Socio-economic Trends and the Rising Age of Marriage among Women in the Developing World: Implications for Policy and Advocacy

by

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Abstract

In the last decades, population surveys have demonstrated a consistent rise in the average age at first marriage among women across the developing world. This demographic shift has coincided with a global campaign against child marriage which often links marriage practices with rates of maternal death and disability in low-income countries. However, in examining socio-demographic indicators of both shifting marriage ages and maternal health more closely, it becomes clear that it is largely considerations of livelihood and economic well-being among communities that determine marriage age. Moreover, maternal health risks are experienced more generally among all women who live in poverty and have poor access to health infrastructures, regardless of their age at marriage. This paper will both explore these demographic and socio-economic trends more closely through an analysis of primary and secondary data sources, in addition to arguing for an expansion in campaigns which develop economic opportunities for young women.

Biography

Julianne Weis, a Senior Research Associate at Anthrologica, is also currently completing her PhD in the History of Medicine at the University of Oxford. While her dissertation focuses on the historic development of public health networks in Ethiopia, Julianne continues to work in the fields of contemporary policy analysis and program development in issues of women's health and gender across the developing world.

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Socio-economic Trends and the Rising Age of Marriage among Women in the Developing World: Implications for Policy and Advocacy

For the majority of women in low-income countries, the age of first marriage is rising. In Ethiopia, a country long blighted for its tendency towards early marriage, the age at entry to marriage for women in urban areas has jumped nearly two years since 2000, from 17 to 19, with even rural areas experiencing a slight increase from 16.2 to 16.6 in the last decade (Ethiopia Central Statistical Authority and ORC Macro 2001; 2012). Similar shifts towards delayed marriage have occurred across nations in Africa and Asia, and concurrent to this demographic trend, global advocacy campaigns targeting child marriage and its eradication have been considerably expanded. With funding from the UN and most major donor bodies, early marriage campaigns have focused on promoting a rights-based discourse that strives to "empower" girls, keep them in school, and avoid the potential health risks in entering reproduction too early, including maternal morbidities like obstetric fistula (Gaym 2008; Girls Not Brides 2013; UNFPA 2013).

Despite the increased international funding and attention towards early marriage's eradication—in 2011, a UK-based consultancy firm was given over £9 million to address child marriage in Ethiopia by "improv[ing] adolescent girls' agency"—advocacy programs often operate under Eurocentric assumptions of marriage and its determinants in low-income country contexts (Gilligan 2012). Policies do not carefully examine why the level of marriage age is in fact rising, and how programming could be more strategic in encouraging a continuation of this global demographic trend. Having created an imagined rights-based scenario where marriage is delayed solely through the empowerment of the girl-child, policies largely ignore not only the local realities of what marriage entails, but also the very pragmatic concerns which drive communities to create marital unions in relation to considerations of livelihood.

In this paper, I will present the current demographic information on the rising age of marriage in low-income countries, and review the literature to expand the understanding of marriage and its meaning in communities targeted by international advocacy campaigns. I intend to contrast those policies which describe early marriage as an arbitrary and dangerous decision enacted by a girl or her family with statistical and anthropological evidence that demonstrates how in most low-income country contexts, marriage is viewed largely as a pragmatic, economic transaction involving the wider community. Indeed, in most instances, families are delaying marriage for their girls because it is more economically viable and profitable to do so. And the age of marriage in low-income countries will continue to rise only if improvements in the livelihoods of families and communities are developed and expanded. This paper will also explore the literature on the connection between early marriage and reproductive health risks for adolescent girls. My presentation of new, primary data helps to corroborate other studies indicating that dangers of maternal health, such as obstetric fistula, are perpetuated primarily because women continue to live in situations of poverty where health infrastructures are poorly developed. I argue that both adolescent and adult women without access to quality obstetric care are at risk of succumbing to a number of maternal morbidities or death, and the two issues of entry into marriage and maternal health should not necessarily be conflated. In this paper, I assert that the root of both problems is poverty, and that moving forward with programs that are more strategic in

combating the insecurities of poverty, including unsustainable livelihoods, will be more effective in both encouraging a rise in marriage age, and also mitigating reproductive health risks to women and girls worldwide.

ORGANIZATION OF PAPER AND METHODS

The paper begins with a brief overview of the statistical trends in marriage, demonstrating how the age at entry into marriage has shifted over the last twenty years. From there, I explore in more depth the literature on socio-economic determinants of marriage age across low-income countries. I describe the livelihood restrictions within communities that lead to instances of both early and delayed marriage practices. I then describe the variants in social definitions of marriage and the actual consequences for young girls entering early marriages in low-income countries, especially as regards reproductive health. Within this section, I use obstetric fistula as a case study to evaluate the relevance of policy discourses which publicize the heightened health risks to young girls entering marriage.[1] Lastly, I examine the current trends in global advocacy campaigns against early marriage, pinpointing the disjunctures between the rights-based discourses of international actors and the socio-economic determinants and definitions of marriage among community members. In the conclusion of the paper, I provide recommendations on how to improve advocacy programming targeted at eradicating the practice of early marriage in low-income countries. In articulating the driving forces behind marriage trends and practices, I hope to demonstrate the limitations of current advocacy programs, and present alternatives for future policies to improve their efficacy and relevance to women in low-income settings.

The source material for this paper comes first from an in-depth review of both advocacy and academic literature which examines social trends in marriage in the developing world. In addition to this review, I rely principally on a secondary analysis of marriage trends from national Demographic and Health Surveys (DHS). I have selected the five case study countries of Ethiopia, Kenya, Uganda, Burkina Faso, and Ghana to illustrate in more detail the rising age of marriage, while also including more global analyses of DHS data up to the year 2000 produced by Barbara Mensch and colleagues (2005; 2006). Within my DHS analysis, I focus on the responses of female participants as, throughout the world, women traditionally enter marriage at an earlier age than men. Women are also prone to drastic changes in their roles and expectations at entry to marriage, including expectations for reproduction and domestic management that restrict their access to educational and career advancement. I also focus on sub-Saharan Africa because again, traditionally it is the region with the lowest average age at marriage for women (Saardchom and Lemaire 2005). The principal data points used from the DHS are median age at entry into first marriage, percentage of respondents married by age 15, and percentage of women under the age of 19 who have never been married. I disaggregate responses based on area of residence (urban v. rural), and also level of educational attainment (no education, some education, primary education, secondary education).

In addition to this secondary analysis I use primary data that I collected while working within the Hôpital National de Niamey, Niger in 2008. Ethical approval for the data collection was obtained both from Oxford University and the Medical Director of the Hôpital National before undertaking the work. After necessary approvals were obtained, I analyzed the medical files of approximately 400 fistula patients from the previous five years of hospital operation towards the

completion of a larger study on the socio-demographic background of obstetric fistula sufferers. These files included all relevant demographic and medical information for each patient, including marital status, age of entry to marriage, parity, and age at onset of fistula. In addition to this quantitative analysis, I collected detailed life histories of ten patients at the hospital to explore possible factors that may have contributed to their development of fistula, including marriage practices. The ten patients were chosen because they were currently living at the hospital facility in recovery from fistula surgery. They all also spoke either Hausa or Zarma, the two languages for which I had translators available. This is, therefore, a limited sample, given my restrictions of fieldwork site and translating capacity. Notwithstanding these limitations, collecting narratives of fistula patients enabled me to contextualize the quantitative data within the medical records. The context of how the women utilized medical services was critical to understanding the correlation between the poorly developed health infrastructure of Niger and the development of the birth injury, adding an additional dimension to fistula's presence in Niger beyond cultural practices or demographic indicators. Both the quantitative and qualitative elements of my data collection in Niger are used briefly in this paper.

There are certain limitations to both sets of data presented: in regards the secondary DHS data, even within the same country, collection protocols of the national DHS can change over time. This makes it difficult to analyze trends in marriage longitudinally, so whenever possible, I choose to work with those data points which were repeated in at least three sequential DHS reports, including the median age at first marriage and percentage of women aged 15-19 who had never been married. Enumerating the age at entry into marriage is also a problematic exercise, particularly in West African countries where multiple forms of marriage exist, including temporary unions formed at early age. I will discuss these limitations in the data further on when explaining more specific cultural trends which determine entry to marriage. At the moment, because DHS respondents were responsible for stating their own age at entry to marriage to data collectors, I operate under the assumption that if the woman considers herself to have been officially married at a particular age, then that is the most reliable estimate of her age at first marriage. Still, ages are often approximations in communities where vital registries do not exist.

For my own data collected in Niger, I was limited in scale to only 400 obstetric fistula patients, a relatively small number from which to make any generalized conclusions about the nature of the birth injury worldwide. Nonetheless, the patients represented in the data are considered to be roughly representative of fistula sufferers in the country of Niger, as at the time of data collection, the Hôpital National de Niamey remained the largest fistula repair unit in the country, where women arrived for treatment from every region, and all patients had already given birth sometime over the past decade, either at home or in a rudimentary rural clinic. Therefore, it is unlikely that the data were substantially biased with respect to the geographic distribution within the country.

At the same time, as I collected data only on those patients presented with obstetric fistula, this dataset does not help describe other common maternal morbidities, e.g. eclampsia, nor does it account for the women who died from birth complications. To supplement this limitation, I include the national maternal mortality ratio for Niger in a later section of the paper, and use this demographic work on fistula patients as an individual case study of the potential dangers to women's reproductive health brought on by early marriage. The intention of this paper is to juxtapose empirical evidence of marriage practices in low-income countries with global policies

aimed at early marriage's eradication. While the secondary DHS data are useful in explaining the demographic trends towards a rising marriage age, the primary fistula data helps contextualize policy debates on the potential dangers of early marriage within targeted communities. It does not on its own refute any claims about the overall risks to adolescent women in entering marriage, but in the context of other studies and data presented, it does help expand the understanding of the nature of maternal morbidities in low-income countries and the continued effects of poverty on both marriage patterns and health outcomes for women.

ANALYSIS OF DEMOGRAPHIC HEALTH SURVEY DATA ON AGE OF MARRIAGE

Figures 1-4 demonstrate the rising median age at first marriage in four African countries: Ethiopia, Kenya, Uganda, and Ghana, disaggregated between rural and urban populations. In Ethiopia, the median age at first marriage for rural women rose from 16.2 in 2000 to 16.6 in 2011, while for urban women, numbers went from 17.8 to 19.3. All countries see a similar national trend towards a rising age of marriage, with a significantly higher increase in urban areas compared to rural: for Ugandan women in rural areas, the numbers are similar to Ethiopia, with 17.2 the median age at marriage in 1989, a number which has risen to only 17.6 by 2006. For women in urban areas, the number has risen significantly from 16.7 to 19.4 during the same time period.

What is perhaps more illuminating than these statistics, however, are the results from the DHS which indicate the percentage of women aged 15-19 who were not yet married (Figures 5-12). The figures on the median age at first marriage include women of all ages who have not felt the impact of recent socio-economic changes in altering age at marriage, whereas in concentrating on a younger age demographic, rapid changes in recent history become evident.[2] Figure 5 demonstrates that while 14.4% of women aged 15-19 were first married by age 15 in 2000, this percentage had dropped to 8% by 2011. In addition, Figure 6 shows that by 2011, 77% of Ethiopian women had never been married by the age 19. In Burkina Faso (Figures 7-8), the percentage of respondents who were first married at 15 dropped from 17 in 1993 to a mere 4.2% in 2003. Uganda's figures (Figures 9-10) fell from 11.6% of women first married at or by age 15 in 1989, to just 3% in 2006. And lastly, in Figures 11-12, respondents in Ghana aged 15-19 who had never been married climbed from 75.6% in 1988 to 90.6% in 2008.

These are incredibly significant figures, demonstrating the steep drop-off in early marriage among young women within the last decades. While I use the statistics of five African nations as illustrative models, this trend has been seen across the board in all low-income countries. Globally, there has been an annual reduction of 0.48 years in the median age at first marriage among women in low-income countries (Mensch, Singh, and Casterline 2005, 39). While 26.6% of women aged 15-19 had been married in 1980, this figure had dropped to 20.8% by 2000 (Ibid). Generationally, while 53% of women aged 40-44 in East and Southern Africa had been married by age 18, this figure dropped to 37% for women aged 20-24. In the same region in the 1970s and 80s, 38% of girls aged 15-19 were married, as compared to 25% in 2000 (Mensch, Grant, and Blanc 2006).[3]

SOCIO-ECONOMIC DETERMINANTS OF ENTRY INTO MARRIAGE

Alerted by this worldwide trend towards an increasing marriage age, in 2008, Narumon Saardchom and Jean Lemaire tested five hypotheses to determine why women in particular were marrying later. In a cross-country regression analysis of 156 nations, the authors plotted variables of economic modernization, supply and demand, socio-cultural and religious influences, the quality of healthcare, and longevity risk sharing. The authors concluded that marriage age rose most prominently in the presence of economic diversification, stating:

> Among the most important forces driving economic development are the expansion of educational opportunities, changes in workforce composition, and urbanization. In the process of modernization, individuals with higher education and modern occupational roles request more independence, time for education and career building. Consequently, we expect them to marry later in life (Saardchom and Lemaire 2005, 81).

The DHS figures cited above corroborate this conclusion, with urban environments providing easier access to educational and economic opportunities, allowing families to delay their daughters' entry into marriage. In addition, a study from South India in 1983 showed that a rise in the age of marriage in urban areas was in part due to families wanting their daughters to "marry up:" parents desired better educated men as son-in-laws, especially those who had more income and could add greater capital to the larger kin network. At the same time, there was a drop in the rate of marriages among relatives with the increased social network provided by urbanization (Caldwell, Reddy, and Caldwell 1983).

The entry into marriage is therefore highly influenced by social factors within the community, rather than solely by the individual determination of a young girl or her family. When there are socio-economic opportunities presented to a girl which would provide both her and her community a larger benefit than marriage, betrothal is delayed. The importance of economic considerations in determining marriage age cannot be overemphasized. Indeed, Fafchamps and Quisumbing's 2005 study from Ethiopia argues that marriage should be seen primarily as an economic rather than cultural institution. The authors argue that especially in resource-scarce environments, marriage is a critical means for communities to conduct intergenerational transfers and reallocate resources within the family. Seen in this light, with the continuing economic diversification of developing nations, children are now privileged to capital previously available only in kinship networks, so delaying marriage becomes a pragmatic decision for a family to achieve new sources of income. Children are privy to more assets than their parents as new generations achieve educational and employment opportunities.

In rural areas of Ethiopia, where economic diversification has had much less impact, marriage takes on a particular importance because of its ability to increase a household's production capacity, and is a clear means of increasing wealth. As Fafchamps and Quisumbing argue, in this agrarian cycle, the accumulation of assets takes time, particularly for the poor, thus "assets brought to marriage play a paramount role in shaping the lifetime prosperity of newly formed households: well married daughters can expect a life of relative comfort while poorly married daughters may spend most of their life in utter poverty" (Fafchamps and Quisumbing 2005, 347). In rural Ethiopia, grooms typically bring ten times more assets to the marriage than brides, including land and livestock, and it is rarely necessary for men to be strategic in their choice of

partner because "the outcome of the marriage market is not an important determinant of their future welfare" (355). The authors demonstrate the ways in which agrarian assets privilege male ownership and accumulation of capital, so marriage becomes a tool for parents of daughters to benefit economically. This leads many families to marry girls as soon as possible in order to improve their often meager incomes. This study from Ethiopia demonstrates how in many cases, this economic boon and increase to the household is not one of mere convenience, but of absolute necessity for the continuation of livelihood, thus a girl's age at marriage can in many ways be pinned to the state of need of her larger kinship network. Such need can be at the whim of a number of outside factors, including political instability, agricultural success or failure, and economic opportunities existent outside the household.

THE MEANING AND CONSEQUENCES OF MARRIAGE AGE

The studies above help explain how the age at which a woman enters marriage is not merely a matter of individual or even family choice, but is driven by larger socio-economic factors which involve a deliberate weighing of options available for improving income and livelihood. As a contractual relationship, the very meaning of marriage, especially first marriages for girls, is therefore complex. Anthropologists have argued for decades that marriage in most African contexts is more of a process than an event, played out in multiple stages of betrothal and divorce (Dodoo 1998; Meekers 1992; Van de Walle 1965). Because of the economic considerations discussed above, early marriages are often entered into temporarily as a way for families to expand economic networks, but are commonly dissolved even before the onset of sexual relations.

In Ethiopia, the rural Amhara tradition contains six types of marriage, with divorce exceptionally common. The first marriage, or *serg*, is often of a mere ceremonial nature to represent the union of family networks, occurs at a young age, and is typically dissolved in favor of *semanya*, civil marriage, or in rare cases, *K'urban*, or religious and indissoluble union. The latter, because of its lack of provision for divorce, is the least common form of union in Ethiopia even today (Pankhurst 1992). In Benin, Laura Bohannan has also identified six forms of marriage, while N'Cho Sombo concluded that due to the complexity of marriage systems in Côte d'Ivoire, "the demographic concept of marriage is not clear-cut, in fact some women have a very 'personal' opinion concerning their marital status" (Bohannan 1949; Sombo 1985, 23).

The processual event of marriage, especially in African contexts, has largely been lost in policy discourses which typically equate the entry into marriage with immediate sexual relations. It is well established that the age at marriage is a proximate determinant of fertility, because there is an undisputed link between marital status and sexual activity. However, the actual effects of marriage on adolescent reproductive health need to be more carefully considered. It is common for international agencies to publicize the health risks of early reproduction in their campaigns to end child marriage. Indeed, Nawal Nour called child marriage a "human rights violation" because of its correlative relationship to increased "sexually transmitted infection, cervical cancer, obstetric fistulas, and maternal mortality" (Nour 2009, 51).

In this section, I examine both the connections between sexual relations and marriage age, and also obstetric fistula and early marriage. In light of the secondary DHS data presented above, I include primary data I collected while working in Niamey, Niger in 2008 to explore further the

significance of policy debates surrounding marriage age as they relate to women's lived experiences.

The analysis of the patient data from the Hôpital National de Niamey in Niger reveals that there is a short, but notable, delay in the onset of reproduction after entry into marriage. For the women admitted to the hospital for fistula repair, the median age at first marriage is 15, but the median age at first birth is 18, indicating that for many women, the first marriage may have been either a temporary union, and/or did not coincide with immediate cohabitation. This is consistent with the processual character of marriages in low-income country contexts. Indeed, in their thorough examination of marriage statistics globally, Mensch and colleagues have argued that "when getting married is viewed as a process, such that the onset of sexual relations, cohabitation and an official ceremony do not necessarily occur simultaneously, the changing interpretation of what the stages of the process mean may determine changes in the reporting of marriage age and entry to sexual activity (Mensch, Grant, and Blanc 2006, 705).

Scholars from India have spoken out against this misinterpretation of local marital customs, criticizing sensationalist discourses on child marriage which continue to view early marriage as universally synonymous with the onset of sexual relations:

> The film crews, journalists, and photographers of glossy magazines who descend on Rajasthan every 'akha teej' bring out the colours of Rajasthan and the misery children experience at being forced to dress up and suffer hours of a bewildering ceremony. What they do not reveal is that the children return to their respective homes until the 'mukava,' 'ana' or 'gohna' ceremony, which takes place years later when the girl goes to her in-laws' home. The so-called marriage ceremony should actually be understood as an engagement (Singh, Dey, and Roy 1994, 1378).

It is worth noting that the delay between entering marriage and sexual relations is by no means universal in countries where girls marry young, and there remain high numbers of girls under the age of 18 who prematurely bear children worldwide. However, it is critical that policies aimed at delaying girls' entry into marriage consider the ways in which marriage and reproduction actually work in targeted communities to ensure campaign messages remain relevant and effective.

Further, the processual nature of marriage evidenced above has important implications for the perceived relationship between reproductive health risks and a woman's age at first marriage. If early marriage was eradicated, would incidences of maternal mortality and morbidity immediately plummet? In the data from obstetric fistula patients of the Niger hospital files, 39% of patients were primiparous at the onset of the fistula, indicating that over 60% of women developed the birth injury with a later baby, at later ages. Hilton and Ward's study of over 2,400 fistula cases in Southeast Nigeria similarly indicate that less than one-third of women developed the fistula in giving birth to their first baby (Hilton and Ward 1998). Both studies demonstrate the prevalence of fistula onset in later life, indicating the importance of additional factors beyond age of marriage in determining a woman's chances of developing the birth injury.

One of the additional factors limiting a woman's reproductive health is cephalo-pelvic disproportion, that is, a disproportionate relationship between a woman's under-developed pelvis

and a baby's head as it descends into the birth canal, often resulting in obstructed labor. Cephalo-pelvic disproportion is found in adolescent girls who are still developing, but is also prevalent in women of all ages who had been subjected to childhood stunting due to severe undernutrition (Neilson et al. 2003; Bhosale, Fonseca, and Nandanwar 2010). In a study of 14,928 women with fistula in Ethiopia, the average height of all patients, with ages ranging from 13 to 70, was nearly 3 centimeters below the female population of Ethiopia in general, speaking to the effects of stunting carried beyond teenage years (Muleta, Rasmussen, and Kiserud 2010).

In addition to the life-long disadvantages of childhood stunting, data from Niger indicate that the paucity of institutional health services for poor women is an additional contributing factor to the development of birth injuries.[4] The life history of one patient from the Niamey hospital helps clarify this connection between weak health infrastructure and maternal morbidity: Fati Moukela comes from a village in the Tillaberi region of Niger which has a basic health clinic that she would frequently attend. At the onset of labor during her second pregnancy at the age of 30, Moukela went immediately to the clinic to deliver the baby under medical supervision. However, the health workers at the clinic were unqualified to deal with Moukela's obstructed delivery and she still developed a fistula. Moukela had seven years of education and is literate. She had taken steps to get the access to healthcare she knew was necessary for a healthy delivery. At the same time, the paucity of Niger's public health system meant no emergency obstetric services were available for her at the time of birth. It was this lack of provision of care which caused the fistula, not Moukela's age, cultural practices, or marital trajectory.

Dr. Catherine Hamlin, the pioneering surgeon renowned for her decades of work treating fistula patients in Ethiopia, has argued plainly that the primary connection between obstetric fistula and early marriage is poverty, asserting that "it is easier to blame cultural issues than to provide far reaching and expensive obstetric care to millions of women worldwide" (Hamlin 2013). The literature presented in this paper helps demonstrate how women who are prone to marry young are typically from families with meager incomes that hope to benefit economically from their daughters' early entry to marriage. In addition, it is widely acknowledged that nearly all women who develop obstetric fistula are from poor backgrounds, meaning not only are they more likely to have been stunted in adulthood from childhood malnutrition, but the majority of them will reside in remote communities where health infrastructures are poorly developed.

Further demographic analysis of low-income countries also helps to demonstrate how early marriage does not automatically result in maternal mortality and injury. Instead, high figures of maternal death are correlated more directly to the poverty of the patient and her access to quality obstetric care. In the Ford Foundation's recent interactive map on early marriage around the globe, statistics on the percentage of the entire female population married by age 18 are juxtaposed with national maternal mortality ratios. With 75% of women married by age 18, the map shows Niger's maternal mortality rate at 820 deaths per 100,000 live births. In neighboring Nigeria, where only 39% of women are married by age 18, the maternal mortality rate is actually higher, at 840/100,000 (Ford Foundation 2011). It is evident that the correlative features of poverty are what connect rates of child marriage with maternal death: the maternal mortality ratios in both Niger and Nigeria are high because both countries have made poor investments in national health structures which target women and provide necessary medical care at the time of delivery. Indeed, crises at birth are not limited to young girls forced into marriage, but can happen to all women of all ages who are living within such resource-scarce environments.

This distinction between the practices of marriage and maternal health determinants is critical given the propensity for international actors to use the dangers of adolescent reproduction as an advocacy tactic in early marriage eradication campaigns. Dr. Amoulkinni Ghaichatou, a Nigerien physician who led the country's UNFPA division on maternal health, stated in an interview the potential danger in focusing maternal health campaigns on the problem of early marriage, arguing, "if you go to the villages and say that early marriage is fistula, the people will not believe you, they will think that you are lying, and they will not listen to you. They will say 'my mother was married at 15, my grandmother at 16, and they had no fistula'" (Ghaichatou 2008). Such campaigns neglect the entrenched social determinants not only of early marriage in such communities, but also of maternal mortality and morbidity. Indeed, campaigns which promote the end of early marriage as a solution to obstetric fistula and other maternal health challenges do not account for the substantial reproductive health risks of all women living in poverty, and the problems of maternal morbidity and mortality will inevitably continue. Further, in focusing advocacy campaigns away from the rooted problems of poverty and poor health infrastructures, these programs are at real risk of alienating the very communities which they are trying to serve.

ADVOCATING CHANGE IN MARRIAGE AGE

Based on the evidence detailed above, both on the increasing age of marriage in low-income countries and also the expanded definition of marriage and its determinants, I now discuss further policy implications for those programs engaged in child marriage advocacy. I first describe a selection of existing programs and their limitations, then conclude with recommendations on how to improve interventions which target the health and well-being of adolescent girls worldwide.

The disjuncture between the lived realities of girls subjected to early marriages and the policy discourse which claims to speak for them is evidence of a dangerous misinterpretation of the systems of poverty that are often at the root of community marital practices. In a study on the determinants of marriage age in Nepal, Dilli Dahal and his colleagues argue that because Euro-American social science traditions have determined the research work on marriage in low-income countries, the focus has been laid "mainly on the individual determinants of marriage processes," and that even if a wider context is sought, this rarely extends beyond the immediate family (Dahal, Fricke, and Thornton 1993, 305). Dahal argues, however, that marriage forms "are evidence of wider strategies of social reproduction," and have implications beyond the choice of the individual or indeed the individual family. Marriage interacts with social concerns stretching beyond the home, and is impacted in ways which cannot necessarily be controlled at the household level.

When examining international campaigns to end child marriage, it is evident that policy makers are aware of the correlative factors of community systems of poverty and a girl's entry to marriage. Considered a direct "barrier to development," international actors have targeted child marriage by promoting educational opportunities for girls, mostly by building school structures and enacting publicity campaigns which encourage families to keep their daughters in school (Jain and Kurz 2007, 7). Unfortunately, these programs poorly address the practical limitations facing families in their decisions to either marry or educate their daughters. One program in Nepal enacted sensitization programs by means of theater, youth clubs, and adult education

courses, all aimed at increasing the age of marriage in both rural and urban areas. At the conclusion of the intervention, it was found that the age of first marriage did in fact rise in urban areas, but experienced no change in the rural, despite the existence of identical advocacy programming (Mathur, Mehta, and Malhotra 2004). The discrepancy between urban and rural areas indicates again that the age at marriage is determined less by the public campaigns of rights activists than by practical considerations of families and communities. While economic diversification in the cities can allow women to delay marriage, advocacy programs have not and cannot invent further economic opportunity that allows for that delay. The example from Nepal demonstrates how despite the strong-handed message of advocacy campaigns, if there is no viable alternative to the induction of an adolescent into marriage, communities will continue to make decisions based on their own priorities for economic survival and mobility.

Realizing that economic constraints guide marital decisions, a separate program in Bangladesh actually provided a monthly stipend to parents of secondary-level female students so long as they would not marry their daughters before the age of 18. Before the onset of the project, 36% of girls aged 11-19 were married, a number which dropped to only 32% three years into the stipend program (Arends-Kuenning and Amin 2000). The poor results in this intervention demonstrate that while the organizers were right to target issues of livelihood within families prone to marry their daughters early, the research revealed that marriage was not merely an immediate concern of financial status, but rather a long-term investment strategy. Despite the immediate increase in family income, over time, families would still benefit more from the marriage of their daughters. If there was no viable economic opportunity for the daughter after she completed school which would continue to improve the status and livelihood of the family, it made little practical sense to delay marriage.

Another program in Ethiopia, Berhane Hewan ("Light for Eve"), worked to reduce child marriage in rural areas through the formation of peer support groups which advocated for girls to stay in school. After two years, among girls aged 10-14, those exposed to the program were more likely to be unmarried and in school than girls of a similar age at a control site. However, among girls aged 15-19, "those in the intervention area had an elevated likelihood of having gotten married by the endline" (Erulkar and Muthengi 2009, 6). Berhane Hewan worked within a poor rural setting, and it is clear that despite the initial boost in confidence among communities to support their girls in going to school and delaying marriage, this rhetoric could only reach so far. By ages 15-19, most girls were still not able to provide their families with a boost in livelihood through attending school comparable to the potential benefit of entry to marriage. The options available for post-schooling employment of rural Ethiopian women are extremely limited and subject to unique conditions including an expansive social network and local political alliances. Without these conditions, graduating from secondary school can provide considerable benefits to girls in terms of increased knowledge and awareness of issues of contraception, safe motherhood, and protection against HIV, but education cannot automatically provide a girl's larger network with requisite material benefit or a desired improvement in the standard of living.

Conventional wisdom, touted in articles like Nimi Briggs' 1993 study "Illiteracy and Maternal Health: Educate or Die," continues on the line of argument that if women are merely educated, they will be protected against conditions leading to maternal mortality. But the limitations of poor nations' healthcare structures can considerably limit the impact of education on a woman's health. Briggs cites another author's conclusions, that "with education, women's health-seeking

behaviors change in a direction which is to their advantage" (Briggs 1993, 1064). The issue remains, however, that without the institutions in place to provide continued education, gainful employment, and advanced health services, women will continue to be subjected to the dangers of poverty, despite increased levels of awareness and knowledge.

There is again a conflation of causation and correlation in the relationship between education, marriage age, and health outcomes: while Figures 13-15 clearly indicate that educated women enter marriage later than their non-educated counterparts, a woman's opportunity for education is more likely determined by the level of poverty within her kin network, and cannot be assumed a universal option for young girls in low-income countries. Barbara Mensch and colleagues published a study in 2005 questioning the prevailing negative discourse surrounding campaigns against child marriage: "Although a focus on marriage before age 18—the internationally established age of adulthood—has gained prominence, research has yet to establish the causal links between early marriage and poor outcomes among women. Is early marriage in and of itself the problem or is it the characteristics of those who marry early?" (Mensch, Singh, and Casterline 2005, 4) A later study by the same author further concluded that early marriage leads to less than 20% of schoolgirl dropouts, while pregnancy accounts for a mere 5%. Instead, Mensch asserts that "school-leaving among girls may be due less to early marriage or pregnancy than to other factors such as poverty, the perceived value of education, distance to school, the safety or quality of the school, or school performance" (Lloyd and Mensch 2008, 2).

Taken in this light, it becomes evident that while advocacy campaigns would assert that to route out poverty and ill-health one must first combat early marriage, it is rather the very constraints of poverty that contribute to early marriage. Mensch's research shows that girls were forced home from school because of constraints within their households as related to domestic duties and lack of income. Girls at home were more likely to be married because of further opportunity for household increase and potential mobility, but the decisions made on where the girl would go in the first place are taken in light of the real options at hand, not imagined notions of empowered agency.

CONCLUSION

The International Centre for Research on Women (ICRW) has evaluated all existing early marriage advocacy programs worldwide, disaggregating the programs based on their principal strategy. The findings indicate that of the 52 programs in operation, only eight provide some form of economic support or incentive to girls and their families to delay marriage. Forty programs focus on "empowering girls" through information, sensitizing communities, and improving access to schooling (Malhotra, Warner, McGonagle and Lee-Rife 2011, 11). This indicates that the vast majority of programs are targeting girls' individual choices without addressing broader socio-economic determinants of marital practices, and focusing primarily on school attendance as a barometer for a girl's likelihood of marrying young. At the same time, authors of the report concluded that the most positive results come from programs which "foster information, skills and networks for girls in combination with community mobilization" (ibid., 2). Thus, not only must programs empower girls with information, they must also provide practical skills and social networks for girls to achieve improved economic status. In addition, they must mobilize the entire community—not just individual families—to support alternative

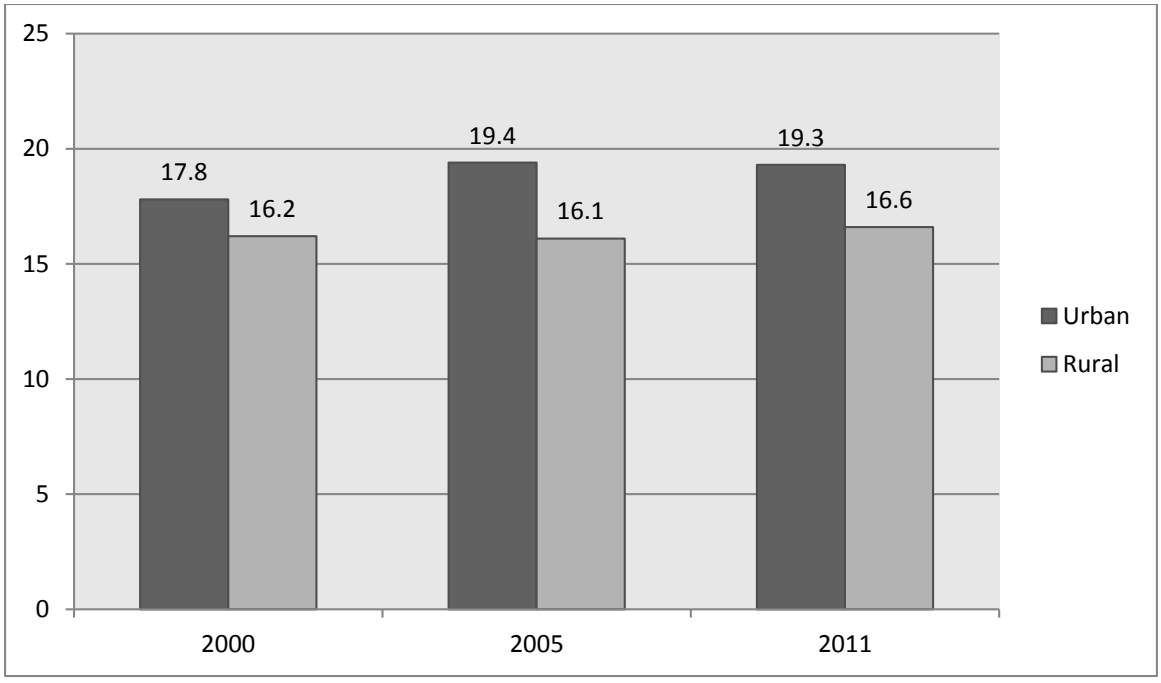
trajectories for girls that could lead to a greater improvement in livelihood than previously possible through mere betrothal.

If programs were more strategic in focusing on community priorities and determinants of marriage, their impact on marital practices would improve considerably. With substantial funding for anti-child marriage campaigns underway, there needs to be a more considerate recognition of the socio-economic determinants of marriage in developing countries, in addition to more sound analysis of more recent statistical evidence which illustrates social shifts in marriage age. While the state of the World's Women Report from 2010 admits that the median age at marriage is rising across the globe, the report uses outdated figures from 2000 to demonstrate what they argue are still dangerous percentages of girls entering marital unions. Data presented in this paper demonstrates quite clearly how significantly the number of girls married before age 18 has decreased since the year 2000, even in nations like Ethiopia, currently synonymous with the practice of child marriage. There is a considerable need for more rigorous data collection and analysis of marriage trends from this pivotal last decade.

Lastly, in those countries where marriage ages are rapidly rising, the conditions of marriage and determinants of age of entry need to be more thoughtfully considered. The plurality of marriage processes, in addition to the correlative rather than causative relationship between marriage and maternal health, need to be reiterated. The demographic variety of obstetric fistula patients is a helpful case study in demonstrating the importance of addressing the problems of women's poverty and poor health infrastructures in developing nations, rather than primarily targeting cultural practices like marriage. It is evident that the rapid expansion of economic opportunities in urban areas of low-income countries has supported a natural increase in marriage age, and such organic trends should be supported and if possible, replicated in directed programming.

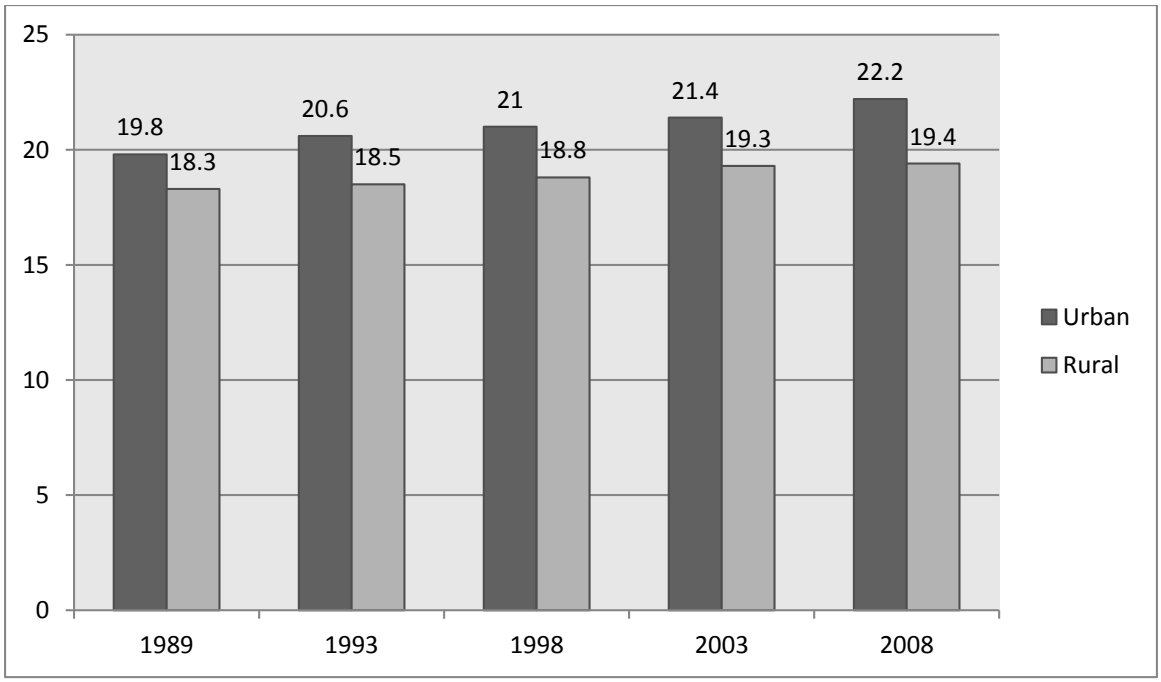
FIGURES

Figure 1: Ethiopia - Median age at first marriage



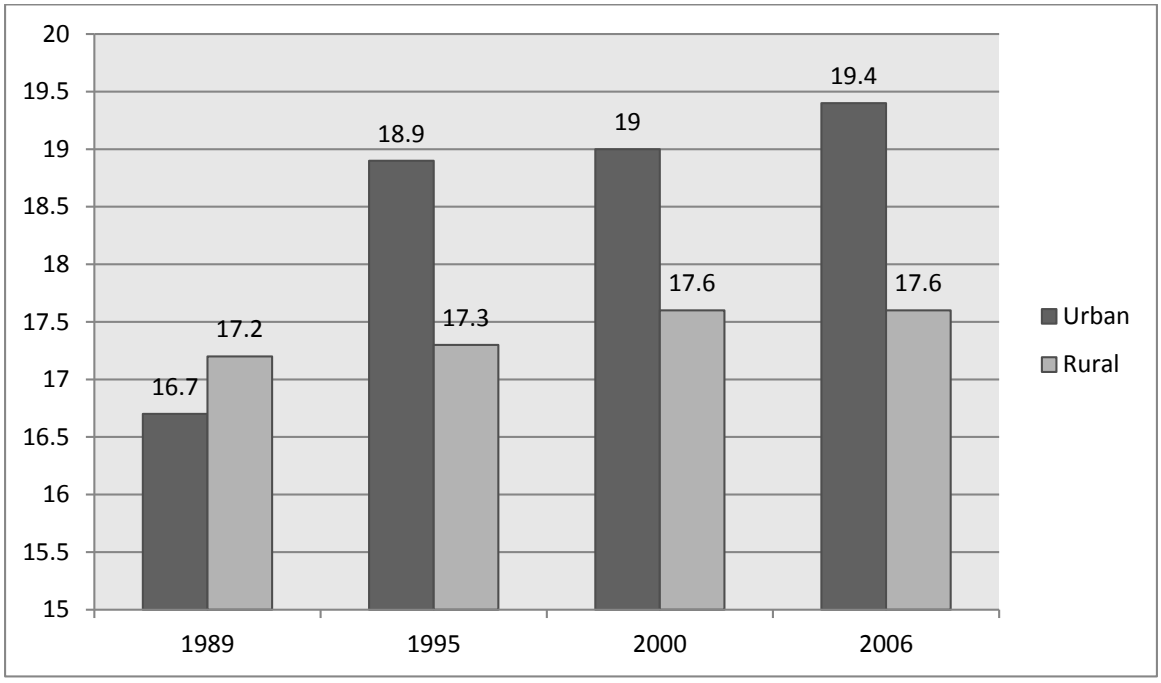
Sources: (Ethiopia Central Statistical Authority and ORC Macro 2001; 2006; 2012)

Figure 2: Kenya - Median age at first marriage



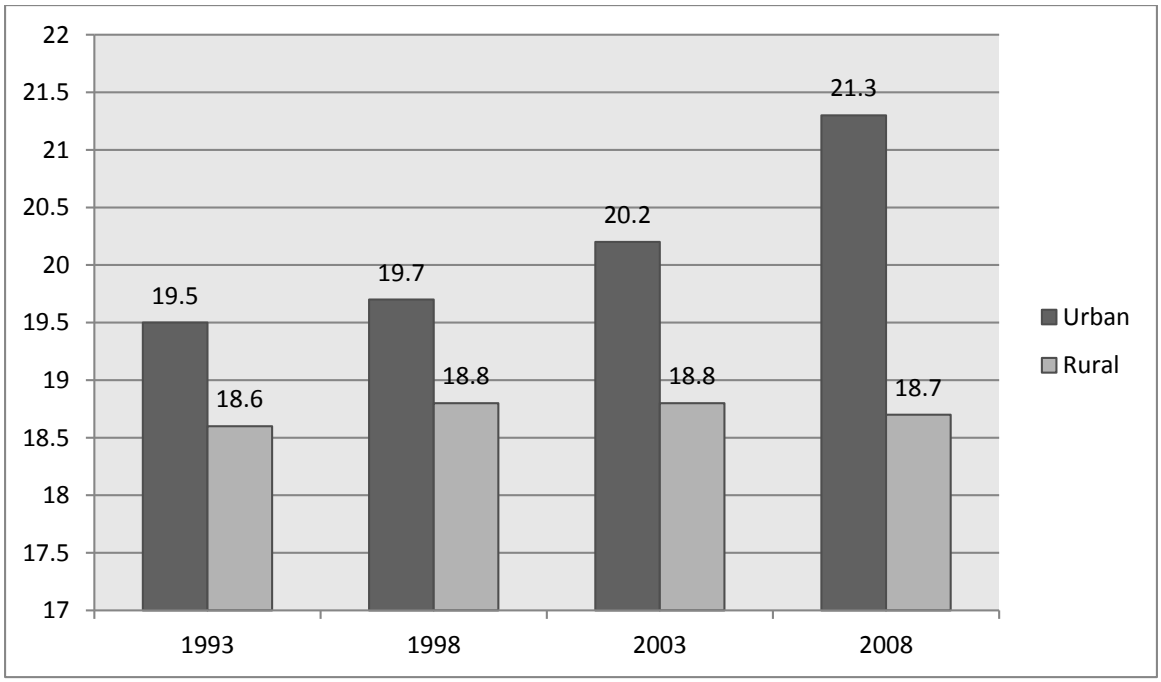
Sources: (Kenya National Council for Population Development and ORC Macro 1990; 1994;1999; 2004; 2009)

Figure 3: Uganda - Median age at first marriage



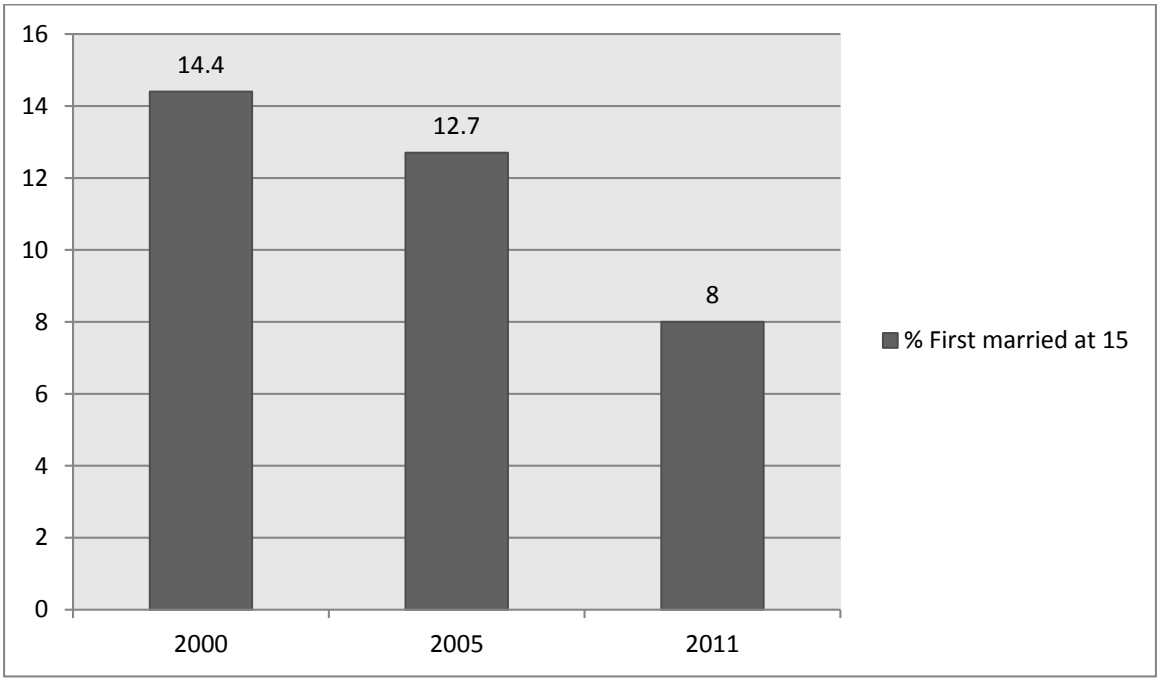
Sources: (Uganda Bureau of Statistics and ORC Macro 1990; 1996; 2001; 2007)

Figure 4: Ghana - Median age at first marriage



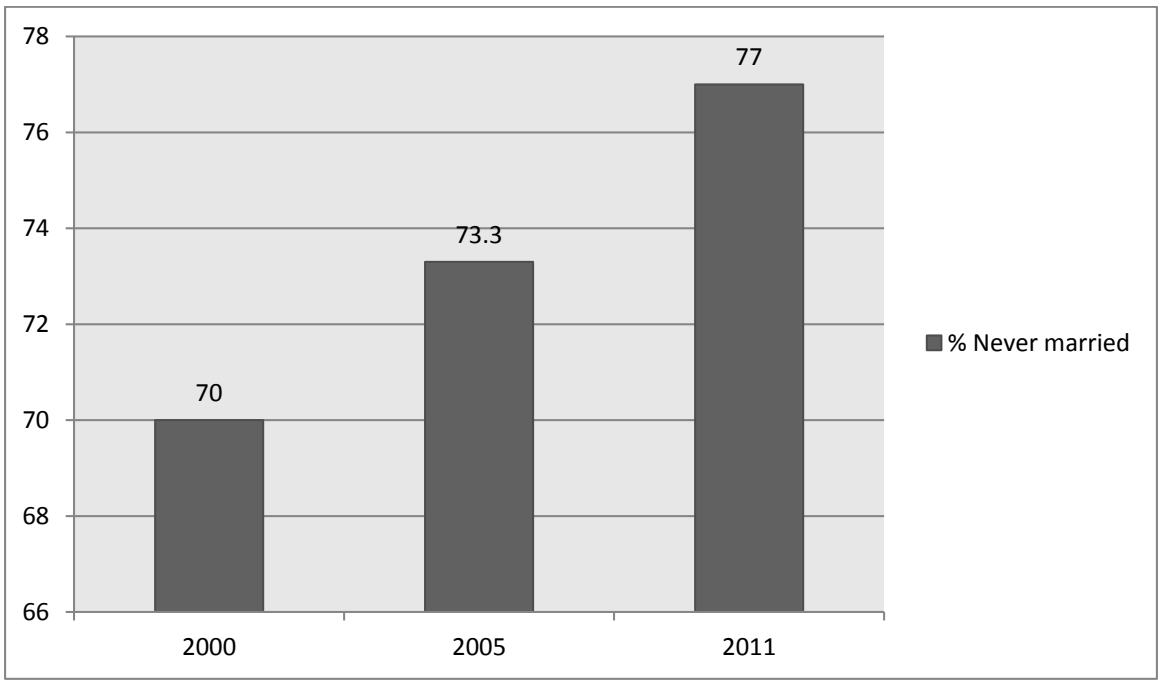
Sources: (Ghana Statistical Service and ORC Macro 1994; 1999; 2004; 2009)

Figure 5: Ethiopia - Respondents aged 15-19



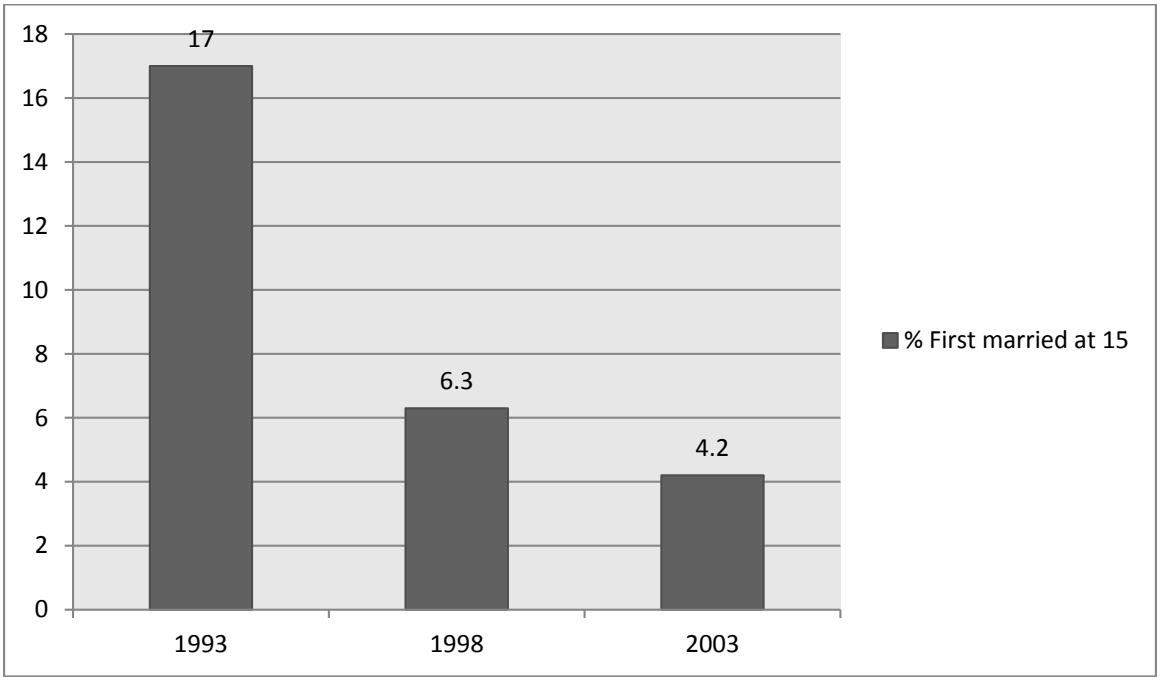
Sources: (Ethiopia Central Statistical Authority and ORC Macro 2001; 2006; 2012)

Figure 6: Ethiopia - Respondents aged 15-19



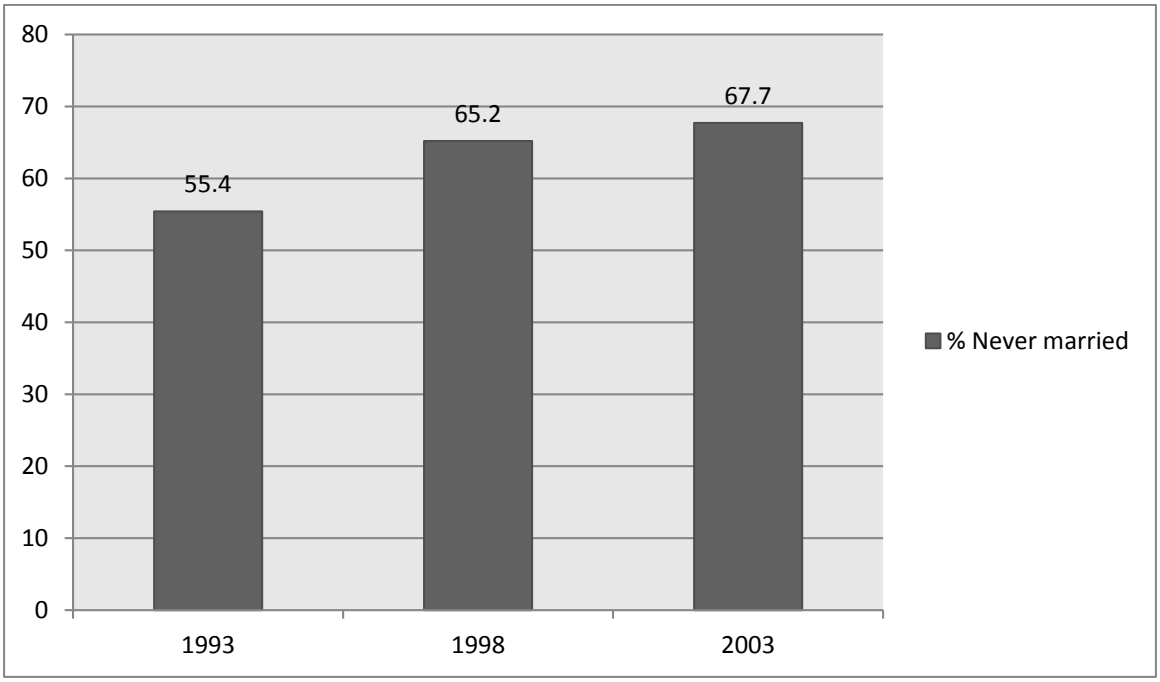
Sources: (Ethiopia Central Statistical Authority and ORC Macro 2001; 2006; 2012)

Figure 7: Burkina Faso - Respondents aged 15-19



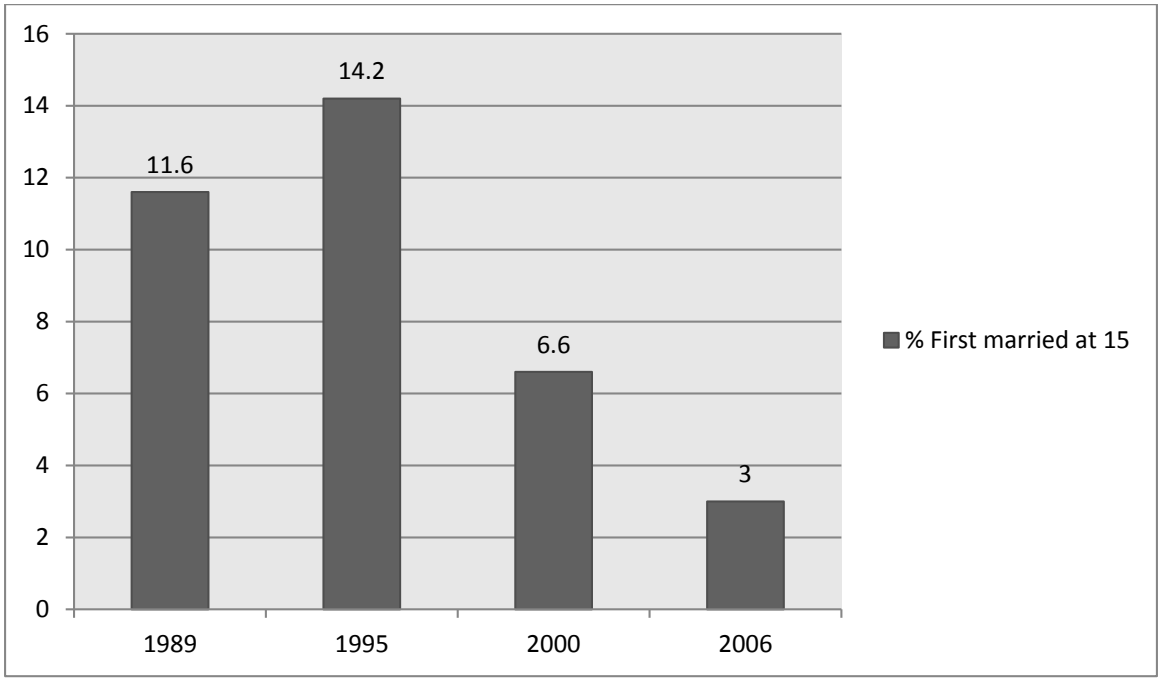
Sources: (National Institute of Statistics and Demography, and ORC Macro 1994; 2000; 2004)

Figure 8: Burkina Faso - Respondents aged 15-19



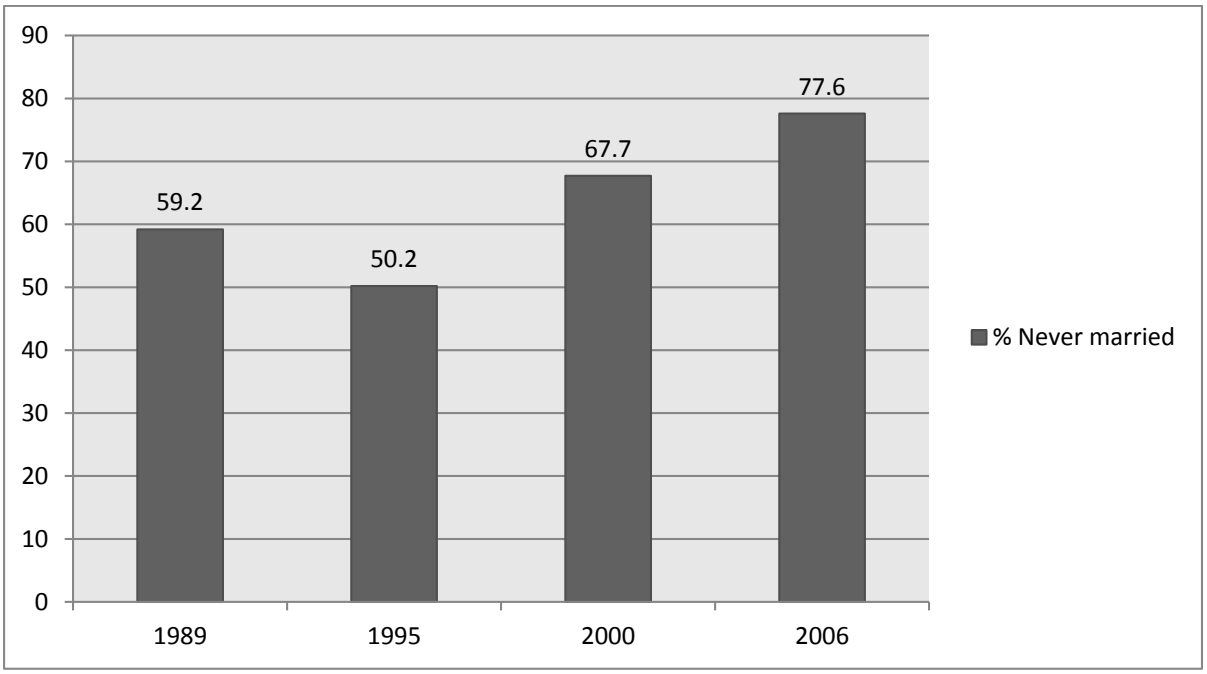
Sources: (National Institute of Statistics and Demography, and ORC Macro 1994; 2000; 2004)

Figure 9: Uganda - Respondents aged 15-19



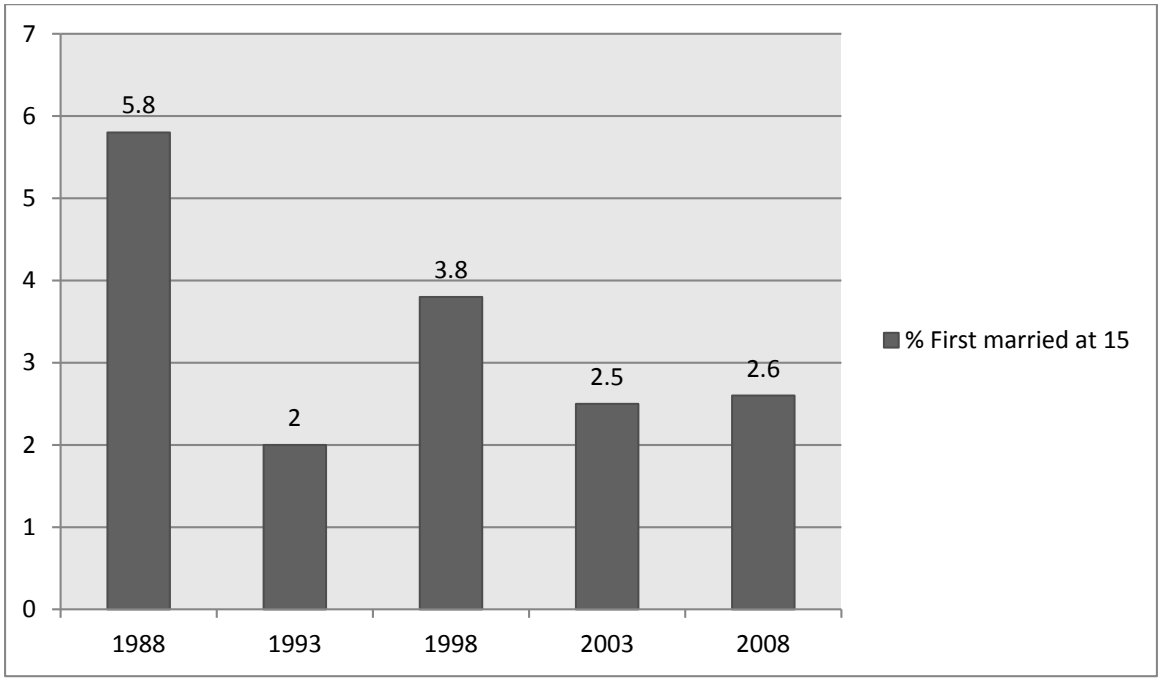
Sources: (Uganda Bureau of Statistics and ORC Macro 1990; 1996; 2001; 2007)

Figure 10: Uganda - Respondents aged 15-19



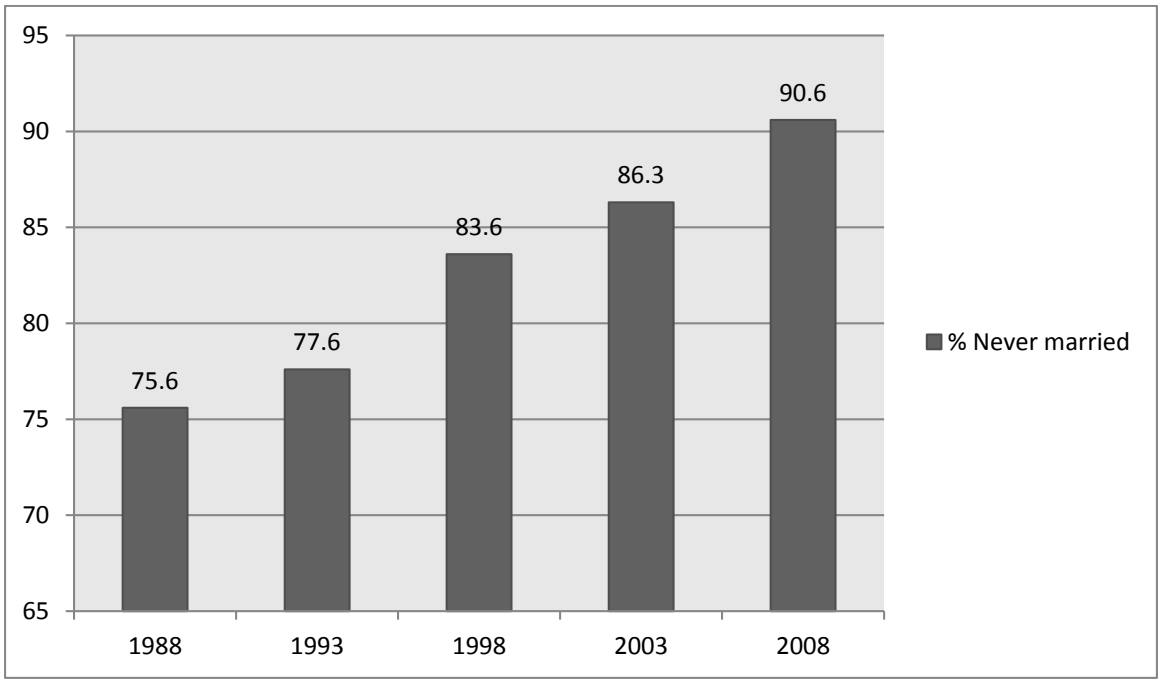
Sources: (Uganda Bureau of Statistics and ORC Macro 1990; 1996; 2001; 2007)

Figure 11: Ghana - Respondents aged 15-19



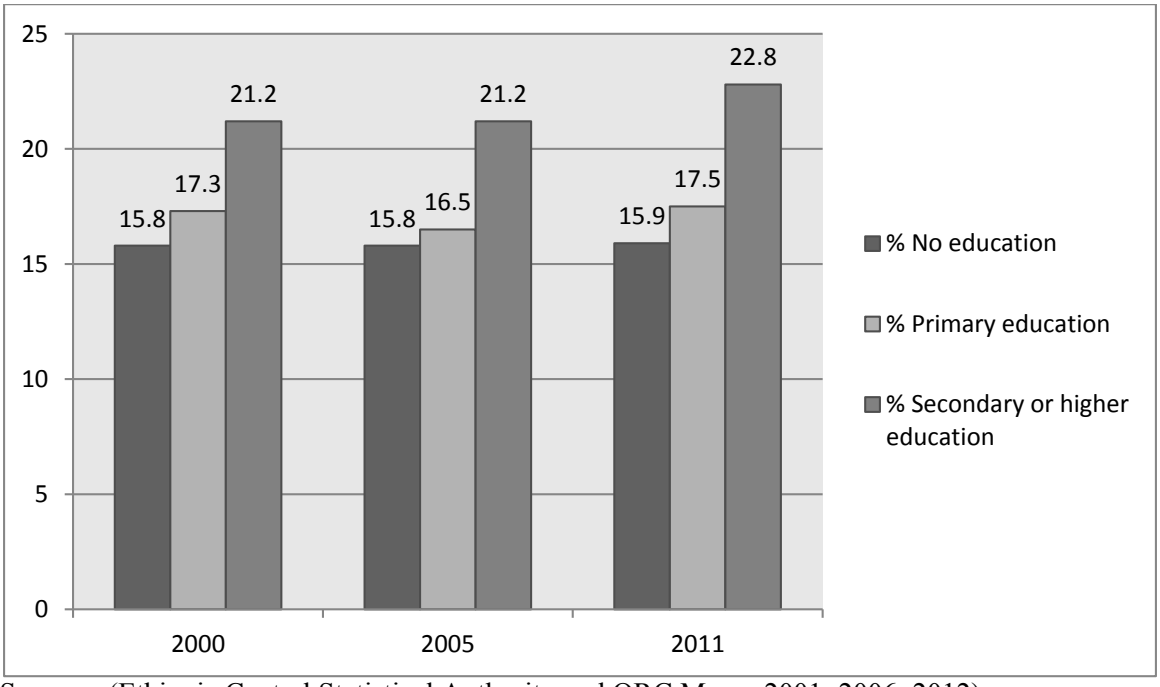
Sources: (Ghana Statistical Service and ORC Macro 1994; 1999; 2004; 2009)

Figure 12: Ghana - Respondents aged 15-19



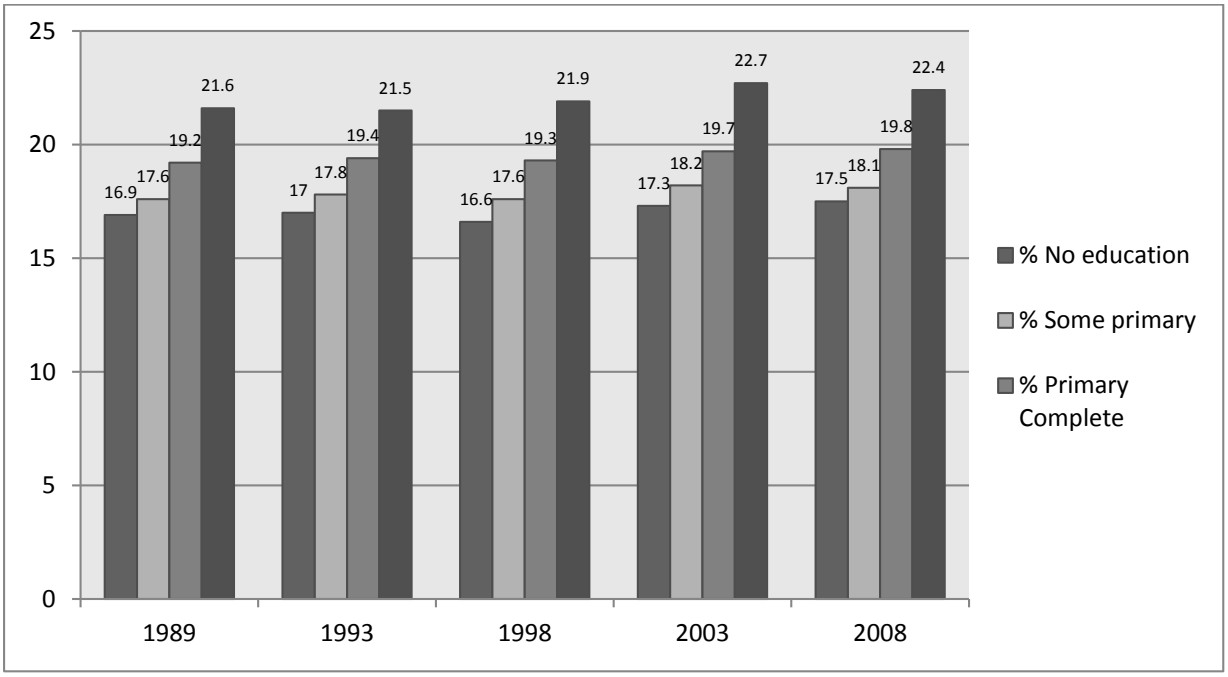
Sources: (Ghana Statistical Service and ORC Macro 1994; 1999; 2004; 2009)

Figure 13: Ethiopia - Median age at first marriage for women aged 25-49 based on education



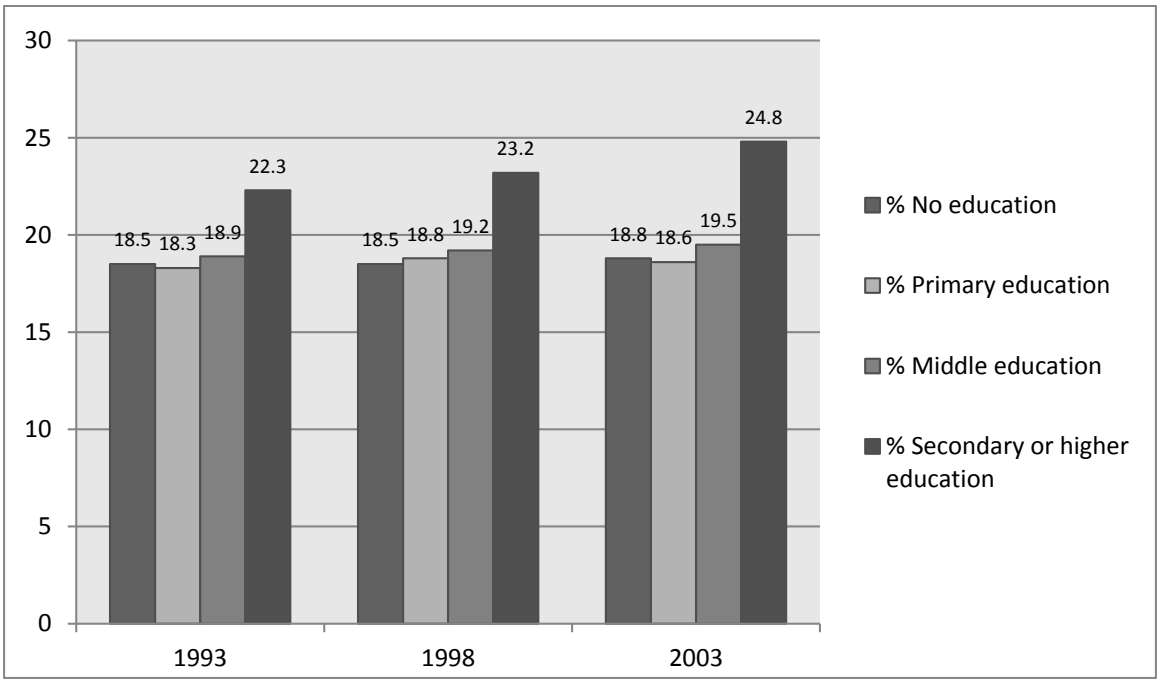
Sources: (Ethiopia Central Statistical Authority and ORC Macro 2001; 2006; 2012)

Figure 14: Kenya - Median age at first marriage for women aged 25-49 based on education



Sources: (Kenya National Council for Population Development and ORC Macro 1990; 1994; 1999; 2004; 2009)

Figure 15: Ghana - Median age at first marriage for women aged 25-49 based on education



Sources: (Ghana Statistical Service and ORC Macro 1994; 1999; 2004; 2009)

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NOTES

[1] Obstetric fistula is a birth injury caused by prolonged and/or obstructed labor. Without access to assisted delivery services, the pressure of the prolonged labor causes a hole to develop between the woman's vagina, bladder and/or rectum, resulting in life-long incontinence unless corrected by surgical intervention.

[2] For similar reasons, other academics have also cautioned against using the median age at marriage to reveal generational and cultural shifts in entry to marriage (Preston, Heuveline, and Guillot 2001, 89).

[3] The global analyses provided by Mensch and colleagues are helpful in elucidating larger cross-national trends in marriage age, but the data used in both studies reached only to the year 2000. The national analyses of marriage in African countries presented in this paper demonstrate clearly that the greatest changes to marriage age have occurred in the last 10-15 years, so further analysis should be completed to update global figures based on the most contemporary trends.

[4] Because obstetric fistula is caused by prolonged and/or obstructed labor, simple surgical and instrumental interventions in the delivery would prevent the labor from becoming prolonged, and relieve an obstructed baby from the birth canal. Such interventions, including vacuum extraction, forcep delivery, and cesearean section, occur routinely throughout the world in maternity wards. If such procedures were made more widely available to women in developing nations, births would not be allowed to continue unassisted, and obstetric fistula could be prevented.

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