs, HIV and AIDS.
- Most unprotected sex by adolescent girls takes place inside marriage.
- Young girls are often married to sexually experienced older men who may be infected.
- Condoms are used less within marriage than outside marriage.

"Almost magically, the same partner who prior to marriage may have been viewed as 'risky', upon marriage becomes safe; sex within marriage is often assumed to be safe. Changing perceptions of risk and bringing condoms across the marital boundary is an important programmatic challenge."

Martha Brady. *Differentiating risk perception and protection needs across the marital transition.*

do to protect themselves. They are relatively powerless within the marriage to decide on issues of contraception and protection. They are encouraged, and often desire, to have a baby as soon as possible to prove their fertility, and are therefore unlikely to use contraception. Even where a girl plans to delay pregnancy, she may use contraception which is not protective against STIs or HIV. In many cultures condoms are "de la calle" (for the street), that is for sexual relationships considered risky, not "de la casa" (for the home) where sex is considered safe. In Asia, Africa, Latin America and the Caribbean, condoms are mainly reserved for short-term sexual relationships.

Bruce and Clark looked at DHS data from 26 countries in Africa, Latin America and the

1. Bruce J and Clark S. 2003. *Including Married Adolescents in Adolescent Reproductive Health and HIV/AIDS Policy*, presented at WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, Geneva.
2. Goldberg R. *Early marriage and HIV in the Dominican Republic*, presented at WHO/UNFPA/Population Council Technical Consultation on Married Adolescents, Geneva.

Caribbean and found that “in most of the 26 countries with data on sexual activity on married and unmarried adolescents the majority of sexually active girls aged 15-19 are married”.¹ In another five countries (Bangladesh, Egypt, India, Indonesia and Turkey) “we can plausibly assume that more than 80% of sexually active girls are married”.¹ Figure 3 shows that a clear majority of sexually active girls who had unprotected sex ‘last week’ were married.

Not only are the majority of adolescents girls who are having sex, married, but Bruce and Clark found that the risk exposure of married adolescents is even higher than these figures suggest, because a married girl is likely to have sex with her husband more frequently than an unmarried sexually active girl has with her boyfriend, and because sex within marriage is much less likely to be protected with condoms. Bruce and Clark conclude: “On average across these 31 countries, 80% of unprotected sexual encounters among adolescent girls occurred within marriage”.¹

Abstinence ‘not an option’

“In Mozambique, the overall HIV infection rate amongst girls and young women — 15% — is twice that of the boys their age, not because the girls are promiscuous but because nearly three in five are married by the age of 18, 40 per cent of them to much older, sexually experienced men, who may expose their wives to HIV and sexually transmitted diseases. Similar patterns are common in other nations where HIV is rapidly spreading. Abstinence is not an option for these child brides. Those who try to negotiate condom use commonly face violence or rejection. And in heterosexual sex, girls and women are biologically more vulnerable to infection than are boys and men ... Parents know little about sexuality, contraception or sexually transmitted diseases, and many believe that early marriage will ‘protect’ their daughters.”

Dr Pascoal Mocumbi, Prime Minister of Mozambique.
2001. *A Time for Frankness on AIDS and Africa*, New York Times, June 20, 2001

Figure 3: Percentage of married girls and of sexually active unmarried girls in selected countries who said that they had had unprotected sex in the previous week.



1. Bruce J and Clark S. 2003. *Including Married Adolescents in Adolescent Reproductive Health and HIV/AIDS Policy*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

The risk of HIV or STIs comes not only as a result of a husband's sexual experience before marriage, but also because of extra-marital sex. In the Dominican Republic, where AIDS is the leading cause of death for women of reproductive age, a study showed that 30% of married men had had extra-marital sex in the previous 12 months and that the figures were even higher for younger men, who are more likely to have younger wives.¹ This researcher expressed the view that: "It is normal for men to enter into and maintain sexual relations with any number of secondary partners, ranging from sex workers to secondary 'spouses' with whom they form secondary family units, at times with children."¹

The relative risk of HIV within marriage is increasingly reflected in statistics.

- ◆ A study in Kenya and Zambia, found that infection rates amongst married girls aged 15-19 were 10 percentiles higher than among unmarried girls the same age.²
- ◆ In India, infection rates are rising fastest among married women, who accounted for 40% of all new infection cases in 2002.³
- ◆ The National AIDS report for Ethiopia for 2002 noted that infection rates had risen amongst 15-19 year old females, attributing this to "earlier sexual activity among females and the fact that they have older partners".⁴ A quarter of adolescent girls in Ethiopia are married, and they represent 94% of girls who are sexually active.
- ◆ In Kisumu, Kenya, almost one in three husbands of married adolescent girls is infected with HIV, compared with only one in ten partners of sexually active unmarried girls.⁵

Reality of forced sex replaced dreams of school for Rakiya

Rakiya dreamed about going to school but never saw the inside of a classroom. She was married aged 12 years to a man she hardly knew. She was raped within her marriage and lived in fear of the nights. Her father beat her when she ran away.

Rakiya was still 12 when she had her first child, a long, terrifying experience. She had five children by the age of 20 and another on the way, when her husband died.

With no source of income she was recruited to the sex trade in Jeddeh. Now she sells bean cakes by the roadside and earns enough to feed her children and send her boys to school.

Rakiya believes that early marriage is due to ignorance amongst parents. "They believe that the girls will spoil, not knowing that is wrong. I never fooled around with men until I found myself in a terrible situation and I had to use what God has given me to feed my children."

Source: Bello M. 2003, presentation at WHO/UNFPA/Population Council technical consultation on married adolescents, Geneva.

In Ndola, Zambia, twice as many husbands of married adolescents are infected with HIV compared with boyfriends of unmarried adolescents.⁵

- ◆ In the Rakai district of Uganda, 88.5% of girls aged 15-19 infected with HIV were married, while only 66.4% of uninfected adolescent girls were married.⁶ Researchers commented, "This suggests that many of the HIV-positive female adolescents were infected by an older husband." ■

1. Goldberg R. *Early marriage and HIV in the Dominican Republic*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

2. Glynn J et al. for the Study Group on Heterogeneity of HIV Epidemics in African Cities. 2001. *Why do young women have a much higher prevalence of HIV than young men? A study in Kisumu, Kenya and Ndola, Zambia*. AIDS 15(suppl 4), S51-60. Cited in Bruce and Clark (op cit)

3. Center for Health and Gender Equity & Sexuality Information and Education Council of the United States. 2004. *Women and HIV/AIDS in the U.S. Global AIDS Strategy*.

4. Bruce J and Clark S. 2003. *Including Married Adolescents in Adolescent Reproductive Health and HIV/AIDS Policy*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

5. Clark S. 2004. *Early marriage and HIV Risks in Sub-Saharan Africa*. Studies in Family Planning, September 2004.

6. Kelly RJ, et al. *Age difference in sexual partners and risk of HIV-1 infection in rural Uganda*. JAIDS 2003; 32(4): 446-451.

Early marriage may be driven by fear

Early marriage tends to be high in poorer countries, in rural areas and amongst girls who have less than six years of education. But surveys show that most adolescent girls would like to delay marriage and childbirth — even if only for a year or two. Few families *want* early marriage. Families negotiate and arrange marriages because of economic reasons or because they fear that shame could be brought onto the family. The main driving force behind early marriage is fear of the alternative.

Historically, early marriage was desirable because it increased the number of children that a woman could have over a lifetime, but today women want fewer children and want them to be better spaced.¹ Early arranged marriages today are more to do with family fears that a girl's marriageable status may be ruined in a society where there are few viable alternatives. Mothers may be committed to their daughters having more opportunities and a less restricted life than they themselves have had. However, they also wish to protect the family honour. Menarche is a warning bell for adolescent girls, and may mark the end of youthful freedoms, while adolescence is a period of experimentation for young men.

Families consider alternatives for their adolescent daughters only if they do not damage marriage prospects. When asked what would be the effect, if her daughter delayed marriage for four years, one mother from Egypt replied: "I would be worried for four more years."² A proverb in Nepal: "Spilled water on the doorstep is very dangerous: anything can hap-

Daughter's reputation may be damaged

"In Nepal everyone wants the age of marriage to be later but parents are worried that their daughter will be harassed and that young men will want to have sex, and her reputation can be damaged even without having sex."

Anju Malhotra, Director Population and Social Transitions, International Center for Research on Women
Variations in the Meanings of Marriage: A Historical and Cultural Perspective

pen," alludes to the threat that a daughter kept at home becomes an invitation to disaster.³

There may be economic disincentives for a family to invest in a daughter's education since a daughter traditionally becomes part of her husband's household. There may also be a disincentive to encourage her to delay marriage.

Dowry is common in South Asia, Western Asia and in Africa, where it is known as 'bridewealth'. There are many variations and the way that dowry works is changing. Traditionally, dowry was a bequest, which a bride takes into her marriage. In some settings, it has been 'modernized' and is now a price in cash or kind paid to the groom or his family. It has also, in some settings, become more institutionalized and burdensome. In rural Maharashtra dowry was seen as optional in the mid-1970s but by 1987, a bride could suffer if dowry was not given.⁴

This can lead to a tendency to see a daughter as a commodity whose value is damaged by delay. Young age can be seen as a guarantee of virginity and husbands may pay a higher bride-price. In arranging early marriage, a family may see itself as protecting a girl's virtue, prospects and value, and the family income.

Dowry and brideprice have a long-term effect on a relationship within marriage. In India, disputes over dowry and failures by the bride's

1. Malhotra A. 2003. *Variations in the Meaning of Marriage: Historical and Cultural Perspective*. ICRW. Presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

2. Mensch B. 2003. *Trends in the Timing of First Marriage*. Analysis for the National Academy of Sciences Report on Transitions in Adulthood in Developing Countries.

3. Waszak et al. 2003. *The influence of gender norms on the reproductive health of adolescents in Nepal - perspectives of youth*. Published in WHO 2003. *Towards adulthood Exploring the sexual and reproductive health of adolescents in South Asia*, edited Bott S et al.

4. Vlassoff C. 1994. *From Rags to Riches: The Impact of Rural Development on Women's Status in an Indian Village*. World Development, Vol 22, No 5, cited in Haberland N et al. 2003. *Married Adolescents: An Overview*.

family to pay what they have promised are common reasons for a woman being beaten by her husband.¹ A groom who has paid a bride price may regard his wife as his property. Asked whether she could refuse sex with her husband and whether he could beat her, a woman in Ghana replied: "He has paid the bridewealth of three cows to my father. That is why he has absolute authority over me and my children."²

In some societies girls are not expected to be virgins at marriage. In some African societies a girl who demonstrates fertility by becoming pregnant before marriage may enhance her prospects of marriage. She may therefore feel under pressure to 'prove she is a woman'.

What do men want from marriage?

There is little evidence about what most men think about marrying young girls. In some settings men also have limited choices about whom they marry.

Researchers in India found that although adolescent males have more freedom than girls, the two most important decisions in their lives — choice of work and partner in marriage — are largely decided by other adults.³ Male university students aged 24–31 years in Kaduna, Nigeria, had postponed marriage so they could finish their studies, but many were coming under pressure from families. One said: "You have to get a girl pregnant before you are married to prove that you are a man. You prove yourself to your family by how many children you have. You know, your mother will say that she wants to have grandchildren."³

Boys can come under pressure to have early sexual experience. Boys in Guinea reported that if they did not have sex their reputations would suffer among their male peers.³ Boys may see paid work as validating their existence and giv-

Girls would prefer to delay marriage

- Families may endorse early marriage because they fear for their daughter's prospects, or that delay will lead to disgrace.

- Most adolescent girls prefer to delay both marriage and childbirth.

- Adolescent males have more autonomy, but may lack the right to choose their wife.

- In many countries boys are under social pressure to seek early sexual experience.

ing them an income to sustain a family. Having no work means having low status with family and potential girlfriends. It has been suggested in Jamaica that one reason for some girls delaying marriage is that they see few young men as potential husbands. These examples show a wide range of outcomes resulting from social pressures on adolescent girls and boys.

Early marriage declines where there are safe alternatives

Early marriage declines if there are viable and safe alternatives for girls. Education and training leading to paid employment are two reasons why girls may postpone marriage. In Bangladesh and China, Province of Taiwan, daughters and parents show interest in delaying marriage, where jobs are available.⁴ ■

1. Rao V. 1997. *Wife-Beating in Rural South India: A Qualitative and Econometric Analysis*. Social Science and Medicine, Vol 44, No 8, cited in Haberland N et al. 2003. *Married Adolescents: An Overview*.

2. Adongo et al. 1997. *Cultural Factors Constraining the Introduction of Family Planning Among the Kassena-Nankana of Northern Ghana*. Social Science and Medicine, Vol 45, No 12, cited in Haberland N et al. 2003. *Married Adolescents: An Overview*.

3. Barker G. 2003. *Reflections on the Roles, Responsibilities, and Realities of Married Adolescent Males and Adolescent Fathers*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

4. Mathur S, Greene M and Malhotra A. 2003. *Too Young to Wed: The Lives, Rights and Health of Young Married Girls*. International Center for Research on Women, citing Amin S et al. 1998. *Transition to adulthood of female garment-factory workers in Bangladesh*. Studies in Family Planning 29(2): 185–200.

Gap between marriage and first child is falling

Although the average age of marriage is rising in most parts of the world, the gap between marriage and having a first baby is decreasing and this offsets some of the benefit of delaying marriage¹. There is a double pressure on a young bride to conceive within a year: a rise in status for a young wife who gives birth, but gossip and disapproval if too much time passes before she proves her fertility.

Young couples often have their first child within 12-20 months of marriage, and while older adolescents are more likely to become pregnant quickly, some of the youngest girls also become mothers at a very young age.

In Bahrain one in five adolescent girls who

Girls under pressure to have first baby

- The delay between getting married and having a first child has fallen over a 20-year period.
- Many married adolescent girls and their husbands would prefer to delay their first baby.
- Young married couples find it difficult to put their wishes into effect.
- They fear that delay will lead to gossip and damage the status of a married adolescent.

gives birth does so before the age of 16, and some child mothers are as young as 11.

In Mali, where 25% of women are married by

Grandmother at 24, great grandmother at 38

Sitting on the floor of her dishevelled home the size of a broom cupboard in Old Delhi, Bano recounts her precocious achievements. She was married at the age of 10, and had her first child when she was 11. Her daughter was 12 when she married and 13 when she had her own first child, making Bano a grandmother at 24.

Bano's granddaughter also married at puberty, and gave birth when she was 14 — thus Bano became a great grandmother at 38.

In another room across a narrow, dank, vertiginous staircase crawling with toddlers and goats, lives Bano's neighbour 16-year-old Rukshana, mother of three children. Her younger sister Yasmin is 13. She will be getting married any day now. In virtually every house in this Muslim neighbourhood it's the same story.

"I had no idea the minimum age for marriage in India is 18. All our girls are married the moment their periods start," says Bano, who, like many child brides who bear children early and frequently, looks 70, although she is 48."

Amrit Dhillon, *A mum at 11, a great grandmother at 38*, The Times (London) 28 August 2002.

1. Mensch, B. 2003. *Trends in the Timing of First Marriage* Analysis conducted for the National Academy of Sciences Report on Transitions to Adulthood in Developing Countries. Much of the data in this section is from this source.

the age of 15, one in ten adolescent girls has been pregnant by the age of 15, and nearly 40% are pregnant or have already had a child by the age of 17.¹

The 1996 Nepal Family Health Survey (NFHS) showed that 44% of female adolescents were married, and that more than half (54.3%) of the married adolescents girls were already mothers or were pregnant.² Other data shows that in Bangladesh, Cameroon, Malawi, Mali, Niger and Nigeria 8%-15% of adolescents were aged 15 or less when they gave birth.³

Figure 4 shows that the gap between getting married and having a baby has fallen over a 20 year period in most parts of the developing world. This was assessed by asking women who had been adolescent brides, but were at the time of interview aged 40-44 years or 20-24 years about their experiences.

Figure 4 shows that the older age group of women in South and South-East Asia, West and Central Africa and Western Asia (Middle East), had delayed their first babies for an average of 30 months. In Central and South America, in the Caribbean and in East and Southern Africa, this older age group had delayed childbirth for more than 20 months.

'My in-laws wanted me to have a child'

"I do not feel any pleasure about this pregnancy. I did not expect to conceive this early as I think I am too young to bear children. This will increase my responsibilities. I will have to look after the children at such a young age. But my in-laws wanted me to have a child."

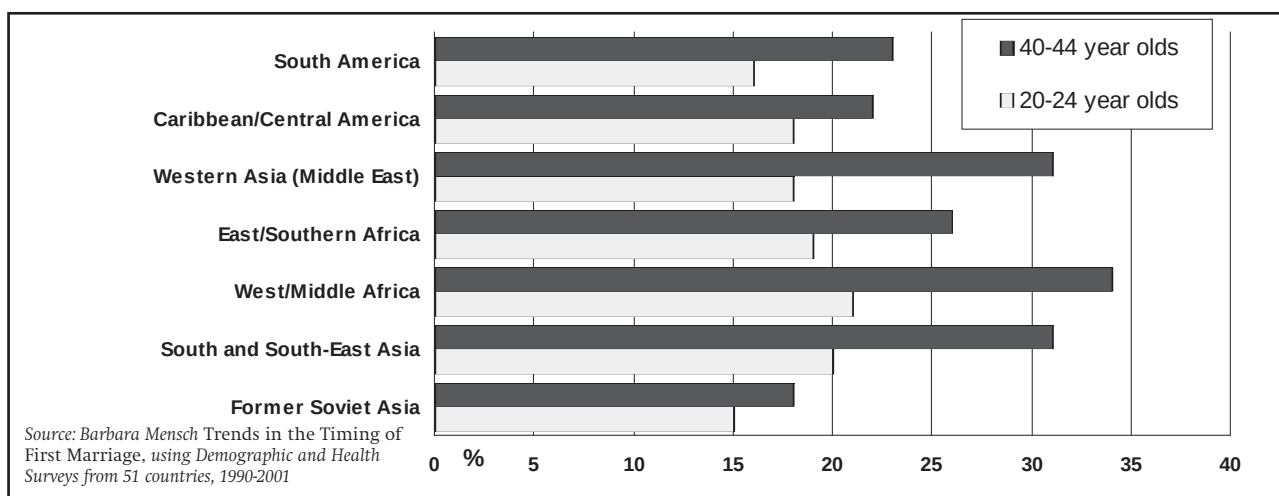
17 year old wife in rural Maharashtra, India

Source: Alka Barua et al Caring Men? 2004. *Husbands' Involvement in the Maternal Care of their Young Wives*, Economic and Political Weekly December 25, 2004

However, in the case of women who had been adolescent wives more recently and were in their 20s when questioned, the average delay had fallen to less than 20 months almost everywhere, and to just over 20 months in South and South-East Asia and in West and Central Africa. The largest decline in waiting time occurred in Western Asia (Middle East), West and Central Africa and South and South-East Asia.

This comparison between the two groups shows that the delay in having a first child is falling. This change offsets some of the gains in the decline in early marriage over this 20-year

Figure 4: Average number of months between marriage and first birth: Women now aged 40-44 and 20-24 who married as adolescents.



1. Katzive L. 2003. *Addressing the Human Rights of Married Adolescents*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva

2. Adhikari R. 2003. *Early marriage and childbearing: risks and consequences*, in WHO 2003. *Towards adulthood, Exploring the sexual and reproductive health of adolescents in South Asia*, editors Bott S et al.

3. Miller S and Lester F. 2003. *Married first time mothers - meeting their special needs*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

period because marriage is delayed to a greater extent than motherhood.

There is evidence that couples in many parts of the world would like to delay starting a family. There are some countries, according to DHS figures, where six out of ten married adolescents wanted their first child within two years: United Republic of Tanzania, Burkina Faso, Guinea, Nigeria and Egypt.¹ However, fewer than half of married adolescents wanted to give birth within two years in a greater number of countries, including Ethiopia, Kenya, Malawi, Rwanda, Uganda, Benin, Guatemala and Bangladesh. In South Africa, Ghana, Brazil, Colombia, Dominican Republic, Nicaragua and Peru, fewer than one in three married adolescents wanted to give birth within two years.¹ In Haiti fewer than one in 14 married adolescents wanted a baby within two years.¹

In Senegal focus groups and in-depth interviews with more than 300 married adolescent girls showed that, despite pressure from families, most wanted to delay the first or subsequent birth.² Those under the age of 15 wanted a four to five year delay, while those aged 15-18 wanted a two to three year delay. Those aged 18 or 19 were more likely to want a baby straight away.

In Nepal married adolescents of both sexes regard the ideal age for a girl to marry as between 17 years 9 months and 18, while unmarried adolescents say that girls should wait until they are over 19.³ Most adolescents believe that a girl should wait two years before having a baby. Married adolescent girls said that the ideal age to give birth is just under 20 years. Unmarried girls and boys thought that girls should wait until they are over 21. Most adolescents would like two or three children.

Such studies reflect wishes and aspirations. However, younger adolescents often lack the

Childless women stigmatised as source of misfortune

"If the couples do not have children for a few years, the girl is called tharangi (infertile) and is considered unlucky. The community members will not even look at such a woman before doing something important for fear she will cause misfortune."

Nepalese mother

Source: Waszak C, Thapa S and Davey J. *The influence of gender norms on the reproductive health of adolescents in Nepal - perspectives of youth*. Published in WHO 2003. *Towards adulthood Exploring the sexual and reproductive health of adolescents in South Asia*, edited Bott S et al.

ability to put these into effect. Negotiation skills and power increase with age, education, employment opportunities and independence.

Fear of infertility can be a significant reason for seeking an early pregnancy. Mothers-in-law, relatives and friends often apply overt or subtle pressure on young married couples to have a baby within the first year, and a newly married adolescent wife is often anxious to prove her fertility as a way of securing her future. Infertility can have serious implications for the life of a young married woman, leading to gossip, lack of respect and poor treatment by relatives.

A survey of 100 pregnant women in Uttar Pradesh, India, showed that women are willing to control their fertility through sterilisation only after they have had what they regard as the right number of children.⁴ One husband referred to a financial crisis at home and said: "I think that the first child should be delayed, especially when the woman is below 19 years of age. ...But my wife does not agree. She wants a child immediately." Condoms were rarely used within marriage, underlining the relative lack of control that young married couples, especially girls, have over fertility. ■

1. Bruce J and Clark S. 2003. *Including Married Adolescents in Adolescent Reproductive Health and HIV/AIDS Policy*. Table 2.

2. Diop N, Myers C and Bruce J. 2003. *Married adolescents: a perspective from Senegal*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

3. Thapa S and Haberland N. *Are married young girls and boys more disadvantaged than their counterparts? Evidence from Nepal*. Unpublished document circulated at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

4. Barua A and Kurz K. 2001. *Reproductive health-seeking by married adolescent girls in Maharashtra, India*, Reproductive Health Matters Vol 9 No 17, May 2001.

The risks of early pregnancy

Early childbirth can be especially risky for adolescent girls and their babies. Many studies report less favourable outcomes for adolescent mothers including higher levels of maternal mortality, the main causes being malaria, pregnancy-induced hypertension, puerperal sepsis and septic abortion.¹ Maternal mortality in adolescent girls is up to twice as high as for mothers aged 20-34 (Figure 5). A World Health Organization review of adolescent pregnancy concludes that, although adolescent pregnant girls are at increased risk of complications, there is doubt whether age alone is the critical risk factor for maternal death, as it is difficult to distinguish between the risks related to the age of the mother and risks related to a first pregnancy.¹ Adolescent first time mothers are at risk, both because they are young and because they are first time mothers. Low levels of education, social status and use of health facilities are also factors.

Girls who have babies below the age of 15

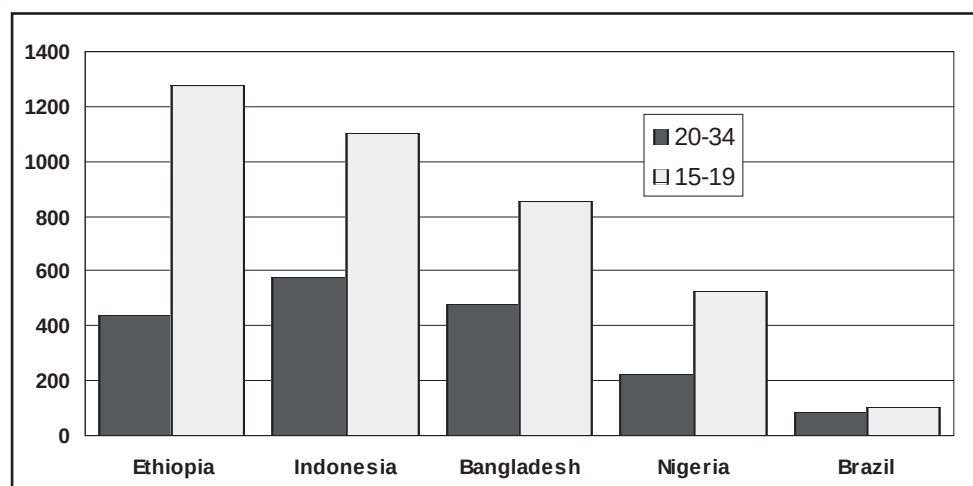
appear to be at extra risk. 'Gynaecological age' is the number of years since menarche, and girls with a gynaecological age of less than two are at higher risk of obstructed labour. Girls who become pregnant at or just after menarche are not ready for childbirth physically or psychologically and are at higher risks of complications. The pelvis continues to grow after menarche, and a growing pregnant girl must compete with her baby in the womb for nutrition. The WHO review concludes, "Low gynaecological age appears to be an independent factor influencing the outcome of adolescent pregnancy."¹ Younger mothers are often less psychologically prepared, especially since 60% of married adolescents report that their first birth is mistimed or unwanted.²

Hypertensive disease

Hypertensive disease is a leading cause of maternal deaths. Pre-eclampsia and eclampsia account for approximately one in seven maternal deaths in Bangladesh, one in five in Nigeria and the Philippines, about a quarter in Mozambique, Ecuador and South Africa, a third in Puerto Rico and almost half in United Republic of Tanzania.³ Pre-eclampsia complicates 5-8% of all pregnancies and 85% of cases are in first time mothers.²

Figure 5: Maternal mortality per 100,000 women by age in selected countries.

Source: Safe Motherhood Initiative Factsheet, *Adolescent Sexuality and Childbearing*, 1998



1. WHO. 2004. *Adolescent pregnancy. Issues in adolescent health and development*. Department of Child and Adolescent Health and Development and Department of Reproductive Health and Research. WHO Discussion Paper on Adolescence.
2. Miller S and Lester F. 2003. *Married Young First Time Mothers: Meeting their special needs*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva. Much of this section follows the Miller and Lester analysis.
3. Duley L. 1992. *Maternal mortality associated with hypertensive disorders of pregnancy in Africa, Asia, Latin America and the Caribbean*. Br J Obstet Gynaecol; 99(7): 547-53. Review. Cited in Miller and Lester. 2003. Op cit.

Anaemia and malaria

More than half of pregnant women are anaemic, with much higher rates in developing countries — 86% in United Republic of Tanzania, 88% in India and 94% in Papua New Guinea.¹ Anaemia is frequently a product of malnutrition, especially deficiencies of iron, vitamin A and folic acid. Girls in many societies are discriminated against when food is shared within a family, and those who become pregnant while they are still growing are likely to become anaemic if undernourished to begin with. While anaemia alone is rarely the primary cause of maternal or child death, it is frequently a co-factor. It has been cited as such in 40% of maternal deaths in the Gambia.² In India, anaemia was found to complicate 35% of adolescent pregnancies but only 22% of the pregnancies of older first time mothers.³ This hospital-based study in India also found significantly higher rates of pregnancy induced hypertension and preterm labour in adolescent mothers.

Malaria and other parasitic diseases are also important causes of anaemia. Malaria infection tends to be more severe in pregnant women and especially in first time mothers. Younger pregnant women in Kenya and Cameroon were twice as likely as older pregnant women to have malaria. In Mozambique, where malaria is the leading cause of hospital based adolescent maternal mortality,⁴ 79% of maternal deaths in a leading Maputo hospital were classified as avoidable, and adolescents tended to be more mismanaged and misdiagnosed.⁵ Health staff tended to underestimate the gravity of the disease in first and young pregnancies, leading to delays in treatment and management. Adolescent mothers are less likely to protect themselves from mosquito bites and less likely to seek treatment for malaria.⁶

Young first time mothers at risk

- Maternal mortality rates are twice as high in adolescent mothers than in older women.
- The risks are related to being a young first-time mother.
- Very young adolescents are physically and psychologically unready for childbirth.
- Hypertension and anaemia are common problems.
- Many young women are disabled by fistulae as a result of prolonged labour.
- There is a higher risk of poor health outcomes for babies of adolescent mothers.

Obstructed labour and fistula

Prolonged or obstructed labour is usually the result of the mother having a small pelvis, or the baby being awkwardly positioned. The risks are greater in first time mothers, smaller women and in very young mothers below the age of 15. Women who have access to emergency obstetric care will have their babies delivered by Caesarean section when labour is prolonged. In poor, particularly rural areas, women may not know when or how to seek help and are often far from obstetric care. Adolescent mothers usually do not have the decision-making power or the means to seek help at the right

1. Brabin B, Hakimi M and Pelletier D. 2001. *An Analysis of Anemia and Pregnancy-Related Maternal Mortality*. Journal of Nutrition; 131:604S-615S.
2. Hoestermann C et al. 1996. *Maternal mortality in the main referral hospital in The Gambia, West Africa*. Trop Med Int Health; 1(5): 710-717.
3. Verma V and Das K. 1997. *Teenage Primigravidae: A Comparative Study*. Indian Journal of Public Health. Apr-June 1997. 41(2).p.52-55.
4. Granja A. 2002. *Maternal deaths in Mozambique: An audit approach with special reference to adolescence, abortion, and violence*. Online at <http://diss.kib.ki.se/2002/91-7349-218-3/> — checked October 2005.
5. Granja ACL, Machungo F, Gomes A et al. *Adolescent maternal mortality in Mozambique*. Journal of Adolescent Health 2001; 28(4):303-06.
6. Okonofua F et al. 1992. *Influence of socioeconomic factors on the treatment and prevention of malaria in pregnant and non-pregnant adolescent girls in Nigeria*. Journal of Tropical Medicine and Hygiene; 95: 309-315.

time. Labour may continue for days with devastating results. If the woman does not receive effective management in time she may die from rupture of the uterus or infection. Fetal deaths are common if obstructed labour is allowed to continue.

In some cultures, long labour is considered 'natural' and mothers are encouraged to bear it with fortitude. But traditional culture is also aware of the dangers, as reflected in the proverb: "The sun should not rise or set twice on a woman in labour."

Prolonged obstructed labour can lead to obstetric fistula, a disability that affects 50,000 to 100,000 mostly young and poor women each year.¹ Pressure from the baby's head kills soft tissue around the pelvis and causes a tear between the woman's vagina and her bladder or rectum. In nearly all cases the baby dies and the woman is left with a unresolved tear or fistula which leaks urine or faeces. Most fistula patients are under 20, poor and illiterate and live in remote areas. A girl with an unrepaired fistula may be deserted by her husband and declared unclean. She can face a life of isolation, as well as being at risk of infection, disability and kidney disease.

In Nigeria alone, it is estimated that 800,000 women live with unrepaired fistulae,² while in Niger, fistula is a factor in more than 60% of divorces.³

In 2003, UNFPA launched a Global Campaign to End Fistula.¹ The campaign seeks to delay marriage and pregnancy and to ensure that women have access to high quality delivery care. The campaign also promotes better repair of fistulae and greater understanding and acceptance in communities. It seeks to end the silence on this cause of pain and stigma.

UNFPA is working with EngenderHealth to conduct surveys in African countries with a

Action against fistula

The Uganda Fistula Project and the Kuleana Center for Children's Rights developed a booklet to raise awareness of the dangers of early marriage, early birth and fistula. 50,000 copies of the booklet, entitled *What about my rights?*, have been sent to religious leaders, community organizations, schools and health centres.

Source: Miller S and Lester F. 2003. *Married first time mothers Meeting their special needs*.

high prevalence of obstetric fistula to identify the scale of the problem and to examine the capacity and skills of health services in providing fistula surgery.⁴ UNFPA and the Bangladesh government have taken steps to establish a Fistula Repair Centre at the Dhaka Medical College, as a training centre for South Asia.

Abortion

Between 2 million and 4.4 million of the estimated 20 million unsafe abortions each year are among adolescent girls.⁵ Although married adolescents seek abortions at a lower rate than those who are unmarried, a decision to seek an abortion may reflect problems between husband and wife.⁶ Adolescents are more likely to seek a late abortion from an unskilled provider, using dangerous methods.⁵ They are more likely to have complications and less likely to seek medical attention. In Bangladesh, 15-19 year old girls who sought abortions were twice as likely to die as older women.⁵ In a Ugandan study, more than half of abortion-related deaths were in adolescent girls.⁵

Risk to the baby

The WHO review of adolescent pregnancy found evidence that adolescent pregnant girls

1. UNFPA Campaign to End Fistula. <http://www.endfistula.org/>

2. Wall L. 2002. *Fitsari 'dan Duniya - An African (Hausa) praise song about vesicovaginal fistulas*. *Obstetrics and Gynecology*, 100(6): 1328-1332.

3. Lendon S. 2001. *Early marriage of girls in Niger*. *Development Bulletin*; 56: 77-9

4. 2003 UNFPA and EngenderHealth. *Obstetric Fistula Needs Assessment Report: Findings from Nine African Countries*

5. Olukoya et al. 2001. *Unsafe abortion in adolescents*. *Int J Gynaecol Obstet*; 75(2): 137-147

6. Singh S. 1998. *Adolescent childbearing in developing countries: a global review*. *Stud Fam Plann*; 29(2): 117-136.

NB: 2, 3 and 5 are cited in Miller and Lester, 2003. *Married Young First Time Mothers: Meeting their special needs*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.



A young patient at the Ethiopia Fistula Hospital. Girls who have babies under the age of 20 are at higher risk of obstetric fistula. This girl's condition was treated, but obstetric fistula often goes untreated, causing adolescent girls to live with disability, stigma and isolation.

Picture: WHO/P Virot (WHO-208391)

are at increased risk for preterm delivery and that the youngest age groups run the highest risk.¹ The review finds that adolescent maternal age appears to be an independent risk factor for preterm birth, and thus for low birth weight.”¹

In developing countries, if a mother dies in childbirth her baby is unlikely to survive. Most newborn deaths are due to infections at birth (neonatal tetanus and sepsis) or shortly after birth (pneumonia, diarrhoea).² About a third of newborn deaths are due to birth asphyxia and trauma.

Prematurity on its own causes 10% of newborn deaths. Miller and Lester say, “Babies born to young mothers are at increased risk of neonatal and infant death. Though the cause of this increased risk is thought to be multifactorial, preterm delivery is thought to significantly contribute to this risk.”³

Making hospital practices relevant to adolescents

20,000 women a year deliver their babies at El-Galaa Teaching Hospital in Cairo, Egypt. A survey showed that this busy hospital was not always adolescent friendly, and practice was not always evidence based.

The hospital is working with the Population Council in Egypt to make delivery and postnatal services more appropriate to the needs of adolescent mothers.

An improvement programme aims at ensuring, for example, that women always have their blood pressure taken on arrival, so that any hypertensive disease will be detected early. Doctors are asked always to introduce themselves to patients and to call women by their names.

Source: Population Council, Reproductive Health Program

1. WHO. 2004. *Adolescent pregnancy. Issues in adolescent health and development*. WHO Discussion Paper on Adolescence.

2. WHO. 1996. *Mother-baby package: Implementing safe motherhood in countries*. Practical Guide.

3. Miller S and Lester F. 2003. *Married Young First Time Mothers: Meeting their special needs*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

Married adolescents miss out on health care

Married adolescents have health needs as young women, as young wives and frequently as pregnant women and young mothers too. They often miss out on services for adolescents because they are married and for married women, because of their age, lack of experience and lack of autonomy. While their health service needs are the same as those of other adolescents and other married women, special efforts may be needed to ensure that they know about services and can access them. This means raising the awareness of family members who may act as gatekeepers to services.

Married adolescents need to be well informed about protecting their health and to have the skills, means and support to use information. They require support from family members who make decisions about how food is shared and how health care is sought. Diet and nutrition, not smoking, avoiding smoky atmospheres, and not using alcohol are important. Married adolescents should know about immunization, hygiene, the prevention of sexually transmitted infections (STIs) and HIV and AIDS and about how to seek treatment. It is important that married adolescents know how and where to obtain reproductive health care, including during pregnancy and childbirth.

Married adolescents often have little knowledge about or control over care while they are pregnant, when delivering their babies, or after the birth.¹ Especially in rural areas, many pregnant women give birth without the attention of

Need for information, autonomy and care

- Married adolescents need better information about their health care needs and support to access care.
- They need to be able to make choices about how to protect their health.
- They should know how to prevent STIs and HIV and how to seek treatment.
- When pregnant, they need access to antenatal, delivery and postpartum care.
- Adolescents lack the knowledge, autonomy or power to seek medical care.
- Husbands and mothers-in-law can help married adolescents to access care.

skilled provider. The low status of adolescent mothers and their lack of income means they are dependent on others — typically husbands or mothers-in-law — for access to care.

This may lead to health needs being neglected. In Egypt, adolescents received antenatal care less and later than older mothers.² One study from India showed that married young first time mothers who returned to their own mothers' homes for care, were more likely to survive delivery than those who remained in their married home.³ Antenatal care, a skilled delivery attendant and postpartum care can reduce the number of mother and baby deaths.⁴

1. This section is partly based on Miller S and Lester F. 2003. *Married Young First Time Mothers: Meeting their special needs*, presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

2. Galal. 1999. *A comparison between adolescents (15-19 years) and 20-24 years old mothers in Egypt and Sudan*. League of Arab States - Population Research Unit. Arab Conference on Maternal and Child Health.

3. Santhya KG and Jejeebhoy SJ. 2003. *Sexual and Reproductive health needs of married adolescent girls*. Economic and Political Weekly October 11, 4370-4377 (Cited by Miller and Lester 2003. Op. Cit.)

4. WHO. 2004. *Making pregnancy safer: the critical role of the skilled attendant*. A joint statement by WHO, ICM and FIGO

Married adolescents, mothers-in-law and husbands: complex decision-making in seeking care

In India, married adolescent girls often delay seeking treatment for reproductive tract infections. Sexual matters may be "shrouded in a culture of silence, embarrassment, shame and blame".¹ In one study in Uttar Pradesh, 56% of pregnant women deferred decisions about health issues to their mothers-in-law and 15% deferred to their husbands.²

A study in Maharashtra surveyed 302 married adolescents aged 15-19, two-thirds of whom had experienced at least one pregnancy. Husbands and mothers-in-law were also surveyed.¹ About 80% of wives and many husbands wanted to limit their families to two or three children. Mothers-in-law agreed, but wanted the first baby to be conceived within the first year of marriage. Many opposed modern methods of birth control.

Almost all (97%) of girls sought treatment for complaints such as coughs, colds, fevers, chills or headaches, but only half sought treatment for gynaecological problems. A third turned to their own mothers for help with menstrual problems. Mothers-in-law wanted daughters-in-law to confide in them, but many were sceptical about 'minor illnesses'. One said: "I think she fakes all these complaints. Maybe she is not able to cope with the work and this is her way of getting rest." Married adolescents with vaginal discharge, itching, bad odour or pain during sex were more likely to talk to husbands, who were, however, reluctant to discuss them, and expected their wives to seek care themselves.¹

In a follow up study (2001), three quarters of husbands said that pregnant women should seek antenatal care. Most said that they wanted to participate, but only half accompanied wives to clinics for routine care.³ Husbands who did accompany wives to the health centre often had to wait outside because of staff attitudes or lack of facilities.

A further report (2004) concludes,⁴ "...young newly-married women experience pregnancy and childbearing in an environment where they have little or no autonomy in decision-making, finances, or mobility to seek care. Thus, it may be crucial to get husbands involved, since husbands are often the decision-makers, the ones who have to accompany the young woman to the clinic, and the ones who pay for care. However, the same report also suggests that women themselves may not want their husbands to be present; and the health system makes it hard for husbands to be present."

1. Barua A and Kurz K, 2001. *Reproductive health-seeking by married adolescent girls in Maharashtra, India*. Reproductive Health Matters May 2001 9:17 53-61.
2. Prakash A, Swain S and Negi K. 1994. *Who decides?* Indian Pediatrics 31(8):978-80.
3. International Center for Research on Women and Foundation for Research in Health Systems 2004. Update 1: *Husband's Involvement in Maternal Care: Young Couples in Rural Maharashtra*.
4. Barua A. et al. 2004. *Caring Men? Husbands' Involvement in Maternal Care of their Young Wives*. Economic and Political Weekly, December 25, 2004: 5661-5668.

Lack of awareness and fear of stigma deter young married women from seeking treatment

In a study of 451 married girls and women aged 16-22 in Tamil Nadu, India, more than half had experienced a gynaecological problem or urinary tract infection, but few had sought treatment. Laboratory tests showed that 38% of the women had a reproductive tract infection (RTI), including 15% who had an STI. Of 211 women who reported no symptoms, 63 (30%) had clinical evidence of RTI. 50 later agreed that they had had symptoms — 23 had regarded them as 'normal', while 27 had been reluctant to discuss their problem.

Of those who had experienced gynaecological problems, almost two thirds (65%) had sought no treatment, citing lack of a female health care worker, lack of privacy at the health centre, distance from home, or lack of concern over symptoms. Of those who did seek treatment, 21% used home remedies or traditional medicines, 57% used unqualified private practitioners and 13% went to the Community Health and Development (CHAD) hospital in Vellore town. Only 9% used government primary health centres.

Researchers comment, "The proportions with STIs are surprisingly high, given the conservative attitudes about extramarital relationships in India. Most of the women were likely infected only within marriage, because most women, particularly in rural India, are not sexually active prior to marriage." They conclude: "The reasons given for not seeking care were similar to those reported in other studies in India: stigma and embarrassment, lack of privacy, lack of female doctors at health facilities and treatment cost."

Source: Prasad J et al. 2005. *Reproductive Tract Infections Among Young Married Women in Tamil Nadu, India*. International Family Planning Perspectives Vol 31 No 2 June 2005.

During antenatal care, anaemia can be detected, and supplements of iron, vitamin A and folic acid as well as tetanus immunization can be provided. Conditions such as malaria or hookworm can be detected and treated.

Most maternal deaths occur because of late or inadequate intervention, often due to one or more of "the three delays" in:

- ◆ recognizing complications and seeking care
- ◆ reaching an appropriate health care facility
- ◆ receiving good quality care at a facility¹

During delivery, women need the presence of a skilled attendant with midwifery skills. In an emergency the attendant can refer women with haemorrhage, eclampsia or prolonged and obstructed labour, to a facility for emergency

obstetric care, including Caesarean section or blood transfusion. Referral for emergency care requires planning and money for transport and treatment. WHO recommends that all pregnant women have a birth plan that covers these eventualities,² but married adolescents need support to make such a plan.

Postnatal care includes support for breast feeding, treatment of complications and family planning information and services.

Seeking care is a learned experience, so that lack of knowledge, lack of autonomy and lack of resources are significant obstacles with long-term effects. Communities need to create environments that encourage married adolescents to use services appropriately. ■

1. WHO. 2003. Press release: *Maternal deaths disproportionately high in developing countries*. October 2003.

2. WHO. 2003. *Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice*.

Programmes to reach married adolescents: programmes to delay marriage

Most programmes for adolescents do not reach married women while most services for married women do not reach adolescents. Married adolescents do not know what services are available or how to access them, while service providers are largely unaware of married adolescents as vulnerable young people. Married adolescents at home are rarely included in surveys of adolescent needs.

Family life education does not reach married adolescents, because it is usually given in school. Peer to peer programmes do not think

of married women as 'peers' of adolescents and fail to include them. Maternal and child health services rarely focus on young first time mothers. Married adolescents do not require special services, but do need positive action to achieve equality of access.

Most HIV and AIDS services fail to address the special needs of married adolescents girls, a significant omission in a population of girls about to start child-bearing. Successful prevention can protect the adolescent girls themselves, prevent transmission of HIV and AIDS to their babies and prevent children becoming orphans, as well as providing an entry point for programmes for their husbands.

Adolescent programmes to reduce the risks of HIV usually encourage them to abstain from sex, to reduce sexual frequency, to change to a safer partner, to use a condom or to have a mutually monogamous relationship with an uninfected person. These are not realistic options for married adolescents, especially

Married adolescents slip through the service net

- ◆ In Nepal, married pregnant adolescents attended antenatal facilities at lower rates than older women even in urban areas where health facilities were within easy reach.¹
- ◆ In Senegal, Project Promotion des Jeunes for out of school adolescents, focused on peer education in the community, at youth centres and health services. It reached unmarried males and some adolescent girls but hardly any married adolescents. A UNICEF/UNFPA programme in Senegal targeted neglected adolescent girls but found that only 6% of clients were married. Most married adolescents lacked the mobility to attend.²
- ◆ In Ghana, the Navrongo project has recognized an urgent need to address married adolescents, who are less likely than unmarried girls to use condoms and more likely to believe that they have no chance of contracting HIV.³ More than 30% of adolescent girls are married but they made up less than 15% of adolescents reached in a survey.

1. Adhikari R. 2003. *Early marriage and childbearing: risks and consequences*, in WHO. 2003. *Towards adulthood, exploring the sexual and reproductive health of adolescents in South Asia*, edited by Bott S et al.

2. Diop N and Meyers C. 2003. *Married Adolescent Girls' Lives: A Perspective from Senegal*. Population Council.

3. Debpur C. 2003. *Married Adolescents in the Kassena-Nankana District*. Navrongo Health Research Centre presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

when couples are trying to start a family. Most married adolescent girls already practice monogamy, but they can rarely know their husband's HIV status or be able to ensure two-way fidelity within marriage. As a result in many parts of the world, marriage and long-term monogamous relationships do not protect women from HIV.¹

A human rights agenda to delay marriage

The most significant improvement in the prospects for adolescent girls would be to delay marriage. Adolescence is a time of preparation for adulthood — for work, marriage and parenthood. Early marriage truncates that process. Younger adolescents who attend school can acquire skills, develop their autonomy, and learn to interact effectively with others, so that, as adults, they can take decisions about their lives, earn an income and feed their families. A strategy for delaying marriage can focus on the human rights of girls and especially the rights to non-discrimination, equity, participation and empowerment. States that ratify the Convention on the Rights of the Child, the Convention on the Elimination of Discrimination Against Women, and the Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights have an obligation to promote, observe and protect the rights of adolescent girls to childhood, to education, to have their views taken into account, and to protect them from too early marriage.

Gender equality, education and safety for girls

Goal 3 of the Millennium Development Goals is to “promote gender equality and empower women”. Delaying marriage contributes to this by giving adolescent girls more opportunity and choice, and more autonomy to take deci-

Cairo project offers incentive to delay marriage to 18+

The Moqattam Project works with communities involved in garbage collection in Cairo.

The Project set up a Crisis Committee to counsel families who plan to marry daughters below the age of 18 against their will. It seeks to resolve disputes between parents and daughters and offers incentives to prevent underage girls from being married. Some young girls tried to harm themselves when they learned of marriage plans.

The Crisis Committee offers 500 Egyptian pounds (about \$150 US) as a wedding present to any girl who is aged 18 years or older on her wedding day.

Between 1995 and 2003, 112 girls successfully claimed this prize. No girl involved in the project was known to have married before the age of 18.

Source: Assaad M and Bruce J. 1997. *Empowering the next generation: Girls of the Moqattam garbage settlement*. Population Council, Seeds 19.

sions and to put them into effect. The UN set a target to eliminate gender disparity in all levels of education by no later than 2015. The indicators to test progress are:

- ◆ The ratio of girls to boys in primary education
- ◆ The ratio of literate females to males aged 15-24
- ◆ The proportion of women engaged in wage employment outside agriculture
- ◆ The proportion of seats held by women in national parliaments²

1. UNAIDS. 2004. *Women and AIDS – A Growing Challenge*. Fact Sheet.
2. See <http://www.unfpa.org/icpd/targets.htm>

In East Asia, where a decline in early marriage has been driven by rapid social and economic change, an increase in secondary education for girls is a particularly telling factor.¹ In South Asia also, education has proved important. Sri Lanka has one of the lowest rates of maternal mortality, and most deliveries are supported by a skilled birth attendant at a health facility. Supportive factors include government commitment to improving education and health care, the relatively high status of women, and high female literacy rates. Adult literacy rates among women are 88% and girls have access to free education up to university level. By 1993, the age of marriage had risen to 25, with women able to take advantage of family planning and maternal health services.²

However, swapping the risks of early marriage for the risks of coerced unprotected sex outside marriage will not be acceptable to girls, families or communities. If communities are going to change customs of early marriage, girls need safe places in their social environment. Safe places can be schools and colleges and training centres, and these can also offer girls greater opportunities for autonomy.

Achieving a safe social environment also

means working with young men, particularly about relationships and marriage and the protection of women from coerced sex inside or outside marriage.

Reduce the age gap

Girls who delay marriage are more likely to wed men nearer to their own age. In areas where STIs and HIV are risks, families need to know that the more years of sexual experience that a man has, the greater the risk that he may be infected. If purity is important within communities, it should be as important for men as for women. Mutual fidelity is also important within marriage.

Make the first year of marriage a place of safety

Give marriage a 'health dowry'³

Marriage celebrations can include important health information. In China, along with the official congratulations, couples are sent details of local maternal and child health clinics.

Preparation for marriage can be an opportunity for a couple discuss whether to get tested for HIV and to find out their status. An uninfected partner in a discordant couple can be

Education leads to later marriage and better care

"Educated girls are likely to marry later — especially if their schooling extends to the junior secondary level and they engage in economic activity outside the home. Educated girls and women also have fewer children, seek medical advice sooner for themselves and their children and provide better care and nutrition for their children.

"Such behaviour reduces the possibility of disease and increases the odds of children surviving past age five. Over time reduced child mortality leads to smaller families and increased contraceptive use — lowering overall fertility. With smaller households child care improves, and with lower fertility the school age population shrinks. Thus the benefits of girls' education accrue from generation to generation."

Source: United Nations Development Programme (UNDP) 2003. *Human Development Report 2003*.

1. Malhotra A. *Variations in the meaning of marriage: Historical and cultural Perspective*. Presented at WHO Technical Consultation, Geneva. Dec 2003.
2. WHO, UNICEF, UNAIDS, WORLD BANK, UNESCO, UNFPA. 2000. *Health a Key to Prosperity - Success Stories in Developing Countries*. See <http://www.who.int/inf-new/mate1.htm>
3. This idea of a health dowry for marriage was put forward by Martha Brady and Judith Bruce of the Population Council at the WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents in Geneva in December 2003.

protected. Couples can also be tested for other sexually transmitted infections and, if necessary, treated before marriage.

Mutual testing leading to mutual trust can be both a 'health dowry' and a 'health brideprice', reassuring both partners that marriage is indeed a place of safety. Health and social care providers should also ensure that married adolescent girls and family members who act as gatekeepers know how to access services.

Delay pregnancy — the role of condoms

There is scope to present the first year of marriage as a place and time of safety, where the couple protect themselves against STIs and

HIV, and delay the first pregnancy, which is what many couples say they want.

Condoms can help to make the first year of marriage a time and place of safety. Currently only the male or female condom protects sexually active girls against STIs and HIV. Bringing condoms across the bridal threshold is difficult in many cultures, where they are used mainly for sex outside stable relationships.

STIs in some regions are among the most common causes of illness, with far-reaching consequences including the potential for infertility in women. Infertility is a major concern of young brides, of husbands and of mothers-in-law, and there is an erroneous belief in some

Proclaiming an end to FGC, child marriage and forced marriage in Senegal and Guinea

Religious and cultural leaders in Matam Region, northern Senegal have made declarations in front of hundreds of people that their communities would abandon female genital cutting (FGC) and early and forced marriage.

The NGO Tostan — the name means breakthrough in the Wolof language — incorporated human rights discussions into education, literacy and micro credit projects in more than 400 villages in Senegal and Guinea, in a traditional Muslim farming area known as the Fouta. At first some religious leaders opposed the changes and some men burned tyres in protest against Tostan. But religious and traditional leaders who met in Ourassougui in July 2003 decided there was no religious justification for FGC or for early or forced marriages. They called for an end to these practices in the name of better health and human rights.

Communities now support the changes. In October 2003, village representatives joined in a public declaration in Sedo Abbas in front of religious leaders, village chiefs, the Governor of Matam, the Swedish Ambassador and journalists. School children performed plays to show the effects of FGC and early forced marriages. In May 2005, 44 villages Kolda region, made a similar declaration, following an 18 month consultation with girls and women, boys and men, traditional and religious leaders, and traditional cutters. In the past girls were married by their relatives as early as 12 years old. This has now been prohibited.

Source: Tostan Women's Health and Human Rights web site: <http://www.tostan.org/>

communities that it can be caused by using contraceptives. Promoting condoms to protect fertility could help to dispel such myths and make condoms a more acceptable form of contraception.¹ A husband and wife who use condoms during the first year of their marriage, would be more likely to continue to use them for birth spacing and protection.

Improve nutrition for girls

Girls are often the least well fed in many families, although they need good nutrition to grow up strong and healthy and to become mothers. A better understanding within marriage of the nutritional needs of girls is a long-term goal. In the short-term, nutritional supplements can be given in school or at any point when adolescent girls come into contact with health services.

Even when given during the second half of pregnancy, malarial drugs and iron and folic acid supplements have shown benefits.²

Adolescent friendly services for married adolescents too

Married adolescents are less likely than older married women to receive health care. A study in Sudan found that girls who are poor, still at school or under 18 are less likely to attend a health facility.³ Health services need to be safe, welcoming and accessible. Married girls require affordable services that provide information, reassurance and clinical expertise. Adolescent friendly health services not only help to deliver the human rights of married adolescents, but also best use of health resources by reaching this critical group within the population.⁴ ■

India: opening communication for young married couples

The First Time Parents Project in Gujarat and West Bengal, India, works with young couples to improve communication between husband and wife, reduce isolation, improve knowledge of reproductive and sexual health and help the couple to act in their best interests.

A survey showed that more than a third of couples in Gujarat and well over half in West Bengal felt that they had married too early, and that adolescent wives had the least freedom of movement, involvement in decision making and reproductive health knowledge.

Male and female health workers and peers hold separate sessions with husband and wife, and senior family members. There are neighbourhood meetings for husbands, and meetings of young women's groups for wives. One key aim is to improve the use of antenatal services, and their quality. If the wife is pregnant the couple is urged to make a birth plan, including provision for emergency transfer if this is needed. The project works to keep the community involved and encourages health NGOs to include social issues in their support. The young wives learn about loans as well as about nutrition and reproductive health.

The First Time Parents Project is a collaboration between the Population Council, the Child in Need Institute in Calcutta, West Bengal, and the Deepak Charitable Trust in Baroda, Gujarat.

1. Martha Brady. *Reproductive Health Matters* 2003; 11(22): 134-141. *Preventing Sexually transmitted infections and unintended pregnancy and safeguarding fertility – triple protection needs of young women.*
2. Harrison K et al. 1985. *Growth During Pregnancy in Nigerian Teenage Primigravidae*. *British Journal of Obstetrics and Gynecology*; 5(Supplement): 32-39. Cited in Miller S and Lester F. 2003. *Married Young First Time Mothers: Meeting their special needs.*
3. LeGrand and Mbacke. 1993. *Teenage pregnancy and child health in urban Sahel*. *Studies in Family Planning*, 24, 137-149
4. WHO. 2003. *Adolescent Friendly Health Services, An Agenda for Change.*

Bangladesh: youth clubs for young married couples

In Bangladesh, three quarters of girls are married by the age of 18 and the median age of marriage is 14. An analysis by UNFPA and UNICEF revealed that married adolescents are an underserved group, invisible to governmental and NGO health services alike.

The Population Council and UNFPA with the Ministry of Sports and Youth, Ministry of Health, Ministry of Women's and Children's Affairs, UNICEF and NGOs set up youth clubs for young married couples in ten districts across the country. The aim was to train peers to deliver social education and to encourage married female adolescents to use health services. The project also set out to educate community and religious leaders about adolescent reproductive health, and to encourage health service providers to provide youth friendly health services to married adolescents.

Each youth club selects two male and two female leaders — often husbands and wives. Each leader then selects 30 married girls and their husbands from each sub district to become peer leaders. Peer leaders receive five days personal and social education in which they learn about reproductive rights, sexual health and personal hygiene, family planning and safe motherhood. They also learn how to build a good relationship between husband and wife. Peer leaders pass on this knowledge to club members.

Source: Rob U. 2003. *Married Adolescents Project: What do we know?* 2003 presented at WHO/UNFPA/ Population Council Technical Consultation on Married Adolescents, Geneva.

Outreach draws young women into services

As part of the Action Research and Training for Health Program (ARTH) in Rajasthan, India, first time mothers, most of whom are adolescents, receive special attention from trained midwives. An outreach program has set up a system of village women volunteers who get to know every first-time pregnant mother in their village and accompany them on their first visit to the clinic.

The service provides a 24-hour delivery service at home and at the health centre. It includes an obstetric flying squad comprising a nurse midwife and a male field worker on a motorbike. They can reach women in remote villages and, in an emergency, arrange transport to hospital. Once women have been in contact with the services they are more likely to also use postnatal and child care services. Services promote the involvement of expectant fathers and fathers of young infants.

Source: Miller S and Lester F. 2003. *Married first time mothers Meeting their special needs.*

India: life skills encourage girls to delay marriage

In India the International Center for Research on Women (ICRW) supports local organisations to work with married couples and single girls. The aim is to delay marriage where possible and to improve the knowledge and understanding of those who are already married.

In rural Maharashtra, unmarried girls aged 12-18 are offered Life Skills, one hour a day, five days a week for a year taught by a village woman who has completed seven years of schooling. The course, designed by the local Institute for Health Management-Pachod (IHMP), targets girls who have left school and who are working. Families agree not to marry off the girls while they are on the course. Only 9% of those who complete the course marry below the age of 18, compared with 22% of girls who complete part of the course and 29% of girls who never enrol. 2,000 girls from 72 villages and 30 areas of Pune city have enrolled.

This is part of a wider programme of work with adolescent girls. Other courses have resulted in increased knowledge of reproductive and sexual health and an increased confidence on the part of girls to tell their parents what they do and do not want from marriage. Work with married couples found that many were prepared to use contraceptives for a year, but after that they were fearful that they would be thought to be infertile.

The overarching lesson that ICRW draws from the work is that reproductive and sexual health is not only an issue for the adolescents, because they do not have the power to take decisions. It is a community issue and it is important to engage husbands and mothers-in-law. Communities are now asking for the projects to be expanded.

Source: IHMP and ICRW. 2004 *Increasing Low Age At Marriage in Rural Maharashtra, India* Update 1.

Nepal: participatory approach reduces early marriage

In Nepal, EngenderHealth and ICRW worked with local NGOs to engage urban and rural adolescents and key adults, such as mothers-in-law. Extensive needs assessment was conducted at study sites, followed by action planning with the community to design the programme. Over one to two years, interventions included adolescent-friendly services, peer education and counselling, information and education, adult peer education, youth clubs, street theatre, economic development and teacher education. The programme helped to increase the rate at which early marriage fell in urban areas. Although the number of girls who married aged 14-21 fell only slightly in the rural study area, this was a significant improvement on the rural control area where the number of married girls rose.

Source: Mathur S, Mehta M and Malhotra A. 2004. *Youth Reproductive Health in Nepal — Is Participation the Answer?* EngenderHealth and ICRW

Every ten years, 100 million married adolescents need services and support

Girls' exposure to early, unwanted sexual activity, early pregnancy, reproductive tract infections (RTIs) and HIV has been widely recognized since the 1994 International Conference on Population and Development. However, many programmes are focused on unmarried adolescents and fail to recognize the huge numbers of girls who are married below the age of 18.

The World Health Organization, the United Nations Population Fund and the Population Council convened a Technical Consultation on married adolescents in Geneva in December 2003 to address this gap in understanding and programming. The meeting looked at key messages from research and best practice from programmes and at ways to draw this significant problem to the attention of policy makers and programme planners. This document is one outcome of that meeting.

This document looks at what we mean by early marriage, and how, although it is declining around the world, 100 million girls will marry before their 18th birthday over the next ten years. As a result of early marriage, many adolescent girls are having unsafe sex within marriage, with an older and sexually experienced man who may be infected with a sexually transmitted infection, or HIV. It notes how, in many countries, the time gap between getting married and having a first baby is declining. It outlines the risks of too early pregnancy and explores the reasons why families and communities feel under pressure to continue the practice of marrying off their daughters while they are still adolescents.

Married Adolescents : No Place of Safety explores how health services for married women and for adolescents fail to reach married adolescents, who are often almost invisible. The document also describes programmes around the world that seek to reach married adolescents with health services, and programmes that are designed to delay marriage .



© 2006 World Health Organization, 20 Avenue Appia,
CH-1211 Geneva 27, Switzerland.

