

ORIGINAL RESEARCH

The Effect of Early Marriage Timing on Women's and Children's Health in Sub-Saharan Africa and Southwest Asia

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Abstract

BACKGROUND Age of marriage is a barrier to mother's health care around pregnancy and children health outcomes.

OBJECTIVE We provide evidence on the health benefits of postponing early marriage among young wives (from age 10-14 to age 15-17) on women's health care and children's health for sub-Saharan Africa (SSA) and Southwest Asia (SWA).

METHODS We use data for 39 countries from the Demographic and Health Surveys to estimate the effects of postponing early marriage for women's health care and children's health outcomes and immunization using matching techniques. We also assess whether women's health empowerment and health constraints are additional barriers.

FINDINGS We found that in SSA, delaying the age of marriage from age 10-14 to age 15-17 and from age 15-17 to age 18 or older leads to an increase in maternal neotetanus vaccinations of 2.4% and 3.2%, respectively; gains in the likelihood of postnatal checks are larger for delayed marriage among the youngest wives (aged 10-14). In SWA, the number of antenatal visits increases by 34% and the likelihood of having a skilled birth attendant goes up to 4.1% if young wives postpone marriage. In SSA, the probability of children receiving basic vaccinations is twice as large and their neonatal mortality reduction is nearly double if their mothers married between ages 15-17 instead of at ages 10-14. The extent of these benefits is also shaped by supply constraints and cultural factors. For instance, we found that weak bargaining power on health decisions for young wives leads to 11% fewer antenatal visits (SWA) and 13% less chance of attending postnatal checks (SSA).

CONCLUSIONS Delaying age of marriage among young wives can lead to considerable gains in health care utilization and children health in SSA and SWA if supported by policies that lessen supply constraints and raise women's health empowerment.

KEY WORDS child mortality, health empowerment, prenatal care, southwest Asia, sub-Saharan Africa, timing of early marriage.

INTRODUCTION

Early marriage is not only a serious human rights violation driven by sociocultural factors and poverty but it is also a significant barrier to women and children's health because girls have not yet attained full

maturity and the capacity to act autonomously.^{1,2} The associated risks to well-being and health as a result of early marriage are widely acknowledged. Young girls who are married early begin childbearing soon after marriage, leading to increased health risks from complications in pregnancy, low infant birth weight, and

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often death during delivery. Other risks for young married girls are due to their short birth spacing³ and greater chances of contracting HIV.⁴ Inadequate access and underuse of health care services are additional reasons for poor health outcomes of young married girls as their decisions to seek care are set back because of their low household wealth and low education.^{5,6} Hence, policies that advocate and support later marriage for young girls have significant health benefits both for young married girls and their children.

Specific country studies indicate the lack of access to basic health coverage among early-married mothers (EMMs). For instance, Nasrullah et al⁷ find that 73% of EMMs in Pakistan have a decreased likelihood of having any prenatal care and increased chances of delivery by unskilled birth attendants—twice the amount compared with non-EMMs. Similarly, child marriage in Niger is negatively associated with the frequency of antenatal visits and having a skilled birth attendant at delivery.⁸ Moreover, the risk of malnutrition is greater in young children born to girls who married young.⁹

Although many countries have established laws prohibiting early marriage, often these laws are not based on revisions of minimum age of marriage, making them difficult to enforce.¹⁰ For the group of girls who ended up marrying very young beyond their will, however, a forward shift of their age of marriage by a few years can be an intermediate step to lessen the negative effects on health through their increasing intrahousehold bargaining power and autonomy. Improved agency for young girls could lead to a larger access and control over resources, more mobility outside the community, and increased ability to negotiate health systems more efficiently.¹¹ In addition, a few more years outside of marriage can increase the likelihood of these young girls to stay in school^{12,13} and, relatedly, increase their degree of health literacy.¹⁴

The aim of the paper is 2-fold. The first objective is to offer new evidence on the impact of the timing of early marriage among the youngest wives on a wide range of women's and children's health exposure outcomes for 39 countries in sub-Saharan Africa (SSA) and Southwest Asia (SWA). In particular, we investigate the benefits of delaying early marriage among the youngest EMMs (ie, those marrying at ages 15-17 instead of at ages 10-14) on health service use (antenatal care, skilled birth attendance, vaccinations, and postnatal checks) as well as in terms of their children's immunization uptake, mortality (neonatal and infant), and nutrition (stunting).

The second objective is to assess whether young wives' health empowerment, access to health ser-

vices, and supply constraints are additional barriers for both their health and the health of their children (after isolating contextual factors driving both marriage decision and health outcomes). To evaluate this, we generated matched subsamples for the EMM and non-EMM groups with similar characteristics (eg, family composition, education, family wealth, and other socioeconomic community variables) by propensity score matching.

We focused on SSA and SWA because they account for 55% of the world's child marriage prevalence and the 10 countries with the highest prevalence are from these 2 regions. Also, SSA and SWA are the furthest away from health equality. For instance, Organization for Economic Cooperation and Development countries have antenatal health coverage of nearly 90%, whereas in SSA and SWA this is less than 50%.¹⁵ In 2013, SSA contributed roughly half (3.1 million) of the under-5 deaths worldwide and Southern Asia almost a third (2.02 million).¹⁶

METHODS

Data. The analysis is based on 39 Demographic and Health Surveys (DHS) from the SSA and SWA regions.¹⁷ We use the more recent DHS for each country (for details of the countries and survey years, see Online [Supplementary Appendix, Supplementary Table 1](#) in the online version at [doi:10.1016/j.aogh.2017.10.005](https://doi.org/10.1016/j.aogh.2017.10.005)). DHS surveys are nationally representative household samples for lower- and middle-income countries, and they are an important source for population health studies^{18,19} because of their comparability, quality, and coverage. The primary working sample populations were women aged 20-29 years who had their last baby born alive in the 5 years preceding the survey. For this group, we compared women (and their children) who first married or entered into union between ages 11 and 17 with those who married at age 18 or older. The lower bound of age 20 was used to avoid both measurement error in age of marriage and girls younger than age 18 where there is uncertainty on whether they will eventually marry, and the upper bound of 29 years of age was chosen to account for decreasing fertility patterns. We created separate samples for maternal and child health variables. As shown in [Table 1](#), sample sizes varied from 209,617 (SSA) and 104,713 (SWA) for the outcome "skilled birth attendant present at birth," to 37,983 (SSA) and 21,544 (SWA) for the outcome "stunting."

Outcomes. The first set of indicators includes outcomes for women's health-seeking behavior around

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