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**POLICY BRIEF: CONSEQUENCES OF CHILD MARRIAGE
FOR SEXUAL AND REPRODUCTIVE HEALTH
IN HUMANITARIAN SETTINGS
IN THE ARAB REGION**



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*This policy brief discusses the sexual and reproductive health implications of child marriage in the context of humanitarian settings in the Arab region, highlighting threats to progress made in the past two decades. It concludes with recommendations for stakeholders, including policymakers and development organizations involved in emergency response, and relief programmes for refugees and internally displaced persons.*¹

Background

The incidence of child marriage in the Arab region has steadily declined over the past 30 years. It is estimated today that one in four women in the region was married before their 18th birthday. In recent years, however, only one in seven women aged between 20 and 24 was married before the age of 18. In countries such as Egypt and Jordan, the level of child marriage has halved since the 1980s. In Libya, Algeria and Djibouti, fewer than 5 per cent of women marry before they turn 18. Child marriage in the Arab region is far less prevalent than in other regions, such as West and Central Africa or South Asia, where 46 per cent and 56 per cent of women respectively marry before turning 18.²

Growing insecurity and upheaval in the region, however, could reverse this progress. In countries such as Somalia, the Sudan and Yemen, which have undergone protracted conflict, more than one in three girls marry before the age of 18.³ As the number of internally displaced persons (IDPs) and cross-border refugees in the region rises (box 2), child marriage appears to be becoming more common, especially among Syrian refugees: half of displaced females in Jordan report marrying before the age of 18.⁴

Box 1. What is child marriage?

The United Nations defines child marriage as a formal marriage or informal union in which at least one of the parties is under the age of 18. Boys and girls may be subject to child marriage, but girls are disproportionately affected. Globally, more than 700 million women were married as children, a third of them before the age of 15.

Child marriage is often discussed in conjunction with early and forced marriage. 'Early marriage' is frequently used interchangeably with 'child marriage' but also refers to marriages where both spouses are 18 or older but unable to consent to marriage for other reasons.

'Forced marriage' occurs without the full and free consent of one or both parties, or where one or both parties are unable to end or leave the marriage. Not all forced marriages are child marriages, but by definition, all child marriages are forced marriages, as a child is unable to provide full consent.

Sources: United Nations Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages; United Nations Children's Fund (UNICEF). Child Marriage. Available from www.unicef.org/protection/57929_58008.html. Accessed on 20 October 2015.

¹ This policy brief was prepared at the ESCWA Centre for Women (ECW) by Julianne Deitch, Associate Social Affairs Officer, under the guidance of Samira Atallah, ECW Director, and after review by the United Nations Population Fund Arab States Regional Office (UNFPA-ASRO). It is part of a joint project by ECW and UNFPA-ASRO on the prevalence, causes, dynamics and implications of child marriage in humanitarian settings in the Arab region.

² United Nations Children's Fund (UNICEF), 2014. *Ending Child Marriage: Progress and Prospects*. New York. Available from www.unicef.org/media/files/Child_Marriage_Report_7_17_LR..pdf.

³ UNICEF, 2010. *Progress for Children: Achieving the MDGs with Equity*. No. 9, September. New York. Available from www.unicef.org/protection/Progress_for_Children-No.9_EN_081710.pdf.

⁴ UN Women, 2013. *Gender-based Violence and Child Protection Among Syrian Refugees in Jordan, with a Focus on Early Marriage*. July. Amman. Available from file:///C:/Users/600847/Downloads/Report-webpdf(1).pdf.

A variety of economic, social and cultural factors contribute to the incidence of child marriage, including poverty, lack of education and the perception that early marriage is a means of protecting young girls. In humanitarian settings, those factors are exacerbated, and child marriage is sometimes seen as a survival strategy. Conflict and insecurity make matters still worse. Sexual and gender-based violence, a halt to education, increasing poverty and lack of access to health services are just some of the many repercussions for young girls of child marriage. Of particular concern is the decline in sexual and reproductive health (SRH), especially among young females married before the age of 18. Child marriage poses a threat to progress made in the Arab region on achieving universal access to sexual and reproductive health services, especially in humanitarian settings.

Box 2. Displaced persons from selected countries in the Arab region (June 2015)

	IDPs	Refugees	Total displaced
Iraq	3 596 356	369 904	3 966 260
Somalia	1 133 000	1 106 068	2 239 068
Sudan	2 192 830	665 954	2 858 784
Syria	7 632 500	3 883 585	11 516 085
Yemen	334 093	2 628	336 721

Source: UNHCR Statistical Online Population Database. Available from www.unhcr.org/pages/4a013eb06.html. Accessed June 2015.

Sexual and reproductive health in the Arab region

In many Arab countries, low rates of maternal mortality have been achieved through improved maternal healthcare

Sexual and reproductive health in the Arab region has steadily improved over the past 20 years, making it one of the best performing regions on the Millennium Development Goal (MDG) 5 target of reducing maternal mortality rates by three quarters. As of 2013, Oman and Lebanon were two of the 19 countries worldwide that had achieved the target of reducing maternal mortality rates by three quarters, and several other Arab countries appear set to do so by the end of 2015.⁵ Indeed, with the exception of Djibouti, Somalia, the Sudan and Yemen, all countries in the region have seen maternal mortality rates fall below 100 deaths per 100,000 live births, considered to be low and in line with targets set at the International Conference for Population and Development (ICPD). This success can be attributed in part to relatively high rates of antenatal care coverage; in almost all countries in the region, more than 90 per cent of births are attended by a skilled birth attendant (chart 1). Exceptions include Somalia (only 33 per cent), the Sudan (23.1 per cent) and Yemen (44.7 per cent).⁶ Somalia has one of the highest maternal mortality rates in the world (1,000 deaths per 100,000 live births). The Sudan and Yemen have made progress but still lag behind the rest of the region.

⁵ The World Health Organization (WHO) categorizes maternal mortality rates as very low (below 20 deaths per 100,000 live births), low (20-99); moderate (100-299); high (300-1,000); and very high (above 1,000). MDG 5 calls for a 75 per cent reduction in those rates between 1990 and 2015 in countries where the rate was above 100 in 1990. The ICPD Programme of Action calls for countries with moderate rates in 1994 to achieve maternal mortality rates below 100 by 2005 and below 60 by 2015. Countries with the highest levels of mortality in 1994 should achieve rates below 125 by 2005 and below 75 by 2015.

⁶ WHO, 2014. *Trends in maternal mortality: 1990 to 2013*. Geneva.

Chart 1. Maternal mortality rates in the Arab region

Country	Number of maternal deaths per 100,000 live births (MMR)					Progress (MDG/ICPD)
	1990	1995	2000	2005	2013	
Algeria	160	140	120	100	89	Off-track/not achieved
Bahrain	21	22	27	16	22	N/A (below 100)
Djibouti	400	390	360	310	230	Off-track/not achieved
Egypt	120	96	75	62	45	On track/achieved
Iraq	110	84	71	77	67	Off-track/not achieved
Jordan	86	73	65	58	50	N/A (below 100)
Kuwait	12	10	8	6	14	N/A (below 100)
Lebanon	64	47	37	26	16	Achieved (below 100 and 75% reduction)
Libya	31	25	21	17	15	N/A (below 100)
Morocco	310	240	200	160	100	On track/not achieved
Oman	48	32	22	16	11	Achieved (below 100 and 75% reduction)
Qatar	11	11	9	8	6	N/A (below 100)
Saudi Arabia	41	31	24	19	16	N/A (below 100)
Somalia	1300	1300	1200	1100	850	Off-track/not achieved
The Sudan	720	640	540	460	360	Off-track/not achieved
Syrian Arab Republic	130	94	75	58	49	On track/achieved
Tunisia	91	81	65	66	46	N/A (below 100)
United Arab Emirates	16	13	8	8	8	N/A (below 100)
Yemen	460	420	370	330	270	Off-track/not achieved

Key: **Very low**, **low**, **moderate**, **high**, **very high**

Source: United Nations Statistics Division, 2014. Millennium Development Goals Indicators. Available from <http://mdgs.un.org/unsd/mdg/Default.aspx>.

Despite strong performance, key challenges remain

Sexual and reproductive health indicators vary considerably across and within Arab countries. Although the region as a whole is performing well with regard to maternal health, substantial progress in other areas remains to be seen. The relatively low uptake of modern contraceptive methods, due to a mismatch between supply and demand for family planning services and, arguably, cultural and traditional barriers, illustrates the region-wide problems associated with expanding family planning programmes.⁷ Many countries, including Egypt, Palestine, Somalia, the Sudan and Yemen, have high adolescent birth rates, which underlines how limited knowledge of and access to sexual and reproductive health services are among young girls in the region.⁸

Changing demands and inequalities

Many countries in the region have a large youth population, bringing new demands for sexual and reproductive healthcare.⁹ Those demands are often not met due to policy and budget constraints and, in some

⁷ UNFPA-ASRO, 2014. "Sexual and Reproductive Health: A Core Component of Universal Health Coverage", UNFPA Arab States Regional Office Position Paper, May. Available from <http://arabstates.unfpa.org/webdav/site/as/shared/docs/Position%20Paper%20ENG.pdf>.

⁸ According to UNSD MDGs data for 2014, the adolescent birth rate in these countries is above the global average of 49 births per 1,000 women aged 15-49.

⁹ Economic and Social Commission for Western Asia, 2011. *Population and Development Report 5: Youth Exclusion in the ESCWA Region: Demographic, Economic, Educational and Cultural Factors*. Beirut.

cases, a reluctance to change long established health systems that cover basic needs for the majority of the population. Disparities between urban and rural populations, as well as education levels and income groups, are also slowing progress towards the achievement of universal access to sexual and reproductive health services. In Yemen, fewer than half of women with no education receive antenatal care, as opposed to more than 80 per cent of those with at least a secondary education.¹⁰ In Somalia, only 18 per cent of women in the lowest two wealth quintiles deliver with a skilled birth attendant, as opposed to 72 per cent in the two richest quintiles.¹¹

Instability and displacement

Countries affected by conflict, such as Somalia, the Sudan and Yemen, have the highest maternal mortality rates in the region and the lowest rates of antenatal care and contraceptive use.¹² During humanitarian crises, service providers are often unable to reach populations most exposed to risk, and the latter may lack the resources to access essential health services. Conflict can lead to a collapse of health care systems, exposing internally displaced people (IDPs) to particular risk. In Syria, for instance, the World Health Organization (WHO) estimates that a quarter of health centres are inoperative and that 27 per cent of those still working are inaccessible.¹³ Health services available to cross-border refugees are often unavailable or inadequate.

Sexual and reproductive health repercussions of child marriage in humanitarian settings

Child marriage represents a major obstacle to the achievement of universal access to sexual and reproductive health. The risks faced by girls who marry before the age of 18 become more acute in times of conflict and insecurity.

Girls face a high risk of death or injury during pregnancy and childbirth

Child marriage often leads to early and closely spaced pregnancies, with young girls expected to prove their fertility without adequate knowledge of or access to maternal health services. According to WHO, complications from pregnancy and childbirth are the main cause of death among girls aged 15-19 in developing countries. They are twice as likely to die during pregnancy or childbirth as women aged 20-24, and those under 15 are five times more likely to perish.¹⁴

For every girl or woman that dies during pregnancy or childbirth, it is estimated that another 20 to 30 sustain life-long, debilitating injuries. Complications such as uterine prolapse or obstetric fistula affect a woman's physical, mental and sexual health, often reduce their ability to function, and ultimately have an impact on their social and economic status.¹⁵ Young girls face an especially high risk of various morbidities, due to biological and social factors. Teenage girls are also more susceptible than older women to spontaneous abortions and sexually transmitted infections (STIs), including HIV.¹⁶

¹⁰ Republic of Yemen, PAFAM and Demographic and Health Surveys, 2015. Yemen National Health and Demographic Survey 2013. Available from <http://dhsprogram.com/publications/publication-FR296-DHS-Final-Reports.cfm>.

¹¹ UNICEF Somaliland and Somalia, Somaliland Ministry of Planning and National Development, Somalia Ministry of Planning and International Cooperation, 2014. Somaliland Final Report 2014 and Final Report Northeast Zone 2014, *Multiple Indicator Cluster Survey 2011*. The data is representative of Somaliland and Somalia Northeast Zone only.

¹² UNFPA-ASRO, "Sexual and Reproductive Health" (see footnote 7).

¹³ WHO, 2015. Summary Report of Public Health Centres in Syria (first quarter 2015).

¹⁴ WHO, 2014. "Adolescent Pregnancy", Factsheet No. 364. Available from www.who.int/mediacentre/factsheets/fs364/en.

¹⁵ Firoz Tabassum and others, 2013. "Measuring maternal health: focus on maternal morbidity". August. WHO. Available from www.who.int/bulletin/volumes/91/10/13-117564/en.

¹⁶ UNICEF, 2007. "Early Marriage: Child Spouses". Innocenti Digest, No. 7, March. Rome. Available from <http://www.unicef-irc.org/publications/291>.

Countries in conflict have consistently high rates of maternal mortality. All but one of the 10 countries with the highest rates are caught up in or recovering from conflict.¹⁷ In Yemen, an estimated 19 per cent of maternal deaths occur among women aged 15-19.¹⁸ Conditions for pregnancy and childbearing are worsened for girls and women living in areas affected by conflict, and many may resort to unsafe abortion methods when facing an unplanned pregnancy. Because abortion is prohibited in most Arab countries, except to save a woman's life, the risk of injury or death is still higher. WHO estimates that unsafe abortions account for 11 per cent of maternal deaths in the region;¹⁹ according to UNFPA, 25 to 50 per cent of maternal deaths in refugee settings worldwide are due to complications arising from unsafe abortions.²⁰

Access to sexual and reproductive health services worsens in humanitarian settings, especially for young girls

The increased risk for young girls of injury or death during pregnancy and childbirth is due in part to biological factors, such as less developed reproductive organs, but also to social factors, such as gender inequality, age difference and power relations. Young girls are less likely to seek out health services during pregnancy or childbirth, and may have less say over crucial health decisions such as family planning, antenatal care and delivering with a skilled health attendant. In Yemen, only 28 per cent of married girls aged 15-19 have their demands met for modern methods of contraceptives, as opposed to nearly half of women aged 20 and above.²¹ Child marriage is more common among poor, undereducated girls in rural areas, for whom accessing SRH services is already a challenge.

In humanitarian settings, access to health services is drastically curtailed, and although a variety of organizations may deliver critical health supplies, they often do not reach the most vulnerable populations. This is due both to a limited understanding of which health services are most needed and a lack of knowledge among displaced populations about what is available. That is especially so of young girls. Adolescent fertility rates in countries in conflict can rise considerably as a result. In Iraq, adolescent fertility rose by more than 50 per cent, from 85 to 135 births per 1,000 girls, after war broke out in 2003 compared to only a 15 per cent increase among women aged 20 to 24. Fertility rates for women over 24 remained stable, or even fell.²²

Young girls face a heightened risk of sexual and gender-based violence

Child marriage is a form of sexual and gender-based violence that threatens the physical, mental and social well-being of young girls. Girls who marry under the age of 18 often have little or no decision-making power due to illiteracy, poor education, economic dependence and psychological trauma. They are at grave risk of being subjected to sexual violence and domestic abuse. In Egypt, 40 per cent of women married before the age of 19 have experienced spousal violence, as opposed to 31 per cent of those married between the ages of 20 and 24, and 25 per cent of who married at the age of 25 or above.²³ Education and economic

¹⁷ Chad (1,100), Somalia (1,000), Sierra Leone (890), Central African Republic (890), Burundi (800), Guinea-Bissau (790), Liberia (770), the Sudan (730), Cameroon (690), Nigeria (630). Source: UNSD, 2014. MDG Data.

¹⁸ United Nations Development Programme (UNDP) Yemen. 'Improve Maternal Health: Where are we?' Available from www.ye.undp.org/content/yemen/en/home/mdgoverview/overview/mdg5.html. Accessed June 2015.

¹⁹ WHO, 2007. *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality (5th ed.)*. Geneva. Available from www.who.int/reproductivehealth/publications/unsafe_abortion/9789241596121/en.

²⁰ UNFPA, 1999. *The State of World Population: Reproductive Health for Refugees and Displaced Persons*. New York.

²¹ Republic of Yemen, PAPFAM and Demographic and Health Surveys, 2015 (see footnote 10).

²² Cetorelli, Valeria, 2014. 'The Effect on Fertility of the 2003-2011 War in Iraq'. *Population and Development Review*, vol. 40, No. 4, pp. 581-604.

²³ Kharboush, Ibrahim and others, 2010. 'Spousal Violence in Egypt'. September. Washington DC: Population Reference Bureau. Available from www.prb.org/pdf10/spousalviolence-egypt.pdf. Accessed June 2015.

status are strong predictors of potential exposure to violence. Girls who marry under the age of 18 often stop their schooling and are likely to be unemployed, and thus face an especially high risk. A study in Jordan found that women with elementary education or less were twice as likely to be subjected to violence as those with a secondary or higher education.²⁴

In humanitarian settings, the risk of violence is heightened by separation from families, unsafe living conditions and an overall breakdown of social norms and behaviour. In times of conflict, access to legal institutions and other protection mechanisms, or services for survivors of sexual and gender-based violence, is limited or non-existent, especially for displaced populations.²⁵ Displaced families sometimes sense an urgent need to marry their young daughters and pay less attention than they would in other circumstances to the background, character and age of potential husbands. A study by the United Nations Children's Fund (UNICEF) on child marriage among Syrian refugees in Jordan found that 31.8 per cent of Syrian child brides married men at least 10 years their senior, and 16.2 per cent men 15 years older, compared to only 7 per cent of Jordanians and 6.3 per cent of Palestinians in Jordan.²⁶

Box 3. Key components of successful adolescent sexual and reproductive health services (ASRH)

- Stakeholder involvement at the community level
- Participation of adolescents
- Provision of comprehensive services, including sexual education; and skills building to negotiate safe sexual practices, family planning, HIV and abortion care
- Holistic, multi-sector approach integrating life skills, and vocational and livelihood training
- Recruitment and capacity-building of qualified staff

Source: Women's Refugee Commission, 2013: Improving Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings. Available from file:///C:/Users/600847/Downloads/ASRH_summary_2-pager-new.pdf.

Conclusions and policy recommendations

An increase in the phenomenon of child marriage is one of the side effects of multiple humanitarian crises in the Arab region. The potential dangers for young married women are heightened in the precarious circumstances characteristic of such situations.

The sexual and reproductive health repercussions of child marriage in humanitarian settings are alarming and call for an immediate response through targeted interventions. Taking into consideration the unique circumstances affecting married girls in such circumstances, the following are key priorities for stakeholders involved in humanitarian response in the Arab region:

Inclusion of child marriage in sexual and reproductive health service strategies

Child marriage should be added as a priority to family planning, antenatal care, and sexual and gender-based violence issues in service provision. Adequate human and financial resources need to be made available in order to address the economic, social and cultural drivers of child marriage, and its results. By making it mandatory to monitor and, where possible, prevent child marriage in humanitarian settings, countries will be better placed not only to reduce it but also to mitigate its broader repercussions, particularly with regard to sexual and reproductive health.

²⁴ Economic and Social Commission for Western Asia (ESCWA), 2013. *Combating Domestic Violence against Women and Girls: Policies to Empower Women in the Arab Region*. October. Beirut.

²⁵ Inter-Agency Standing Committee, 2005. *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*. September. Geneva. Available from <http://www.unfpa.org/publications/guidelines-gender-based-violence-interventions-humanitarian-settings>.

²⁶ UNICEF, 2014. *A Study on Early Marriage in Jordan 2014*. Amman. Available from www.unicef.org/jordan/UNICEFJordan_EarlyMarriageStudy2014-E_COPY.pdf.

Study of the availability of and demand for key sexual and reproductive health services for girls

The sheer number of service providers in humanitarian settings and rapidly changing demands for sexual and reproductive health services often leads to a mismatch between what is needed and what is provided. Displaced populations may have additional health service needs that are not being met, while the many service providers may be poorly coordinated. Studies based on solid data on the prevalence of child marriage are needed. A similarly well documented needs assessment, especially of the most vulnerable population groups such as displaced girls, is also required. Only then can targeted sexual and reproductive health care reflecting the particular circumstances pertaining to child marriage be provided.

Awareness-raising on the availability of sexual and reproductive health services

Even when the necessary health services do exist in humanitarian settings, young girls may lack the knowledge, resources or decision-making power to seek them out. It is therefore critical to ensure that they are aware of, have access to and use such services. Culturally sensitive outreach campaigns targeting girls, their families and male relatives should be run with the involvement of local organizations that have an intimate knowledge of and connection to the displaced communities. Such campaigns must also target men and boys as a means of bridging the gap between what adolescent girls need and their ability to seek out and access services. Making displaced communities more aware of the sexual and reproductive health consequences of child marriage may help to discourage the practice.

Further reading

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UN Women (2013). *Gender-Based Violence and Child Protection among Syrian Refugees in Jordan, with a Focus on Early Marriage*. July. Amman. Available from www.unwomen.org/~media/Headquarters/Attachments/Sections/Library/Publications/2013/7/Report-web%20pdf.

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