

CHILD MARRIAGE AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Girls who are – or have been – married (ever-married girls), pregnant or parents often have little control over their own sexual and reproductive choices; they also have specific needs that health care, education and social service systems often do not adequately address.^{1,2,3} An estimated 640 million girls and women alive today were married or in a union before age 18,⁴ and 12 million more girls marry every year⁵ – that is the scale of response needed to ensure all girls and women can enjoy their sexual and reproductive health and rights (SRHR).^a



PICTURED: Two adolescent girls hold hands during a workshop in Livingston, Guatemala.
Photo: Girls Not Brides/Priscilla Mora Flores/Colectivo Nómada.

This brief explores the links between child marriage^b and SRHR, progress made since the landmark 1994 International Conference on Population and Development, promising practise and recommendations – validated with *Girls Not Brides* member organisations – for governments, United Nations (UN) Agencies, donors and civil society organisations.



Key takeaways

- **Child marriage is rooted in gender inequality and deprives girls and young women of their fundamental rights** – including their SRHR – and significantly limits their life choices. Ending child marriage and enhancing access to quality, stigma-free, affordable SRHR services will significantly enhance the health and development outcomes for millions of children, adolescents and women around the world.
- **Child marriage often drives early or adolescent pregnancy and has a negative impact on the health and wellbeing of adolescent girls and young women, and their children.** It leads to increased risks of depression, intimate partner violence (IPV), sexually transmitted infections (STIs), cervical cancer and maternal mortality. Children born to adolescent mothers are at a higher risk of low birth weight, premature birth and severe neonatal complications.⁶
- **Adolescent pregnancy can drive child marriage**, especially where pre-marital sexuality is taboo and virginity is connected to notions of purity and family honour,⁷ where contraception is scarce or inaccessible, and where safe abortion services are limited.⁸
- **A comprehensive, multi-sectoral, rights-based, gender-transformative approach – delivered through partnerships – are needed to ensure girls can decide for themselves** when and with whom to have sex, marry and have children, to negotiate safe sexual practices, access appropriate and quality SRHR services, and enjoy better sexual and reproductive health.
- **Zero child marriage and universal access to sexual and reproductive health care services by 2030 are globally agreed commitments.**

^aAs defined by the Guttmacher-Lancet Commission, which builds on previous international and regional agreements, and technical reports and guidelines. [Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission](#)

^b“Child marriage” refers to all forms of child, early and forced marriage and unions – whether formal or informal – where at least one party is under age 18.

“Sexual and reproductive health” is a state of complete physical, mental and social wellbeing in all matters relating to sexuality and the reproductive system. It implies that individuals can have a satisfying and safe sex life free of coercion or discrimination, the capability to reproduce, and the freedom to decide if, when and how often to do so.

^cThe [World Health Organisation](#) (WHO) defines “adolescents” as people aged 10 to 19 years.

Progress on SRHR

It is 30 years since the [Programme of Action](#) was adopted at the International Conference on Population and Development (ICPD) in Cairo. The ICPD recognised that to enjoy the highest possible sexual and reproductive health (SRH),^c all individuals need to be able to exercise their sexual and reproductive rights (SRR), including:



freedom to decide whether, when and with whom to engage in **sexual relationships**;



freedom of **sexual expression**;



freedom to enter into **marriage** with consent, to start a **family**, and to choose the timing, spacing and number of children to have;



to have access to **information** and **means** to achieve their reproductive goals;



to be free from **discrimination**, degrading treatment, coercion and violence.

A groundbreaking call was also made to place adolescent^d SRHR on the agenda. Specifically, it called for “meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.”⁹

Countering the rollback on SRHR

SRHR are under threat. Multiple crises – including the ongoing impact of the COVID-19 pandemic and humanitarian crises related to climate and conflict – and well-organised and funded political opposition to girls’ and women’s rights and choices have caused setbacks and require intensified vigilance and solidarity.

Recent rollbacks and backlash against SRHR initiatives worldwide are characterised by:

- reduced domestic funding for relevant services;
- erosion of SRR;
- retreat from gender equality measures;
- restricted rights, including the legal prohibition and punishment of certain sexual behaviours, expressions and identities.

This backlash challenges the rights and wellbeing of individuals – particularly girls, women and marginalised communities – and threatens to undermine decades of progress in promoting reproductive rights and health equity.

Lack of funding and de-prioritisation of SRHR in crisis situations also has profound and potentially long-lasting^{21,22} impacts for the children, adolescents and women who have been most marginalised.

Addressing the dual challenges of anti-SRHR movements and the impact of crises requires **solidarity for collective care, collaboration between governments, civil society organisations and international agencies, and comprehensive approaches that are also girl-centred, rights-based and intersectional** – that is, that acknowledge and respond to the overlapping effects of factors like gender, age, class, sexuality, race, ethnicity, caste and citizenship.

PICTURED: Roe v. Wade Rally, Pittsburgh
Photo: Mark Dixon.



In focus: Progress and challenges in SRHR since 1994

SRHR and child marriage have featured prominently in **international fora and global agreements**

including the Millennium Development Goals, the Sustainable Development Goals (SDGs), and the Global Strategy for Women's, Children's, and Adolescents' Health (2016 to 2030).¹⁰ The SDGs also include a target to end child marriage by 2030

Mental health disorders are

5x

higher for those who marry before age 18 and experience unwanted pregnancy, according to new evidence from Zimbabwe.²⁰

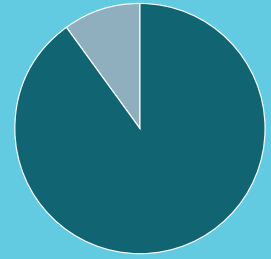
Births to adolescent girls aged 15 to 19 have decreased, but there are still an estimated

12 million

births to adolescents in low- and middle-income countries every year¹¹ – that is about the population of Tunisia

90%

of births to adolescents take place within the context of marriage.¹²



About 1 in 4



adolescent pregnancies in low- and middle-income countries ends in (often unsafe) abortion.¹⁸

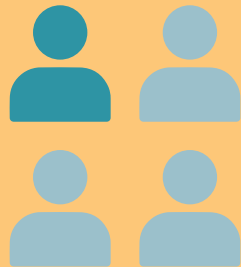
Less than



1 in 3

girls aged 15 to 24 have comprehensive & accurate knowledge about HIV, and child marriage puts them at greater risk of acquiring it.¹⁹

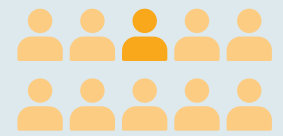
1 in 4



women still cannot make their own health decisions in 69 countries.¹³

Nearly

1 in 10



women have no choice in the use of contraception.¹³

Global contraceptive uptake has increased

25%

since 1994, but almost

0.25 billion

women of reproductive age do not have access to modern contraceptives¹⁴ – that is almost the population of Brazil and Kenya combined.



About **half** of married women living in humanitarian crisis-affected countries who want to avoid pregnancy are not using any form of contraception, modern or traditional.¹⁵



The global maternal mortality ratio fell by

34%

between 2000 and 2020, but progress has been uneven and has stagnated in 133 countries, and worsened in 17 since 2015.¹⁶



Over half

of all preventable maternal deaths are estimated to occur in countries experiencing humanitarian crises and conflicts – that's nearly **500 deaths per day.**¹⁷



The latest evidence on child marriage and SRHR

Child marriage and adolescent girls' sexuality

The question of when and with whom to begin sexual activity is often decided for girls and women in violation of their basic SRHR. The desire to control female sexuality and preserve virginity before marriage is often one of the main factors motivating parents to marry their daughters early.²² So, child marriage can deny girls the right to make decisions about their own sexuality and health. In contrast, having control over one's own sexual choices can greatly reduce the chances of unintended pregnancy. The availability and use of modern contraception methods leads to better reproductive health outcomes. Having sexual autonomy can influence other important decisions related to reproductive health, like when to engage in sexual activity, planning for pregnancy and deciding to use contraceptives.²³

Even where services exist, negative attitudes towards adolescent sexuality can block adolescents' access to and use of SRHR services. Service providers often deny contraception, abortion or HIV prevention and testing services to those they consider too young to be sexually active^{24,25} – like unmarried adolescents. Married girls also face provider stigma due to social norms around having children soon after marriage, and myths that only certain contraception methods are appropriate for younger women who are supposed to be starting families.²⁶

Laws and regulations create the framework for enacting policies, programmes and services related to SRHR; they can facilitate or constrain access to services and the realisation of health and human rights.²⁷ Legislation often enforces legal restrictions on SRHR services, particularly targeting abortion, contraception and comprehensive sexuality education. Adolescent girls and young women seeking abortion or contraceptive services in many contexts are disproportionately affected by limitations on access to SRHR services outlined in legal and regulatory frameworks.²⁸

Restrictive social norms combined with age of consent laws create significant barriers for sexually active adolescents seeking essential SRHR services:

- Age of consent laws often lack clear exceptions for consensual sex between peers under the legal age, leading to the **prosecution of adolescents for consensual sexual activity**. Higher age of consent laws further restrict adolescents' access to services.
- Regulations like parental or spousal consent laws also frequently **limit access to medical treatments and SRH information and services**, including contraceptives and abortion.²⁹

- **The criminal law is often used by adults – primarily parents – to reinforce dominant norms at the expense of girls' autonomy.** In El Salvador, the sexual consent law is perceived as a tool to prevent youth sexual activity and is primarily used to break up relationships disapproved of by parents, or in cases of adolescent pregnancy.³⁰ In India and Nepal, some parents use marriage and sexual consent laws to criminalise their daughters' husbands when they do not approve of the (self-initiated) marriage or elopement, especially in inter-caste relationships.³¹

Failing to acknowledge adolescents' evolving capacities^e undermines their right to health, particularly their SRHR.

In India, the Prevention of Child Sexual Offences Act categorises all sexual activity under age 18 as exploitative and harmful regardless of consent, and mandates medical professionals to report cases of pregnancy under age 18.³² Consequently, some doctors refuse to treat pregnant adolescents to avoid legal complications.

Child marriage, girls' education and comprehensive sexuality education

There is strong evidence showing a positive relationship between increased girls' education and improved SRHR outcomes, including higher age of marriage, greater contraceptive use, higher age for birth of first child, and increased use of health services.³³ Across 15 countries in Asia and Africa, girls who completed secondary education scored higher on an index of HIV/AIDS knowledge than girls with only primary education.³⁴ Education can be a powerful tool in achieving gender equality and enhancing girls' skills, knowledge and power to challenge discriminatory norms and access their SRHR.³⁵ At the same time, programmes that improve girls' health and nutrition, and support their socio-emotional development – including SRHR and menstrual hygiene programmes – can help address barriers to girls' retention and success in school.³⁶

The protective impact of education on child marriage is greatest at secondary level,³⁷ which is also when schools are most critical in connecting adolescent girls with SRHR information and services, and caring adults. Addressing child marriage requires strong, adolescent-friendly reporting, referral and response systems in schools and communities. Training and sensitisation for teachers, learners, community members and district officials and collaboration with the relevant government agencies and service providers is also important.³⁸

Child marriage is a driver and a consequence of adolescent pregnancy, with negative impacts for girls' education and health. Child marriage and/or pregnancy can lead girls to leave or be excluded from school due to a lack of adequate re-entry policies, punitive or discriminatory measures against pregnant girls, and stigma.³⁹ Access to effective comprehensive sexuality education (CSE)^f programmes can

^e“Evolving capacities” refers to the way young people gradually develop the ability to take full responsibility for their own actions and decisions. Applying the principle means recognising the changing relationship between parents and children as they grow up, and focusing on capacity, rather than age, as the determinant in the exercise of human rights.

^fUNESCO defines “CSE” as “a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others.”

help prevent early and unintended pregnancies, and the implementation of strong re-entry policies and supportive learning environments can support pregnant and parenting adolescents to return to school.^{40,41}

Alongside efforts to support girls to remain in and return to school, mobile SRHR clinics, safe space programming, and one-stop centres for health, legal, psychosocial support and referrals may be effective in reaching adolescent **girls who are out of school**.

In focus: Political challenges to CSE and SRHR

Pressure by the anti-rights movement has led to state rollbacks on the provision of CSE.

In Latin America and the Caribbean, CSE is one of the areas that has seen least progress against the commitments of the [Montevideo Consensus on Population and Development](#).

Although some countries (like Argentina, Mexico and Venezuela) have updated CSE curricula, others have withdrawn or made state CSE provision optional (El Salvador, Mexico, Panama and Uruguay).

For more details, check out this analysis by Mira que te Miro, 2023: [10 años del Consenso de Montevideo: Una mirada desde la iniciativa de monitoreo social](#)".

Effective CSE offers girls and boys accurate information about SRHR, enabling them to develop the critical life skills needed to make healthy, safe choices, which reduce risky sexual behaviours.⁸ By addressing topics like consent, CSE plays a pivotal role in preventing sexual and gender-based violence (SGBV), so reducing unplanned pregnancy and STIs.⁴² Evidence shows CSE that includes discussions of gender and power from an early age, and in keeping with the evolving capacities of young people, has a positive impact on SRHR outcomes.⁴³

In contexts where adolescent sexuality is taboo, CSE may not be provided in school, key topics may be omitted, or discussions around sexuality and SRHR may be discouraged. Denying adolescents access to accurate information on SRHR means they lack basic knowledge about how to protect themselves from unwanted pregnancy and STIs. Lack of comprehensive and accurate knowledge about HIV can, for example, undermine the ability of girls to negotiate condom use and other safer sex practices.⁴⁴ Globally, only 30% of girls aged 15 to 24 have comprehensive and accurate knowledge about HIV.⁴⁵ Similarly, lack of knowledge around menstruation, in combination with period poverty^h and a lack of safe, private toilets and sanitation facilities can lead to girls leaving school prematurely,⁴⁶ which in turn increases the risk of child marriage and poor SRHR outcomes generally.



Case study: Myth-busting and practical support for menstrual hygiene in Nigeria

Gender advocate [Dorinda](#) – with the [Child and Youth Protection Foundation](#) – has worked with school authorities, community volunteers and “I am a girl not bride” clubs in three schools to address child marriage alongside SRHR education and the menstrual health needs of adolescent girls.

The **girls’ clubs** provide space for girls to share knowledge and build solidarity and confidence around menstruation and SRHR with their peers, dismantling misconceptions and stigma. A “**pad banks**” initiative providing menstrual hygiene products was also socialised through these clubs, and contributed to improved attendance and academic achievement among girls.

By engaging with this issue, girls and teachers – including male teachers – have become **advocates** for improved SRHR and an end to child marriage in their communities.



Tip! The impact of these interventions can be measured by **monitoring** school attendance and attainment records, and through interviews with girls, teachers and other school authorities.

Child marriage and adolescent pregnancy

90% of births to adolescents take place within the context of marriage, affecting millions of girls and adolescents worldwide.⁴⁷ Every year, an estimated 21 million girls aged 15 to 19 and 2 million girls aged under 15 become pregnant in low- and middle-income countries; about half of these pregnancies are unplanned.^{48,49,50} Approximately 16 million girls aged 15 to 19 and 2.5 million girls under age 16 give birth every year.⁵¹

Globally, the adolescent birth rateⁱ has declined, but progress has been uneven. The global adolescent birthrate declined from 64.5 to 41.3 births per 1,000 women (aged 15 to 19) over 2000 to 2023,⁵² with the most significant decrease being in South Asia. Latin America and the Caribbean, and West, Central, East and Southern Africa have experienced comparatively slower declines and still have the highest rates globally at 99.4 and 52.1 births per 1,000 women respectively.⁵³

In many contexts, child marriage drives adolescent pregnancy, as girls face social pressure to prove their fertility, which they lack the means or tools to resist.⁵⁴ So, they have limited agency over when to begin or how many children to have, in violation of their basic SRHR. Children born to adolescent mothers are at higher risk of low birth weight, premature birth and severe neonatal complications.⁵⁵

⁸Risky sexual behaviours known to lead to poor health outcomes include early sexual debut, non-use of contraception, non-use of barrier methods, multiple concurrent sexual partners, engaging in transactional sex, and engaging in sexual activity under the influence of drugs and/or alcohol.

^h“**Period poverty**” is a global social injustice affecting people who cannot access products to manage menstruation, whether for financial reasons or otherwise.

ⁱBirth rate for girls aged 15 to 19 years.

In some contexts, adolescent pregnancies drive child marriage, especially where girls' pre-marital sexuality is taboo^{56,57,58} – like West, Central, East and Southern Africa and South Asia – and virginity is connected to notions of purity and family honour.⁵⁹ This link is common in contexts where contraception is scarce or inaccessible and where safe abortion services are limited.⁶⁰

Mental health disorders are five times higher for those who marry before age 18 and experience unwanted pregnancy, according to new evidence from Zimbabwe.⁶¹ Existing evidence shows a range of poor mental health outcomes for girls and women who experience child marriage – including low self-esteem, anxiety, depression and suicidal ideation, but that support services are limited and poorly resourced.^{62,63} The impact is greater the younger a girl is married, and is compounded by experiences of sexual violence, unwanted pregnancy, divorce/separation/becoming a widow, and conflict or crisis.⁶⁴

Child marriage and access to safe abortion and post-abortion care services

The link between child marriage and safe abortion and post-abortion care services is multifaceted and deeply interconnected with issues of SRHR. Lack of access to contraception, lack of information and education, and high levels of sexual violence all drive unintended pregnancy among adolescent girls.^{65,66} Married girls often have even less control over their reproductive choices, including the decision to terminate a pregnancy.⁶⁷ This lack of autonomy can lead to unwanted pregnancies and forced continuation of pregnancies.

Globally, a high proportion of pregnancies are reported as unintended. In more than a third of African countries, over 40% of births to girls under age 20 were unintended, and in most countries in Latin America and the Caribbean more than half of births to adolescents were unintended.⁶⁸

Globally, 61% of unintended pregnancies end in abortion, showing the need for safe abortion services and post-abortion care.^j Data on abortion among adolescents is scarce, but analysis by the Guttmacher Institute indicates that in 2019, an estimated 55% of unintended pregnancies among adolescents aged to 15 to 19 in low- and middle-income countries ended in induced abortion.^{k,69}

There is no evidence showing that restrictions lead to lower abortion rates,⁷⁰ but plenty of evidence and testimony showing that where there are restrictions, abortions are often unsafe, resulting in complications or even death.⁷¹ As of 2017, 47% of women of reproductive age live in countries where abortion is highly restricted, so they must either continue with unwanted pregnancies or turn to unsafe providers or unapproved abortion methods that put their health and life at risk.⁷² Married adolescent girls, who are often isolated, controlled and economically dependent on their partners and in-laws, face even greater risks. Decades of data show unsafe abortion contributes to maternal mortality. It is estimated that 8 to 11% of all maternal deaths are due to unsafe abortion,⁷³ and that adolescent girls are more likely than older women to go to unsafe providers.



In focus: Adolescent pregnancy and abortion⁷⁴

- About **21 million** adolescents (aged 15-19 years) in low- and middle-income countries become pregnant every year.
- About **half** of these pregnancies are unintended.
- **Over half** (55%) of these unintended pregnancies end in (often unsafe) abortions.

This means about **1 in 4** adolescent pregnancies in low- and middle-income countries ends in (often unsafe) abortion.

Child marriage and maternal and child health

Complications arising from pregnancy and childbirth are consistently among the leading causes of death for 15- to 19-year-old girls globally, with most happening in low- and middle-income countries.^{75,76} Common – but largely preventable – complications of childbirth, like hypertensive disorders, haemorrhage, premature labour, systemic infections, and obstructed labour are more likely to affect girls aged 15 to 19 than those just a few years older; those aged under 15 are at even greater risk.^{77,78} Adolescent girls are also at increased risk of post-pregnancy-related complications. Up to 86% of cases of obstetric fistula occur in girls under age 18.⁷⁹

Systemic racism in reproductive health settings contributes significantly to maternal mortality and creates barriers to health services for marginalised girls and women.⁸⁰ Most countries do not have disaggregated data, but the much higher incidence of maternal death for Black as compared to White women in the United Kingdom and the United States suggests persistent forms of discrimination and exclusion – and not just limited resources – play a significant role in many global inequalities in SRHR.^{81,82} In the UK, Black women are four times more likely die from complications related to pregnancy or childbirth than White women.⁸³

Children born to adolescent mothers face greater health risks and even death compared to those born to older mothers. They are also more likely to have low birth weight and poor nutritional status throughout their childhood.⁸⁴



In focus: Child marriage and child health

A study by the World Bank and International Centre for Research on Women estimated⁸⁵ that **if we end child marriage**, over a 15-year period:

2.2 million

more children could survive past age five

3.6 million

more children could avoid stunting

^j"Post-abortion care" refers to the treatment of complications arising from attempts to induce abortion using unapproved methods. A core indicator for quality post-abortion care is the provision of contraception immediately after treatment to prevent any subsequent unwanted pregnancies.

^k"Induced abortion" refers to the deliberate termination of pregnancy, as opposed to spontaneous abortion (also known as miscarriage)

Child marriage and access to contraception

The use of modern contraceptive methods is one of the most effective ways to minimise the likelihood of unintended pregnancies. Contraception means girls and women can decide for themselves if, when and how many children to have, and to better protect themselves against STIs, including HIV.⁸⁶

Married adolescent girls have the lowest contraceptive use and the highest unmet need, leading to higher rates of unintended pregnancies.⁸⁷ There have been small gains in the use of contraception, but 1 in 3 women aged 15 to 49 still lack access to modern contraception methods.⁸⁸ The greatest gaps in meeting contraception needs are among adolescents aged 15 to 19 (39.1%) and young women aged 20 to 24 (33%).⁸⁹

The most common barrier to adolescents' access to contraception and abortion services is provider attitudes.⁹⁰ Providers may refuse to deliver contraception or abortion services to adolescents because of their age, or because they disapprove of adolescent premarital sexual activity. Adolescents often report avoiding using sexual health services for fear of recrimination or punishment for being sexually active.⁹¹ When providers are willing to provide contraception, they may only offer less effective short-term methods due to misconceptions about the suitability of other methods for young people, like their perceived effect on fertility.⁹²

Married adolescents also face difficulties accessing the full range of contraceptive methods on account of their age, beliefs held by providers about the need for spousal consent, and the expectation that girls should have a child soon after marriage.^{93,94}

In addition to the common barriers faced by individuals of all ages in low- and middle-income settings – like cost, distance and lack of availability of the full range of methods – adolescents face additional difficulties accessing services. These include clinic opening times which may clash with school; indiscreet or inconvenient clinic locations; and laws, policies and practices which require parental consent, or prohibit provision of contraception to unmarried adolescents or those under a certain age.⁹⁵ Adolescents often have fears around contraception based on myths and misconceptions about side effects, and the stigma associated with its use.⁹⁶

Urban poverty, displacement and humanitarian crisis further exacerbate challenges to access for adolescents, especially for adolescent girls in informal settlements, camps for refugees or internally displaced persons, who face greater risks and limited access to quality SRHR services.⁹⁷

Even when adolescents can access contraception, there are barriers to them using it. Married adolescents may have to use contraception secretly due to social pressures to demonstrate fertility. Unmarried adolescents may find it difficult to insist on using contraception due to the stigma associated with its use. When they do insist, they are often uninformed about correct usage.⁹⁸



Case study: Peer education in communities and public health facilities in Uganda

The China-Uganda Friendship Hospital has a designated area for youth-led and youth-friendly services delivered by trained facility- and community-based peer educators. The initiative is delivered under the Community Health Department, and supported by Naguru Youth Health Network.

The youth area is furnished with **recreation and edutainment** materials to engage young people as they wait for clinical services, which are delivered by health workers who are also trained in **youth-friendly service delivery**.

Service uptake increased from 118 to 500 per month in the first year (2012-13) of the initiative, and has now reached 1,000 thanks to referrals from **peers in the community**.



Tip! This success relies on careful **selection of peer educators** – by age, gender and risk behaviours – who are trusted in the community and allow for more open discussions.

Child marriage and HIV

Globally, young women are twice as likely to acquire HIV as their male counterparts. In 2022, girls accounted for 4 out of 5 new HIV infections among adolescents.⁹⁹ Eastern and Southern Africa – the region most heavily impacted by HIV¹⁰⁰ – is also the region with the second-highest prevalence of child marriage in the world, at 32%.¹⁰¹ Although the region has made significant progress in reducing numbers of new HIV infections and AIDS-related deaths, the declines differ between countries and populations. Women and adolescent girls aged 15 years and above still bear the greatest burden, accounting for 61% of all people living with HIV in the region as of 2022; adolescent girls and young women aged 15 to 24 years are at a higher risk of acquiring HIV than males in the same age group and older women.¹⁰²

Some of the factors which put girls at higher risk of acquiring HIV are the same as those that put them at risk of child marriage. These include poverty, low educational attainment and gender inequalities which limit girls' ability to make decisions about their own health, who to have sex with, if and what contraception they use, and who and when to marry.^{103,104}

In some contexts, child marriage can put girls at greater risk of acquiring HIV. Girls married before 18 are often exposed to frequent unprotected sexual activity, they may marry older men who have had multiple sexual partners, they often lack the agency needed to negotiate safe sex, or access vital SRHR services, and can experience high rates of IPV, which increases their risk of acquiring HIV.¹⁰⁵

Child marriage and intimate partner violence/violence against women and girls

Globally, 1 in 3 girls and women experience physical and/or sexual violence in their lifetime, mostly by an intimate partner.¹⁰⁶ Violence against women and girls (VAWG) takes many forms, including forced marriage. This puts girls and women at increased risk of sexual, physical and psychological violence and related outcomes like poor health – including SRHR, and mental and psychosocial health – throughout their lives.¹⁰⁷

Girls and women who marry before age 18 are at increased risk of violence from their partners or partners' families.

The greater the age difference between girls and their husbands, the more likely they are to experience IPV.¹⁰⁸

IPV and other forms of VAWG are human rights violations and are associated with poor SRHR outcomes, including unplanned pregnancies, induced abortions, gynaecological problems and STIs, including HIV. IPV during pregnancy also increases the likelihood of miscarriage, stillbirth, preterm delivery and low-birthweight infants.¹⁰⁹

In focus: Child marriage and sexual and IPV

Globally, girls married before age 15 are almost

**50%
more likely**

to have experienced physical or sexual IPV than those married after age 18.¹¹⁰

Recent evidence from Lesotho, Namibia and Zimbabwe found that:¹¹¹

1 in 4

girls and women who married before age 18 and experienced childhood sexual violence experienced mental distress in the last month.

A history of sexual violence increased the risk of mental distress by

**2.5
times**

Child marriage and SRHR during polycrisis

The polycrisis – comprised of the ongoing impacts of COVID-19, conflict and climate crisis – is driving increases in child marriage. For each tenfold increase in conflict-related fatalities, child marriage increases 7%; for every 10% change in rainfall due to climate change, child marriage increases by 1%.³

In times of crisis and conflict, girls' access to critical, protective services like education, GBV and SRHR can be severely disrupted. Educational institutions may be

the target of direct attacks, putting girls at risk of sexual violence and trafficking, and incentivising child marriage as a perceived way to protect them. Married, pregnant and parenting girls are very unlikely to return to school once they reopen, further limiting their access to CSE and other information and support.¹¹²

COVID-19 is predicted to cause an additional 10 million child marriages over the next decade, some of which may be due to disrupted SRHR and other protective services.¹¹³

The pandemic disrupted contraceptive use for about 12 million women, leading to nearly 1.4 million unplanned pregnancies across 115 low- and middle-income countries over 2020.¹¹⁴

Safe spaces can play a critical role in connecting girls to SRHR information and services during conflict and crisis.

They also offer girls and women spaces where they feel physically and emotionally secure enough to discuss SRHR and GBV, and access SRHR services and supplies.¹¹⁵

There is a growing body of evidence on promising practice for delivering flexible, context-specific SRHR services for adolescent girls in humanitarian settings, including the use of mobile SRHR clinics and camps which have shown positive results with outreach to more marginalised adolescents.¹¹⁶

Recommendations

A rights-based, gender-transformative, intersectional, intergenerational and multi-sectoral approach is needed to end child marriage and respect, protect and fulfil girls' and women's sexual and reproductive health and rights (SRHR).

This approach needs to combine demand- and supply-side interventions,¹ and ensure girls can decide for themselves – as holders of rights – if, when and with whom to have sex, marry, enter a union or have children, negotiate safe sexual practices, access appropriate and quality SRHR services, and enjoy the highest possible standard of SRHR.¹¹⁷

National governments should:

- 1. Allocate national budget for a comprehensive range of quality, affordable and adolescent-friendly SRHR services in line with the provisions of the ICPD Programme of Action.**
 - **Allocate a minimum 10% of national development budgets** and development assistance budgets to the implementation of the ICPD Programme of Action, including in humanitarian settings. Official Development Assistance should amount to at least 0.7% of Gross National Income.
 - **Expand girls' access to comprehensive and quality SRHR information and services.** This should include access to contraceptives as part of efforts to achieve universal health coverage, removing requirements for parental consent and increasing efforts to transform the gendered social norms and stereotypes around young people's sexuality.

Demand-side interventions focus on increasing the awareness, willingness and ability of individuals and communities to seek and use services related to child marriage prevention and SRHR. These interventions aim to change behaviours, attitudes and social norms.

Supply-side interventions focus on improving the availability, accessibility, quality and responsiveness of services related to SRHR and child marriage prevention. These interventions ensure that the necessary infrastructure, resources and trained personnel are in place to meet the demand.



Case study: Working with diverse stakeholders to build support for adolescent SRHR in Mozambique

The Associação Moçambicana para o Desenvolvimento da Família ([AMODEFA](#)) works with community members, religious leaders, teachers, government officials and other civil society organisations – including youth organisations – to link advocacy at all levels, and to transform the gender norms that limit girls' and women's access to SRHR services.

At the national level, they advocate for **political-legislative changes** that promote SRHR with greater involvement of communities, and youth and women leaders.

At the community level, they focus on social and **behavioural change and demand creation**. With support from AMODEFA and teachers, members of the youth action movement and peer educators share accurate and up-to-date information on adolescent SRHR and comprehensive sexuality education in schools and communities. As a result, community and religious leaders have committed to raising awareness and reporting cases of early unions and gender-based violence.

AMODEFA also address **supply-side** issues by providing SRH services.



Tips!

- Engaging with adolescents and young people requires **coordination** to enhance learning and avoid duplication.
- Community and religious leaders, youth associations, police officers and government officials should be included in training to build relationships and perspectives. Engagement should be **clear, based in human rights** and respond to their concerns **without judgement**. When done right, potential opponents can be engaged to become important allies in promoting adolescents' SRHR.
- Training should be part of a well-planned and monitored **sequence of interventions** that encourages engagement and ownership over the longer term.

UN agencies and international organisations should:

1. **Partner with civil society organisations**, particularly youth- and women-led organisations working in communities with high prevalence of child marriage, and with girls and populations most at risk or affected by the practice.
2. **Develop programmes that apply a life-stage and socioecological lens^m to SRHR programmes for young first-time mothers**, going beyond health to improve outcomes in couple communication, gender equitable attitudes and wellbeing.
3. **Create safe spaces for girls and women in conflict- and crisis-affected settings** to talk freely, support each other, voice their needs, and participate in the design of programmes and services.

- **Invest in training for health care workers and ancillary staff** to provide equitable, non-discriminatory and quality attention for adolescent girls' SRHR needs, including those who are married, pregnant or parents.
2. **Provide for the changing SRHR needs of adolescent girls and women in all their diversity, throughout their lifetime**, including the full range of contraceptive options and menstrual hygiene; access to quality maternal health services; safe abortion and post-abortion services and care; accessible and confidential STI testing, treatment and prevention services; psychological support and counselling, especially for girls who have experienced early pregnancy and childbirth; survivor-centred services for survivors of SGBV, including child marriage.
 3. **Provide comprehensive sexuality education** that is scientifically accurate, curriculum-based, non-discriminatory and accounts for young people's evolving capacities. This should be available both in and out of schools, including in humanitarian settings.
 4. **Review and, where necessary, change legislation and policies to respect girls' bodily integrity and autonomy without discrimination**. Remove all normative barriers that seek to control married and unmarried girls' sexuality and access to SRHR services and essential information. This includes removing the need for third party consent, decriminalising consensual adolescent sex and guaranteeing confidentiality.
 5. **Support the meaningful, safe and inclusive participation and leadership of adolescents and young people** – in all their diversity – in decisions about the formulation, implementation, monitoring and evaluation of SRHR initiatives.
 6. **Coordinate multi-sectoral strategies for accessible and equitable, gender-transformative services and systems** – including education, SRHR, GBV and justice – to complement youth- and civil society-led social norms change interventions to ensure girls have alternatives to marriage.
 7. **Ensure SRHR remains a priority throughout all phases of emergency response cycles:**
 - **Integrate SRHR into a multi-sectoral package of interventions**, developing, implementing and resourcing comprehensive preparedness plans in accordance with the [Minimum Initial Service Package](#) and informed by the SRHR needs and concerns expressed by children, adolescent girls and ever-married girls at the onset of humanitarian crises.
 - **Address the SRHR needs of girls and women affected by crisis within a comprehensive framework of support**. Positive SRHR outcomes are reliant on satisfaction of other rights, including education, food and water, safety, shelter and sanitation.
 8. **Improve data collection methodologies and systems to accurately capture information on child marriage and uptake of SRHR**. Disaggregate by gender and age as a minimum, and include specific indicators for targeting the girls and groups who have been most marginalised and face additional difficulties in accessing services.

^mProgrammes that apply a life-stage and socio-ecological lens to SRHR consider the diverse needs of individuals at different stages of life and address the multiple layers of influence on SRHR, from personal education to societal norms and policies

Donors should:

- 1. Invest in multi-year, context-sensitive, age-appropriate, youth-informed, gender-transformative programmes working with girls in their communities.** Such programmes should provide accurate and accessible information on SRHR; provide referral pathways to access SRHR and other services, including specialised support for GBV, legal aid and social protection schemes; and transform gender norms and drivers of child marriage.
- 2. Invest in civil society organisations who are key to the success of SRHR and child marriage programmes:**
 - **Enhance the organisational capacity of civil society organisations through technical and financial partnerships** to strengthen the design and implementation of gender-transformative strategies to build girls' and young people's leadership and agency.
 - **Invest in community-led development initiatives** – especially those led by girls, adolescents and young people – to strengthen civic space and citizen participation at local, national and international levels.
- 3. Invest in research, evidence and accountability mechanisms** that prioritise the collection of disaggregated data – by age, gender, ethnicity and socio-economic status – to inform targeted interventions, the evaluation of interventions and policy development.

Civil society organisations should:

- 1. Create safe spaces for children and adolescents** – in all their diversity – to build critical thinking skills and access the information they need to deconstruct internalised gender norms and behaviours which negatively impact on their SRHR and other life choices and outcomes.
- 2. Take a gender-transformative approach, engaging with boys and men** – as peers, brothers, fathers, traditional and religious leaders, husbands and partners – to build critical awareness of the negative impact of patriarchal control of girls' bodily autonomy, and the role they can play in transforming their own attitudes and behaviours as allies for SRHR, gender equality and the prevention of child marriage.
- 3. Take an intersectional and crisis-informed approach to advocate for the satisfaction of the SRHR needs of all girls**, including the SRHR needs of adolescent girls who are married, pregnant, parents, displaced, refugees, disabled, from a minoritised caste, Indigenous or ethnic group, or who do not self-identify as cisgender.
- 4. Strengthen movement-and alliance-building for collective advocacy, learning, solidarity and collective care** to advance the ICPD Plan of Action and counter pushback on SRHR rights from the anti-rights movement around the world.



Case study: A comprehensive, multi-level approach to child marriage and SRHR in Jarkhand, India

Sinduartola Gramodaya Vikas Vidyalaya's (SGVV) comprehensive "Two feet ahead together" initiative works through schools and communities to combine training, collaboration and awareness raising with supply-side support for adolescents' SRHR.

The initiative includes **training** on SRHR for adolescent girls and boys, and a **peer leadership** programme through which they can collectively find solutions to the challenges they see in their communities. This well-trained and motivated federation of peer leaders has created a strong support network around SRHR and child marriage at the community level.

SGVV has also established "pad banks" providing **menstrual hygiene products** in 40 schools, meeting adolescent girls' needs and so improving their school attendance.

Alongside this work with adolescents, SGVV has also **raised awareness** around child marriage and SRHR with community members, fostering a more informed and proactive environment. They have developed close relationships with government officials – including Block-level Child Marriage Prohibition Officers – to facilitate better **coordination** in responses to SRHR and child marriage.



Tip! Fostering **strong relationships** is key, whether working with government officials or supporting young people to connect and learn together.

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