

CHILD MARRIAGE AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Every year 12 million girls are married before the age of 18. Child marriage has many causes, but is primarily driven by inequitable gender norms which deprive girls and young women of their sexual and reproductive rights and limit their life choices. A key driver of adolescent pregnancy, child marriage has a hugely detrimental impact on the health and well-being of girls and young women, as well as on that of their children. Adolescent pregnancy also acts as a driver of child marriage in contexts where pre-marital sexuality is taboo. By acting to prevent child marriage, and by improving married and unmarried adolescent girls' access to sexual and reproductive health services, we can dramatically improve health and broader development outcomes for millions of girls and children worldwide.

A comprehensive, multi-sectoral approach is needed to empower girls to decide for themselves when and with whom to have sex, when to marry and bear children, to negotiate safe sexual practices, to access appropriate and quality sexual and reproductive health services, and ultimately to enjoy better sexual and reproductive health.



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This brief is part of a series on child marriage and how it relates to other sectors. For more information, please visit our resources page: www.GirlsNotBrides.org/resource-centre

The problem: child marriage violates girls' sexual and reproductive rights and leads to poor health outcomes

Sexual and reproductive health (SRH) is a state of complete physical, mental and social well-being in all matters relating to sexuality and the reproductive system. It implies that individuals are able to 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.

In order to enjoy good SRH, individuals need to be able to exercise their sexual and reproductive rights (SRR), which include: 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 found 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, and; to be free from discrimination, degrading treatment, coercion and violence. Together, SRH and SRR are known as sexual and reproductive health and rights (SRHR).^a SRHR are enshrined in a number of human rights instruments and international agreements, including the Programme of Action of the International Conference on Population and Development, Platform for Action of the International Conference of Women, the Convention on the Rights of the Child, and the Convention on the Elimination of All Forms of Discrimination Against Women.

When girls marry as children they are denied the ability to make critical choices about their futures, and are thereby denied their basic SRR. Child marriage is also a significant contributor to poor sexual and reproductive health outcomes for adolescent girls, which can follow them into adulthood and also affect the well-being of their own children. This section outlines the key SRHR issues that are closely linked to child marriage, and the next section presents an effective approach to improve SRHR outcomes.

Child marriage and sexuality

- Child marriage is underpinned by harmful gender norms and discrimination against girls and women. The question of when and with whom to begin sexual activity is often decided for them in violation of their basic sexual and reproductive rights. The desire to control female sexuality and preserve virginity before marriage is often one of the main motivating factors behind parents' decision to marry their daughter early.² Child marriage therefore denies girls the right to make fundamental decisions about their own sexuality and health.
- Negative attitudes towards adolescent sexuality are one of the main barriers girls face in accessing sexual and reproductive health services, as service providers often refuse to provide contraception, abortion, or HIV prevention and testing services to people who they deem too young to be sexually active.^{3,4} This is particularly the case for unmarried

adolescents, but married girls still face provider stigma due to social norms which demand that girls and young women have a child soon after marriage, and the mistaken perception that only certain contraception methods are appropriate for younger women who are supposed to be forming families.⁵

Child marriage and education, including comprehensive sexuality education^b (CSE)

- Child marriage often leads to girls dropping out of school, which limits their ability to complete their education and also limits their access to information and education about SRHR.
- A strong evidence base demonstrates positive relationships between increased girls' education and improved sexual and reproductive health outcomes, including higher age of marriage, greater contraceptive use, higher age at first birth, and increased use of health services.⁶ Across 15 countries in Asia and Africa, for example, girls who completed secondary education scored higher on an index of HIV/AIDS knowledge than girls with only primary education.⁷
- Evidence shows that effective comprehensive sexuality education (CSE) provides girls (and boys) with accurate information about sexual and reproductive health, enabling them to develop the critical life skills needed to make healthy, safe choices, which reduce risky sexual behaviours^c that lead to unintended pregnancy and sexually transmitted infections.⁸ CSE that includes discussions of gender and power have been proven more effective than sexuality education programs that do not.⁹
- In contexts where adolescent sexuality is taboo, CSE may not be provided in school at all, key topics may be omitted, or discussions around sexuality and SRHR may be discouraged. Denying adolescents access to accurate information on SRHR means that they lack basic knowledge about how to protect themselves from unwanted pregnancy and sexually transmitted infections. Globally, only 30% of girls aged 15 to 24 have comprehensive and accurate

^aUNESCO 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."

^cRisky 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.

knowledge about HIV;¹⁰ undermining their ability to negotiate condom use and other safer sex practices.¹¹

Child marriage and adolescent pregnancy

- Every year an estimated 21 million girls aged 15 to 19 and 2 million girls aged under 15 become pregnant in developing countries.^{12,13} Approximately 16 million girls aged 15 to 19 and 2.5 million girls under the age of 16 give birth every year.^{10,14}
- The vast majority of births to adolescents take place within marriage, and 90% of adolescent births are to girls already married or in a union.¹³ In many contexts child marriage acts as a driver of adolescent pregnancy because child brides are often under intense social pressure to prove their fertility, which they lack the means or tools to resist.¹⁵ They therefore have limited agency to decide when to begin child bearing or how many children to have, in violation of their basic sexual and reproductive rights.¹²
- In some contexts, particularly where girls' extramarital sexuality is taboo, adolescent pregnancies act as a catalyst for child marriage.^{16,17,18} Globally, a high proportion of pregnancies are reported as unplanned, and unplanned pregnancy can lead girls to marry earlier than they otherwise would have. In more than a third of African countries, over 40% of births to girls under the age of 20 were unplanned, and in most countries in Latin America and the Caribbean more than half of adolescent births were unplanned.¹⁹ Lack of access to contraception, lack of information and education, and high levels of sexual violence all act as drivers of unplanned pregnancy among unmarried adolescent girls.^{20,21}
- High levels of unplanned pregnancies also fuel the need for safe abortion services, including post abortion care (PAC).^d Data on abortion among adolescents is scarce, although analysis by the Guttmacher Institute indicates that in 2016, an estimated 27% of all pregnancies to 15- to 19-year-old girls ended in induced abortion.^{12e} In contexts where abortion is highly restricted, these abortions are



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often unsafe, resulting in complications or even death.^{19,21}

- Child marriage increases fertility rates, as girls who marry as children start their reproductive lives early and go on to have more children over their lifetimes.²² At a national level, this translates into increased population growth rates.

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.²³ Common complications of childbirth such as hypertensive disorders, haemorrhage, premature labour, systemic infections, and obstructed labour are more likely among girls aged 15 to 19 than those just a few years older, and those aged under 15 are at even greater risk.^{13,24,25}
- High levels of unplanned pregnancy and restrictive abortion laws mean that pregnant adolescent girls in developing countries frequently turn to clandestine, unqualified abortion providers who put their health and even lives at risk. While data is unreliable, Guttmacher estimates that between 8–11% of all maternal deaths are due to unsafe abortion¹⁹ and that adolescent girls are more likely than older women to go to unsafe providers.²¹

^dPost-abortion care (PAC) refers to the treatment of complications arising from attempts to induce abortion using unapproved methods. A core indicator for quality PAC is the provision of contraception immediately after treatment in order to prevent any subsequent unwanted pregnancies.

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

- Girls are also at increased risk of post pregnancy-related complications. A systematic review found that up to 86% of cases of obstetric fistula occur in girls under the age of 18.²⁶
- Child brides are more likely to have more children over their lifetimes than their peers who marry later,¹³ and to have short intervals between each birth, both of which increase the lifetime risk of developing complications during pregnancy.^{27,28}
- Children born of child brides 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.^{13,29} A recent study by the World Bank and International Center for Research on Women estimated that over a 15-year period, an estimated 2.1 million children could survive past age five and 3.6 million children could avoid stunting if child marriage was eliminated.³⁰

Child marriage and contraception

- Both married and unmarried adolescent girls have a high unmet need^f for contraception, resulting in high rates of unintended, unplanned and unwanted pregnancy.¹² Compared to older married women, married adolescent girls have the lowest use of, and the highest unmet need for contraception.¹³ The inability to access and use contraception prevents girls and young women from exercising their basic right to decide if, when and how many children to have.
- Unwanted pregnancies create the need for safe abortion services, including PAC. As of 2017, 47% of women of reproductive age live in countries where abortion is highly restricted, meaning that they either must continue with unwanted pregnancies or turn to unsafe providers or unapproved abortion methods that put their life at risk.¹⁹
- The most common barrier adolescents face to accessing contraception and abortion services is judgmental provider attitudes.³⁴ Providers may refuse to give contraception or abortion services to both married and unmarried adolescents on account of their age, or because they disapprove of adolescent premarital sexual activity. Adolescents often report that they avoid seeking out sexual health services for fear of recrimination or punishment for being sexually active.³
- 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, such as their perceived effect on fertility.³
- While unmarried adolescents may face greater stigma from providers, 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.^{4,31}
- In addition to the common barriers faced by individuals of all ages in low- and middle-income settings, such as cost, distance, and lack of availability of the full method mix, adolescents face particular 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.³ Adolescents themselves often have fears around contraception based on myths and misconceptions about side effects, as well as the stigma associated with its use.³⁴
- Even when adolescents are able to access contraception, there remain barriers to them using it. Married adolescents may have to resort to clandestine use of contraception 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.³⁴

^fWomen with unmet need are those who sexually active and report wanting to delay or limit future pregnancies, but are not currently using contraception.

Child marriage and HIV

- Adolescent girls are disproportionately affected by HIV. Globally, young women are twice as likely to acquire HIV as their male counterparts.³²
- In Eastern and Southern Africa, despite making up only 10% of the population, girls and young women aged 15 to 24 account for around 25% of new infections.²⁰
- Some of the factors which put girls at higher risk of HIV infection are the same as those that put girls 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, or whom and when to marry.^{33,34}
- In some contexts child marriage can even make girls more vulnerable to HIV infection:
 - Child brides are often exposed to frequent unprotected sexual activity.³⁵
 - They may marry older men who have had multiple sexual partners.^{36,37}
 - They often lack the agency needed to negotiate safe sex, or access vital sexual and reproductive health services.³⁸

- Child brides experience high rates of intimate partner violence (see more below) which increases their risk of HIV infection.^{39,40}

Child marriage and gender-based violence (GBV)

- Approximately one in three women and girls experience physical and/or sexual violence in their lifetime.⁴¹ Child marriage is a manifestation of that violence, putting women and girls at increased risk of sexual, physical, and psychological violence and related outcomes, such as poor health and depression, throughout their lives.
- Girls who marry as children are at increased risk of violence from their partners or their partners' families. The greater the age difference between girls and their husbands, the more likely they are to experience intimate partner violence (IPV).⁴² Recent analysis of Demographic and Health Survey data found that globally, girls married before the age of 15 were almost 50% more likely to have experienced either physical or sexual IPV than those married after 18.³⁹
- IPV and other forms of violence against women, in addition to being a rights violation in and of themselves, are associated with poor SRH outcomes such as HIV infection, unintended pregnancy, unsafe abortion, and other outcomes such as poor mental health, depression and even suicide.

A comprehensive approach to improving girls' sexual and reproductive health

Due to the interlinked nature of SRHR issues, a comprehensive, multi-sectoral approach is needed which combines demand generation at both the community and individual level, with direct referrals to service delivery points. Young people should be provided with accurate information on SRHR, and be supported to build the skills they need to make decisions about their own lives and SRH. At the

same time communities, including parents and other gatekeepers, should be engaged to gain buy-in for girls to exercise their SRR and access SRH services. Service providers should be trained on an ongoing basis about the rights of adolescents—married and unmarried—to access SRH services, and how to interact with them, including quality counselling and communication skills. Service delivery programmes should be tailored

to their needs, which are often quite different than those of women who are even just a few years older. SRH services for adolescents must be youth friendly (see more below), and incorporate their meaningful participation in assessing what works best for them. Lastly, community members and service providers should be trained on gender-based violence, with service providers and teachers able to provide referrals to appropriate legal, social or child protection mechanisms.

Demand side interventions

- Programmes which provide girls (and boys) with information and resources about SRHR provide space for them to reflect on harmful social norms, and enable them to develop the necessary life skills to make decisions about their own SRH, are a first step towards improving girls' sexual and reproductive health.
- Examples of successful approaches include CSE offered in schools, safe spaces and girls' clubs, which provide mentoring and life skills, and training girls to be SRH "peer ambassadors" who share information about sexuality and where to access family planning services with girls in their communities. Specifically:
 - Evidence shows that CSE provides girls (and boys) with the skills, knowledge and confidence to make healthy, safe choices, promotes well-being, and reduces risky sexual behaviours that lead to unintended pregnancy and sexually transmitted infections.⁶
 - CSE should be age-appropriate and go beyond biology to include teaching on sexual orientation, pleasurable experiences, bodily autonomy, healthy relationships, menstrual and bodily hygiene, as well as contraception methods and how to avoid sexually transmitted infections.⁴³ Recent research found that sexuality and HIV education which explicitly addressed gender and power was five times more likely to reduce rates of pregnancy and sexually transmitted infections as those that did not.⁹
 - Safe space programmes offer an alternative setting for out-of-school girls to learn about SRHR. Studies

have shown that safe spaces can achieve a range of positive SRHR outcomes including reducing gender inequitable norms and acceptance of GBV, and increasing girls' health knowledge and use of health services, such as contraception, HIV testing and treatment, and maternal health and first time parent support services.^{9,44}

- As girls themselves are often not the decision makers when it comes to their own health, engaging with boys, husbands or partners, in-laws, parents, and the wider community is crucial for changing gender inequitable social norms around adolescent sexuality and use of contraception and other SRH services.⁴ A recent review of evidence found that girls clubs which also engage with parents and other family and community members are more likely to achieve behaviour change—as opposed to changes in attitudes only—such as reductions in violence and child marriage.⁴⁵
- Programmes which attempt to change social norms should always be tailored to the local context.⁴

Supply-side approaches

- Demand-side interventions should be combined with provision of quality youth-friendly services. Programmes which deliver services and social norms change initiatives at the community and individual level together are particularly successful in increasing service uptake. For example, by combining dialogue with young people and their communities with service provision and referrals, one major service provider doubled the number of 15- to 19-year-olds served in their programmes between January 2017 and March 2018 to one million globally. Partnering with civil society and youth organisations was identified as a critical success factor across their global programmes spanning 37 countries.⁴
- More generally, youth-friendly SRH programmes should be confidential, open outside of school hours, offer free, or at least affordable services, be tailored to the local context, and be convenient and discreet in terms of location and access.⁴⁶ For example, in the Sahel region where use of contraception is often only considered acceptable to space, rather than to delay or limit births, young



Photo: Jessica Lea/ Department for International Development

women with no children or a desire to limit further births reported that integrating contraception service delivery into malaria and antenatal clinics allowed them to access services discretely.⁴⁷

- As highlighted above, changing provider attitudes towards, and building their competencies in serving adolescents is critical. This can be achieved through ongoing provider support and training on what the legal and policy environment allows, values clarification exercises, and regular client feedback and monitoring via mystery client surveys to ensure any provider bias is detected and addressed.⁴
- Maternal and neonatal health care providers should be trained on the additional complications that pregnant adolescents may face during pregnancy, childbirth and in the post-partum period, as well prevention of obstetric violence, and youth-friendly service provision more generally. As part of quality maternal health services, adolescents should be counselled on post-partum contraception options.
- All SRH programmes should include specific indicators for targeting hard-to-reach girls who face particular difficulties in accessing services, including child brides, girls living below the poverty line, girls with disabilities, and those in the most remote rural locations. Data on hard-to-reach girls' unmet need for contraception, which is often lacking, should be improved.

- All SRH service providers should also be trained in GBV, its impact on SRH outcomes, and how to identify girls who may be at risk or have experienced violence, and how to respond to it. Linkages with appropriate legal, social, mental health or child protection services should be created so that providers can refer at-risk adolescents for support.
- In order to avoid complications arising from unsafe abortion, safe abortion services and post-abortion care should be made available where possible, including routine counselling on post-abortion contraception options. Information on safe abortion and referrals should be provided by other relevant service providers.
- Lastly, legal and policy barriers which prevent adolescents from accessing SRH services on the grounds of age, sex, marital status, or the number of children they have, should be reviewed.

About *Girls Not Brides*

In consultation with members, *Girls Not Brides* created a common Theory of Change, which outlines the range of approaches needed to end child marriage.

This brief was developed by the Girls Not Brides secretariat, and does not necessarily reflect the views of every member of the Girls Not Brides Partnership.

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