

## Consistent Laws and Child Marriage

We have read with great interest the article “Minimum Marriage Age Laws and the Prevalence of Child Marriage and Adolescent Birth: Evidence from Sub-Saharan Africa” [2015, 41(2):58–68, doi: 10.1363/4105815], by Brenda Maswikwa et al. The authors have conducted a rigorous analysis of selected data from a selection of countries and brought forward interesting findings. However, we are very uncomfortable with the authors’ conclusion that the “results support the hypothesis that consistent minimum marriage age laws protect against the exploitation of girls,” as stated in the abstract, and that “We found some suggestion that consistent laws against child marriage are negatively associated with the prevalence of child marriage and adolescent birth,” as stated in the conclusion of the main body of the article. Whereas the authors have been cautious not to use explicit causal language, the formulations noted above clearly suggest to the reader that low child marriage rates result from consistent laws on child marriage. For the small sample of countries analyzed, it may be correct that “consistent laws against child marriage are negatively associated with the prevalence of child marriage and adolescent birth,” but for several reasons we disagree that the results can be said to support the hypothesis.

First, the authors present no time series data that would provide an indication that any causal relationship whatsoever exists. Two countries in their sample, Rwanda and Burundi, distinguish themselves by having far lower child marriage rates than the rest of the sample and, with very few exceptions, the rest of Africa. To draw any conclusion about whether laws contribute to protection against exploitation, the authors would, as a minimum, have needed to look at rates before and after the enactment and implementation of “consistent laws” in these two countries. Second, the authors have not investigated and do not present information on the implementation of the laws that could indicate if and how the laws have made any difference. It is well established that the implementation

of laws related to child marriage in Africa is mostly nonexistent.<sup>1,2</sup> And third, the selection of countries is highly questionable. The sample of only 12 countries is far from being representative of Africa or countries across the world where child marriage is prevalent. For example, the results would have been quite different if Rwanda had been replaced by Kenya, which is acknowledged as having a good legal framework, but still has a much higher child marriage rate (26% married before age 18).

Any association between laws and low child marriage rates at one point in time may very well exist because it is easier to introduce laws against child marriage in countries and cultures where the practice is not common. It is thus possible to reframe the conclusion to be: The results confirm the hypothesis that rare exploitation of girls facilitates the adoption of consistent laws. However, the data do not support such a conclusion any more than the opposite.

Another point should be made about the concept of “consistent laws,” defined by the authors as laws “that set the minimum marriage age at 18 or older for girls; that is, the general minimum marriage age, the minimum age for marriage with parental consent and the age of sexual consent were all at least 18” (page 60). This definition is not in line with what others consider a good legislative framework. The international literature on child marriage-related laws emphasize three major problems. First, many countries use customary or religious laws as justification to allow child marriage before the legal permissible age. The authors also point to this in the last paragraph on page 58. Second, the implementation of laws is very weak and in most cases nonexistent. Prosecutions and sanctions are very rare, and most people have no or little knowledge about the laws. Third, many countries do not have laws that make it obligatory to register births and marriages, and where these laws do exist, they are often not implemented. This makes it difficult to establish the real age of the couple to be mar-

ried. We have no indication that the legal age of sexual consent has any effect on child marriage rates or even on pregnancy rates. Consequently, a more valid and interesting definition of consistent laws could be laws that set the minimum marriage age at 18 years with no exceptions, make it obligatory to register births and marriages, and provide clear sanctions for breaking the law.

Finally, a few words about categorizing countries into those with consistent laws and those without them: Despite a lack of data on one of the three laws (minimum age of marriage with parental consent), Uganda and Rwanda have been categorized as having consistent laws (Table 2, page 60). And in the discussion section, the authors note that almost all countries surveyed (including Uganda) allow marriage at a younger age under exceptions.

We would like to emphasize that we believe that having strong and consistent laws is an important step toward the eradication of child marriages and other harmful practices. They give an important signal and lay the ground for advocacy work and community awareness campaigns. However, to have any effect, laws must be followed up by implementation and be accompanied by community mobilization against the practice. To draw any conclusion about the effect of laws, the key question is whether we have data or information that give reason to believe that they have contributed to low rates. The article presents no such information and does not even discuss the issue.

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## Authors' Response

We thank Joar Svanemyr and Venktraman Chandra-Mouli for their comments regarding our article. They focus on three main issues: causal inference, the selection of countries and the definition of consistent laws. They believe the article asserts a causal relationship, largely because of the following sentence: "Our results support the hypothesis that consistent minimum marriage age laws protect against the exploitation of girls." We see how this sentence may be misleading. It was an oversight on our part, and we sincerely apologize for any implication of a causal relationship. However, we believe our true intent is evident if one considers the article as a whole. We made a concerted effort to avoid causal language throughout the text, to refer to associations rather than effects and to explain that the study is exploratory and descriptive; furthermore, we explicitly point out on page 66 that "The results...do not imply causality, and need to be tested using more rigorous approaches that adjust for longitudinal variation, changing social trends and country-level confounding."

Svanemyr and Chandra-Mouli also take issue with the selection of countries, arguing that the sample of 12 countries is not representative of Sub-Saharan Africa. Sampling, representativeness and generalizability are core concerns for the vast majority of research studies. The only way to answer these questions with absolute certainty is to study entire populations, which is often not feasible—in our case, there are approximately 100 million girls aged 15–24 living in 48 Sub-Saharan African countries. We selected the study countries a priori based on data availability, namely, 2010–2012 Demographic and Health Surveys (DHS). At the time of the study (December 2013), DHS data were available only for the 12 countries studied. We recognize that these 12 countries may be different from the excluded ones, in that they released their DHS surveys earlier than the majority of SSA countries. So, even though our sample size of more than 79,000 women is large and distributed across various regions on the continent, on page 62 we acknowledge that "Because multivariate analyses were not weighted, the results of these analyses are generalizable only to our analytic sample." In addition, our methods are explained in great detail to allow the study to be replicated and to enable readers to decide on the issues of representativeness and generalizability.

It is important to note that Kenya could not have "replaced" Rwanda at the time of the study. Kenya certainly made significant strides in the year following the study by increasing the general minimum age of marriage for girls to 18 years for civil, customary and religious marriages. Prior to this change, the country had an exception to the general marriage age, allowing girls to marry at 16 years with parental consent. According to the definition of consistency used in our research, Kenya would have been classified as having inconsistent laws on child marriage.

According to Svanemyr and Chandra-Mouli, our definition of law consistency "is not in line with what others consider a good legislative framework" and is not valid or interesting because the implementation of laws is very weak and in most cases nonexistent.

Although our conceptual definition of law consistency was developed solely for use within the ecology of this study, it is also in line with global consensus based on international law. For instance, the Committee for the Elimination of Discrimination against Women (CEDAW) has been very explicit about setting the minimum age of marriage at 18 years and not allowing for exceptions based on parental consent.<sup>1</sup>

We agree that implementation of laws is weak across the continent and that implementation and enforcement regulations are important for the laws to work. We also agree that other legal aspects—such as additional exceptions and registration of marriages—may play an important role. We highlighted the importance of all these measures on page 66 of our article. Legal frameworks are the entirety of the constitutional, regulatory, legislative and other mechanisms to protect, monitor, enforce and prosecute violations of child marriage laws. To the best of our knowledge, there are no reliable, complete and consistent data on legal frameworks in Sub-Saharan Africa. Nonetheless, we feel this is a valuable and interesting topic worthy of further study, particularly with respect to any associations with child marriage.

However, we believe there is a more fundamental issue. Child marriage laws must be passed before they can be implemented or enforced. Clear and consistent laws prohibiting child marriage are a very important first step. Our exploratory study examined only three laws, yet efforts on those have been largely inconsistent, and governments have not been held accountable. Therefore, there

is a very real and urgent need to build a reliable body of evidence focusing on minimum marriage age laws, particularly on rigorous studies that have been peer-reviewed for quality of research and methodology. A comparison of different sets of marriage laws is a policy-relevant issue, regardless of their implementation or enforcement.

Svanemyr and Chandra-Mouli also state that "We have no indication that the legal age of sexual consent has any effect on child marriage rates or even on pregnancy rates." Given the paucity of evidence, we do not believe that omission from the literature is indicative of irrelevance. Minimum marriage age policy approaches have generally been top-down, mostly driven by international and regional bodies. The age of sexual consent is relatively "national," and is thus more likely to reflect the values, interests and beliefs of the governing elite. For instance, Malawi has a general minimum marriage age of 18 years for girls, but has an exception allowing girls to marry at 15 years with parental consent. In addition, a girl is legally able to consent to sex with an adult male at the age of 13 years. This is problematic within the Sub-Saharan African context, given the relatively informal nature of customary unions, and the dominant public discourse discouraging premarital sex for sociocultural, religious or other reasons, such as the prevention of sexually transmitted infections (notably HIV). Low ages of sexual consent may thus reflect and reinforce existing norms that girl children are "protected" in relationships with "marriageable" men, a term that is inextricably linked with notions of maturity and economic self-sufficiency.

In regard to the rationale for Ethiopia and Rwanda's classification as having consistent laws, the first paragraph of the results section points out that the two countries have general minimum marriage ages of 18 and 21 years respectively, and do not allow for exceptions to the general marriage age based on parental consent. As explained in the footnote of the Table 2 (page 60), "unavailable" means legislation does not have provisions for parents to lower the general minimum age of marriage. Therefore, it is not true that there are no data on the laws of these two countries, but rather that in Ethiopia and Rwanda the minimum age of marriage with parental consent is the same as the general marriage age. These two countries also set the age of sexual consent at 18 years.

We would like to thank Joar Svanemyr and

Venktraman Chandra-Mouli once again for their comments and hope this response clarifies the points they raised.

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## Approaches to Postpartum Family Planning

In “A Fresh Look at the Level of Unmet Need for Family Planning in the Postpartum Period, Its Causes and Program Implications” [2015, 41(3):155–162], John Cleland, Iqbal Shah and Lenka Benova suggest that early postpartum family planning is superfluous and may result in shorter interpregnancy intervals. They point to postpartum abstinence and postpartum amenorrhea as prevalent among women 0–6 months postpartum. This position seems irresponsible when up to 60% of interpregnancy intervals are shorter than the WHO-recommended 24 months,<sup>1</sup> as is the case in Pakistan.<sup>2</sup> Classifying countries according to postpartum abstinence traditions is dangerous, given the lack of uniformity in practices within countries.<sup>3</sup> Cleland and colleagues rightly note that pregnancy is possible during lactational amenorrhea, especially later in the first year postpartum, but they dismiss this as a small percentage. Yet, Shaaban et al. found that 15% of breast-feeding women became pregnant prior to the return of menses.<sup>4</sup> This is not an insignificant percentage.

Postpartum family planning programs seek to use the multiple service contacts that women experience during pregnancy, childbirth and the postpartum period to initiate conversations about the benefits of adequate timing and spacing of pregnancies, inform on the return to fertility, provide information on immediate long-acting and reversible contraceptives or other effective methods and, at the time of childbirth or soon thereafter, encourage women to initiate an effective contraceptive method of their choice prior to discharge from the facility. Cleland and colleagues are right that women need to be equipped with adequate information to make choices. This is well articulated in recommendations and principles of the U.S. Agency for International Development (USAID),<sup>5</sup> the World Health Organization (WHO)<sup>6</sup> and the FP2020 ini-

tiative.<sup>7</sup> We go further to promote initiation of family planning as soon as possible in the postpartum. This approach requires integrating family planning counseling with antenatal care and organizing delivery and postnatal services in a way that facilitates uptake of a method either at the time of a facility birth<sup>8</sup> or in the early months after childbirth through another health service, such as immunization.<sup>9</sup> While Cleland and colleagues cite two articles showing higher rates of pregnancy among women adopting contraceptives early in the postpartum period, including a DHS analysis of calendar data,<sup>10,11</sup> more recent studies contradict this outcome. Tawfik et al.<sup>12</sup> found that early adoption of family planning in the postpartum period resulted in greater protection from becoming pregnant too soon in facilities in Afghanistan. A recent Cochrane review of postpartum insertion of IUDs found that, even with potentially elevated expulsion rates, higher continuation at one year postpartum led to overall greater use of a highly effective contraceptive method for women who received an IUD within 48 hours of childbirth than for those who delayed insertion.<sup>13</sup> Recent literature shows that the rate of IUD expulsion for postpartum IUD insertion is similar to that for interval insertion.<sup>8</sup> There is danger in delaying postpartum family planning uptake because women often assume that they cannot become pregnant again until menses return or while breast-feeding, even after they introduce supplementary foods.<sup>14</sup> In areas where facility births are less common, immunization visits, with their high coverage, offer another opportunity for referrals. As a result, WHO issued recommendations for integration of family planning into as many health contact points as feasible.<sup>15</sup>

Cleland and colleagues argue that providers lack time to effectively counsel women on the lactational amenorrhea method (LAM). We dispute their contention that counseling about LAM is unlikely to be effective for most women. While they acknowledge the child health benefits of exclusive breast-feeding, the argument is inconsistent with global priorities and strategies that point to family planning as having a significant impact not only on reducing fertility and empowering women, but also on child survival. The landmark Healthy Fertility Study—which implemented postpartum family planning through community health workers making home visits, engaging communities and delivering contraceptives door-to-door on a regular basis—found that women

who actively chose LAM were more likely than those who did not to be using modern methods of contraception after six months. At 12 months after childbirth, 15% more of the LAM users than the non-LAM users were using modern contraceptives. The population receiving postpartum family planning interventions also experienced 23% lower odds of a short interpregnancy interval than did the comparison population.<sup>16</sup> With this evidence in hand, the dismissal of counseling women about LAM seems contraindicated if postpartum family planning programs are to be successful and offer a full range of method choices.

Cleland and colleagues do make a valuable call for more research on discontinuation, particularly cogent for short-acting methods. Furthermore, women should understand the relative effectiveness of their contraceptive options.<sup>17</sup> The global community should rally around a common cause to meet the needs of postpartum women for effective methods of contraception rather than relying on presumptions about postpartum abstinence or amenorrhea. With FP2020, WHO, USAID and other organizations behind this effort, now is not the time to sow doubt about the value of early adoption of postpartum family planning.

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### Authors' Response

We thank Anne Pfitzer and her coauthors for their interest in our article, the main purpose of which was to stimulate discussion. One central issue of contention concerns the view of Pfitzer and colleagues that initiation of family planning should be promoted “as soon as possible in the postpartum.” A careful reading of our article would reveal that we totally agree in settings where lactational protection typically lasts for only 3–4 months. Indeed, we state that “early uptake of contraceptives should be promoted without hesitation” in such settings. We are also in agreement that, when continuation of use is likely to be high (as with IUDs and implants) or irrelevant (as with sterilization), early promotion of contra-

ceptives is justified and the “problem of redundant protection stemming from the overlap between amenorrhea and contraceptive use can be dismissed.” It is absurd to claim that we regard early postpartum family planning as superfluous.

Disagreement thus narrows to the question of whether methods with typically high rates of discontinuation (such as oral contraceptives, injectables and condoms) should be promoted in the early postpartum in settings where lactational amenorrhea lasts for around 12 months, as it does in most of Sub-Saharan Africa. Nothing in the letter dissuades us from our conclusion, based on the evidence, that a general strategy of encouraging early postpartum uptake of these methods in Africa is ill-advised, though, of course, it will suit the needs and preferences of some women. Postpartum family planning strategies need to take account of context.

A second disagreement concerns the lactational amenorrhea method (LAM). While we can agree on its health benefits, we remain unconvinced that it plays an important role in postpartum family planning. Despite promotional efforts in many countries since 1988, self-reported use remains very low and most users are not fulfilling all three conditions of use.<sup>1,2</sup> Even if the acceptability of this method could be improved, the gain in terms of pregnancy prevention would be trivial in populations where infants are breast-fed for many months. LAM has a failure rate of 2% or less against a 3% risk of pregnancy at month six among breast-feeding amenorrheic women, regardless of supplementary feeding.<sup>3</sup> Possibly, women who are prepared to use LAM are more likely to progress to effective methods later in the postpartum, but the evidence is very thin. In any case, LAM users are a highly selective group, and it is thus unjustified to attribute their subsequent contraceptive practice to exposure to LAM counseling.

Pfitzer et al. state that women should be told about the relative effectiveness of their contraceptive options. We agree. In our article, we simply extend this fundamental principle to lactational amenorrhea, freed from the definitional shackles of LAM. Our article is all about extending informed choice. Do Pfitzer and colleagues really think that accurate information about the risks and benefits of relying on lactational amenorrhea should be withheld from women? Based on one study in Egypt reporting that 15% of women became pregnant while breast-feeding and

amenorrheic, Pfitzer et al. deem these risks to be acceptably high.<sup>4</sup> But this 15% figure is not expressed in terms of postpartum length and thus cannot be compared to the estimate of Kennedy and Visness, based on nine carefully controlled prospective studies, that the risk of pregnancy at 12 months postpartum for breast-feeding, amenorrheic women is on average 6%,<sup>3</sup> similar to the failure rate for oral contraceptives.

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