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Causes and Health Consequence of Early Marriage as Perceived by Egyptian Females in Rural and Urban Areas: a Comparative Study

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Abstract: *Early or child marriage is a silent and yet widespread practice in Egypt. Early marriage has profound adverse physical, intellectual, psychological and emotional health consequences, cutting off educational opportunities and chances for personal growth. Moreover, early married girls are more likely to experience pregnancy related complications, delivery concerns as well as maternal mortality, in turn increases risk for neonatal death, premature or low-weight infants and poor health outcomes. This indicates a need to understand the various perceptions of causes and health consequences of early marriage that exist among Egyptian early married females. Thus, the aim of this study is to compare causes and adverse health consequences of early marriage as perceived by Egyptian females in rural versus urban areas. A purposive sample of 200 early married females was selected from 2 urban and 2 rural family health centers. Study tools: a three parts questionnaire was developed by researcher including sociodemographic data sheet, medical and obstetrical health history as well as perception of causes and health consequences of early marriage. Using a comparative descriptive research design, results revealed that the mean age at marriage of females was 15.58 in the urban and 14.94 in the rural area. Significant difference were observed between rural and urban females in relation to number of miscarriage and number of preterm babies at 0.000* and 0.004* respectively. It is recommended to raise awareness among adolescents, religious and local influential people and families regarding the legal marital age and the possible devastating adverse health consequences of child marriage for the girl, family and the community as a whole, and enforcing strict laws against child marriage practice in Egypt.*

Key words: *Causes, Health Consequence, Early Marriage*

I. Introduction

As defined by the Office of the High Commissioner for Human Rights (OHCHR, 2014), "early marriage" is often used interchangeably with "child marriage" and refers to "any marriage carried out below the age of 18 years, before the girl is physically, physiologically, and psychologically ready to shoulder the responsibilities of marriage and childbearing. It therefore has major consequences for public health, national security, social development, human rights, economic development and gender equality (Walker, 2013). In 2010, approximately 70 million young women aged 20-24 years were married before the age of 18 years (UNFPA, 2012). According to UNICEF, 2014, worldwide, 720 million women alive today were married before their 18th birthday. As such, More than one in three (about 250 million) entered into union before age 15.

Globally 36% of females aged 20-24 were married before they'd reached 18 years old. Furthermore, girls are often married to considerably older men. The age difference between the girl and her husband tends to reinforce the powerlessness of the girl and increasing risk of abuse and lack of self-assertiveness. An estimated 14 million girls between the ages of 15 and 19 give birth each year (Population Council analysis of DHS data, 2007). UNICEF (2006) also added that there is a strong correlation between the age of a mother and maternal mortality. Girls ages 10-14 are five times more likely to die in pregnancy or child birth than women aged 20-24 and girls aged 15-19 are twice as likely to die.

Unfortunately, Egypt—the most populous Arab country—is home to the largest number of child brides in the Arab region. In Egypt, despite the legislative amendments, 23 per cent of girls were married before the age of 18 and child marriage was an age-old tradition entrenched in culture (United Nations human rights council, 2014). The Egyptian Demographic Health Survey (EDHS, 2014), also reported that overall, 6 percent of women age 15-17 had ever married before their 18th birthday. The survey also added that early age at first marriage is usually associated with a longer period of exposure to the risk of pregnancy and thus higher fertility levels. The early initiation of childbearing associated with early marriage may also adversely affect women's and children's health.

Moreover, early marriage is a critical social, health, and development issue in the Arab region. The practice violates girls' human rights and takes a toll on families and societies and perpetuates a generational cycle of poverty, low education, and early childbearing and poor health. Thus, a collective regional political

commitment is needed. Arab countries' governmental and nongovernmental organizations from all sectors and at all levels need to collaborate to raise community awareness about sexual and reproductive health and the harmful consequences of early marriage. As such, ending early marriage would protect girls' rights to education and protection, save the lives of young mothers and their newborns, and improve family health and well-being. Since families have tremendous influence in their daughters' marriages, they need to be involved in the solutions and are key to ensuring a healthy transition to adulthood for all girls (Farzaneh, 2014).

As such, recent studies reiterate the adverse health consequences of early marriage among young females and their children even after a host of confounding factors are controlled. The current evidence is conclusive with regard to many indicators: unintended pregnancy, pregnancy-related complications, preterm delivery, and delivery of low birth weight babies, fetal mortality and violence within marriage (Santhya, 2011). Furthermore, child marriage has far-reaching health, social, economic, and political implications for the girl and community. It truncates a girl's childhood, creates grave physical and psychological health risks, and robs her of internationally recognized human rights. Thus, ending child marriage requires collective efforts from all those involved, including fathers and all fronts: social, economic, judicial, religious, and political parties (Farzaneh, 2014).

In the same line, Nour, 2008 reported that early marriage is driven by poverty and has many effects on girls' health such as increased risk for sexually transmitted diseases, cervical cancer, death during childbirth and obstetric fistulas. Girls' offspring are at increased risk for premature birth and death as neonates, infants, or children. To stop child marriage, policies and programs must educate communities, raise awareness, engage local and religious leaders, involve parents, and empower girls through education and employment.

II. Significance of the study

According to UNICEF report, 2014, globally, 1 in 4 girls globally are married before the age of 18. Meanwhile, 1 in 3 girls in the developing world are married before the age of 18. Moreover, 1 in 9 girls in the developing world are married before the age of 15. The report also warned that, if there is no reduction in child marriage, 1.2 billion girls will marry as children by 2050. In the Arab region 1 in 7 girls marries before her 18th birthday. According to Sutay, 2010, early marriage constitutes the major socioeconomic and socio-cultural factors facilitating adolescent childbearing in Egypt. Early marriage often leads to a higher total number of lifetime births. The proportion of ever-married adolescent women (aged 15-19) who have begun childbearing (or are pregnant with a first child) is slightly more than 10 percent in Egypt.

Clearly, early marriage is a clear violation of the Universal Declaration of Human Rights 1948 and the International Covenant on Civil and Political Rights 1966 (Lane, 2011) and adversely affects their health and well-being. While age at marriage is increasing in most regions of the developing world, early marriage persists for large populations. A number of underlying factors help perpetuate early marriage: traditional gender norms, the high value placed upon female virginity, parental concerns surrounding premarital sex and pregnancy, dowry pressures, the perception that marriage provides protection from HIV and other sexually transmitted infections, and the desire to secure social, economic, or political alliances (Amin, 2011).

Therefore, the United Nations highlight the need of reducing child marriage and its effect on maternal and child health through the Millennium Development Goals for improving maternal health, reducing child mortality, and promoting gender equality and women empowerment (United Nations, 2011). Hence, early marriage is considered a human rights issue. Nonetheless, in many developing countries, particularly in poorer rural areas, girls are often betrothed or committed to an arranged marriage without their knowledge or consent. Such an arrangement can occur as early as infancy. Parents see marriage as a cultural rite that provides protection for their daughter from sexual assault and offers the care of a male guardian (McIntyre, 2006). Many parents often feel that a young girl is an economic burden and therefore wish to marry off their young daughters before they become an economic liability (McIntyre, 2006). The findings of Santhya, 2011 study call for further examination of the health consequences of early marriage and the pathways through which the associations between early marriage and adverse outcomes take place. Nurses working in rural and urban area family health centers are in a front line position to explore and examine these factors, involve parents and raise family awareness about the adverse health consequences of early marriage. Thus, this research further explores possible causes and health consequences of this old practice as perceived by early married females in rural as well as urban areas in Egypt.

III. Aim of the Study

This study aim to compare causes and health consequence of early marriage as perceived by Egyptian females in rural versus urban areas.

Research questions: What are the causes and adverse health consequences of early marriage as perceived by Egyptian females in rural versus urban areas?

IV. Materials and Methods

Research Design: Descriptive comparative research design was adopted for the study.

Setting: Early married females were purposively selected from four family health centers. Two rural health centers (El- Badreashin and El- Hawamdya) and two urban health centers (Abo El So'ood and Amr Bn El-'aas).

Sample: Purposive sample of 200 females in reproductive age (15–49 years) who were married prior to 18 years, for at least 5 years and had at least one child birth were recruited (based on rule of sum calculated by number of variables multiplied by a constant of 10). Females were recruited as 50% for urban (n=100) and 50% for rural (n=100).

Tools for data collection: A 3 parts questionnaire was developed by researcher and included:

1-Socioeconomic data sheet including current age, age at marriage, marital status, educational level, occupation, address, income, and number of children, medical and obstetrical/gynecological history and HCI. The household crowding index (HCI) was defined as the total number of co-residents per household, excluding the newborn infant, divided by the total number of rooms, excluding the kitchen and bathrooms. The continuous variable was re-grouped into three distinct categories: (1) <1, (2) 1–2, and (3) >2 residents per room.

2- Perception of early marriage causes such as protection of the family name/honor, decrease family burden, and for religious reasons…etc.

3- Perception of adverse bio-psycho-social health consequences of early marriage include physical health consequences after marriage such as physical health problems, social health consequence such as continues conflict with spouse and domestic violence and psychological health consequences after marriage such as tension and stress.

Pilot Study: It was conducted on (10%) of participants to check clarity of items and determine the feasibility of the research. Pilot sample was excluded from research sample.

Procedure: data was collected through a period of 4 months from March 2014 till June 2014, two days per week from 10 am till 1 pm. After the females had been fully informed and consented for participation in the research, the researcher started to collect data through structured interview which took 30 minutes. An Arabic educational booklet including outlines such as scope and statistics of early marriage in Egypt, causes, adverse health consequences and recommendation for prevention (law reinforcement, girl empowerment through education, changing minds and social norms and the role of religion and media..etc.) was distributed to study participants at the end of interview.

Protection of ethical and human rights: An official permission was granted from the directors of health centers, the researcher introduced herself to females who met the criteria of selection, then informed them about the purpose of research. A written consent was obtained from females who were voluntarily agreed to participate in the research and can read and write whereas; an oral consent was taken from females who couldn't read and write. Confidentiality was maintained as the tools were not shared and females were reassured that data will not be reused in another researches.

Validity of study tools: Tool was submitted to a panel of five experts in the field of community and maternity health nursing to test the content validity. Modification was carried out according to the panel judgment on clarity of sentences and appropriateness of content

V. Statistical data analysis

Collected data were coded and tabulated using personal computer. Statistical package for social science (SPSS) version 16 was used. Descriptive as well as inferential statistics were used to answer research question. Statistical significance was considered at p-value <0.05.

VI. Results

Statistical findings of the current study are presented as comparison between females in rural and urban areas in relation to four main sections:

Section I: - Socio-demographic data.

Section II: - Medical and obstetrical history.

Section III: - Perception of early marriage and its causes.

Section IV: - Perception of adverse health consequences of early marriage.

<u>Section I: - Comparison between females in rural and urban areas regarding socio-demographic data:</u>

As regards to marital status of females, it was found that 74.9% and 67.7% of females in urban and rural area respectively were currently married while 11.0% and 28.3% of them were divorced. Additionally, 14.1% and 4% were widowed. The mean age of females was X ±SD= 33.31+9.24 for urban and X ±SD=

33.87+8.33 for rural group. Meanwhile, the mean age at marriage of females was 15.58 for urban and 14.94 for rural females showing a significant difference at f ratio = 0.383and p value = 0.002*. Moreover, the minimum age at marriage was 12 years old for rural females and 13 years old for urban females while the maximum age at marriage was 17 years old for rural female and 18 years old for urban females. Furthermore, A gap between spouse mean ages at marriage existed at X ±SD = 24.59+6.10 for rural spouses and X ±SD= 25.40+4.33 for urban spouse. Regarding children number, study results revealed that 72% and 24% of rural and urban females respectively had more than 4 children. The mean number of children in urban area was X ±SD= 3.49+2.04 and X ±SD = 4.01+1.639 for rural area.

Regarding education, it was found that 35.4% and 51.5% of urban and rural females respectively were illiterate while 43.4% and 33.3% of them respectively could read and write only. Moreover, 15.2% of rural and 13.1% of urban females has technical education. Whereas, 8.1 % of urban females and none of rural females had completed their university education. As regards to females' occupation, study results revealed that among 53.5% and 88% of urban and rural females respectively were house wives while 39.4% and 11.1% of them were employees. Furthermore, regarding consanguineous marriages and familial relationship between wife and husband, it was found that 25.3% and 39.4% of urban and rural female spouse were blood relatives while 74.7% and 56.6% of them respectively didn't have any family relationship between wife and husband. Regarding the mean monthly family income it was 9992.9± 322.1 for rural and 1035±450.7 for urban families. Moreover, the minimum familial monthly income was 500 L.E and 700 L.E and the maximum income was 2000 L.E for rural and urban families respectively. Furthermore, there is a significance statistical difference between place of residence in rural or urban area and the current wife marital status at chi= 27.227 and p value = 0.005*, occupation at chi = 31.368 and p value = 0.005*, family monthly income at chi= 198 and p value=0.000* and familial relationship at chi= 13.883and p value = 0.001*. Crowding index for 70% and 75% of rural and urban families was >2.

<u>Section II: - Comparison between females in rural and urban areas regarding medical and obstetrical history:</u>

In relation to current complains of chronic diseases, it was found that 36.4% and 48.5 of urban and rural females respectively have chronic diseases. For example, 26% of urban females have hypertension while 19% of rural females have diabetes mellitus while 9.1% of rural and 17.1% of urban females mentioned that they suffer from iron deficiency anemia and 29.3% and 9.1% of rural and urban females respectively complain of chronic vaginal infections. Meanwhile, 72% and 64% of rural and urban females get pregnant immediately (less than 1 year) after marriage without planning for getting pregnant. Furthermore, regarding frequency of delivery, 79.8 % of rural females and 73.7% of urban females get pregnant from two to 6 times. The mean number of delivery was 4.36± 1.75 and 3.72± 2.12 for rural and urban females respectively. Furthermore, the mean number of pregnancy follow up was 6.19±3.4 for rural and 9.69±5.4 for urban females with a significant relationship f=4.507 and P value= 0.000*. Moreover, 69.7% and 66.7% of urban and rural females respectively have delivered normally and 30.3% and 33.3% of them has delivered by cesarean section. Family planning methods are currently used by 49.5% and 50.5% of rural and urban females respectively.

It was also found that 50.4 % and 65.5 % of rural and urban female respectively have health problems during their pregnancy. The top three health problems during females' pregnancy included chronic fatigue, eclampsia and anemia among 12.1% and 11.1%, 13.1% and 18.2%, and 9.1% and 16.1% of rural and urban females respectively. The lowest five reported health problems among rural and urban females respectively were hyperemesis gravidirum (1%, 4%), diminished water around fetus (3%, 4%), pelvic inflammatory diseases (6%, 9%), bleeding (3%, 1%) and spouse violence (19%, 17.9%). Table (1) shows pregnancy- related complication among early married females. Meanwhile, The mean of abortion numbers were X ±SD= 1.28+0.452 for rural and X ±SD= 1.7+0.832 for urban. Furthermore, numbers of still births were 1.53+0.516 for rural and 1.38+0.495 and for urban. Moreover, the mean Number of preterm infants was X ±SD = 2.09+0.831 and X ±SD = 1+0.00 of for rural and urban. A significant difference were observed between rural and urban females in relation to Number of miscarriages/abortions at Chi-Square=15.753 and P value=0.000*, number of preterm babies at Chi-Square=10.909 and P value=0.004*.

Table (1) Frequency distribution of pregnancy-related complications among females in rural and urban areas (n=198).

Pregnancy complication	Rural n= (99)		Urban n =(99)	
	No	%	No	%
Frequency of miscarriage/abortions				
None	38	38.3	56	56.5
Once	44	44.4	23	23.2
Twice	17	17.2	10	10.1
Three times	0	0	10	10.1
Total Mean ±SD	1.28±0.452		1.7±0.832	
Number of still births				
None	84	84.8	75	75.7
One child	7	7.1	15	15.2
Two child	8	8.1	9	9.1
Total Mean ±SD	1.53±0.516		1.38±0.495	
Number of preterm babies				
None	88	88.8	90	90.9
One preterm	3	3	9	9.1
Two preterm	4	4	0	0
Three preterm	4	4	0	0
Total Mean ±SD	2.09± 0.831		1± 0.00	

Section III: - Perception of early marriage and its causes:

It is worth saying that, 82.8% and 57.6% of rural and urban females respectively reported that early marriage is a widespread practice within their place of residence. Regarding knowledge of the minimum legal marital age, it was found that 39.4% and 52.5% of rural and urban females respectively mentioned that the legal marriage age is from 15 to less than 18 years old. Moreover, 40.5%&20.3% of them respectively reported that it is more than 18 while 16.1% of females didn't know the legal marriage age. Surprisingly, 4% and 11.1% of rural and urban females reported that it is less than 15 years old. Meanwhile 4% of rural females believed that the age suitable for female marriage is less than fourteen years old. It was also found that 62.7% and 75.8% of rural and urban females respectively were forced to get marry at an age less than 18 years old. Meanwhile, 64.6% and 51.8% of rural and urban females also reported that family father is the person who has the decision of their marriage. Furthermore, 24% and17 % of rural and urban females respectively reported that they have an intention to get their daughters marry before the age of 18 to reduce familial financial burden.

As shown in table (2), causes of early marriage as perceived by females in rural and urban areas were enforcement by parents (62.6%&70.7%), Lack of knowledge about related- health consequences (71.7%&69.7%) protecting chastity/virginity of the girl (70.7% &64.4%), perpetuating family name (63.6%&49.5%), follow traditions and customs (40.4%&35.3%), reduce financial and social familial burden (60.6%&69.7%), poverty (84.8%&64.6%), respecting religious instruction (43.4%&46.5%), appearance of puberty signs (62.5&72.7%) and fear of spinsterhood/delaying marriage (14.2%&10.1%). No statistical difference was found between rural and urban females opinions regarding perception of causes of early marriage.

Table (2) Frequency Distribution of females' perception of causes of early marriage in rural and urban areas (n=198).

Causes of early marriage	Rural n= (99)		Urban =n (99)	
	No	%	No	%
Parents forced their daughters to get marry	62	62.6	70	70.7
Lack of knowledge about related- health consequences	71	71.7	69	69.7
To protect chastity of the girl	70	70.7	64	64.6

To perpetuate family name/honor	63	63.6	49	49.5
To follow traditions and customs	40	40.4	35	35.3
To reduce familial financial burden	60	60.6	69	69.7
Poverty	84	84.8	64	64.6
Respect of religious instructions	43	43.4	46	46.5
Appearance of puberty signs	62	62.6	72	72.7
Fear of delayed marriage (spinsterhood)	14	14.2	10	10.1

All responses are not mutually exclusive

Section IV: - Perception of adverse biopsychosocial health consequences of early marriage:

In relation to general adverse physical health consequences as perceived by females, it was found that 31.3% & 68.7% of rural and urban females respectively agreed that it is vulnerability to health problems due to increased frequency of delivery and physical immaturity of girl at the age of marriage, while chronic fatigue was reported by12% & 20.2% of females respectively, while, back pain was mentioned by 12.1% & 38.4% of them respectively. Meanwhile, females agreed that adverse social health consequences include continuous familial conflict (55.6%&70.7%), school termination (10.1% & 18.2%) and social isolation (20.1%&30.9%), among rural and urban females respectively. Furthermore, 45.5% &76.8% of females in rural and urban areas agreed that early marriage has psychological health consequences including tension (35.4%&35.4%), anxiety (18.2%&36.4%), and psychological pressure (19.2% & 46.6%) and sleep problems (26.3% & 16.2%). As shown in the table 3&4, specific adverse health effects of early marriage also included children's' health problems (80.8%&77.7%), increased divorce rate (60.6%&83%) and obstetrical health problems (42.2%&65.7%). Significant relationships were found between vulnerability to physical problems, types of health problems and psychological pressure among rural and urban females at 0.000*.

Table (3) Frequency distribution of females' perception of about adverse health consequences of early marriage and its' preventive procedures in rural and urban areas (n=198).

Variables	Rural n = (99)		Urban n = (99)	
	No	%	No	%
Specific adverse physical health consequences of early marriage				
Infant mortality	31	31.3	40	40.4
Maternal mortality	38	38.4	40	40.4
Physical health problems	31	31.3	68	68.7
Disturbed menstrual cycle	21	21.2	27	27.3
Obstetric health problems	42	42.2	65	65.7
Children health problems	80	80.8	77	77.7
Adverse Psychological health consequences of early marriage				
Psychological health problems	3	3	10	10.1
Adverse social health consequences of early marriage				
Marital problems	7	7.1	3	3
Inability to rear children	20	20.2	19	19.2
Difficulty managing home issues	21	21.2	27	27.3
Increase divorce rate	60	60.6	83	83.9
No health consequences	21	21.2	19	19.2
Procedures to prevent early marriage				
Law enforcement	36	36.4	41	41.4
Parent education	29	29.3	48	48.5
Girls' education	45	45.5	46	46.5
Don't Know	15	15.2	20	20.2

All responses are not mutually exclusive

Table (4) Relationship between adverse health consequences of early marriage and place of residence among females in rural and urban areas (n=198).

Variables		Place of Residence (Rural &Urban)
Perceived adverse physical consequences of early marriage		
Vulnerability to physical problems	Chi-Square P value	20.034 0.000*
Types of health problems	Chi-Square P value	19.278 0.000*
Perceived adverse social consequences of early marriage		
Familial conflict	Chi-Square P value	5.818 0.23
Social isolation	Chi-Square P value	2.662 0.152
Perceived adverse psychological consequences of early marriage		
Psychological pressure	Chi-Square P value	20.423 0.000*

* Significant at P≤ 0.05.

VII. Discussion

Results of this research will be discussed in the following frame; description of females' socio-demographic data, medical and obstetrical history and perception of early marriage, its' causes and its' adverse health consequences. As regards the crowding index, it was found that more than half of females lived in houses with crowding index more than two which may indicate low socioeconomic status of these females. This fact is evidenced by low family monthly income level, as well as illiteracy among more than half of rural females and more than one third of urban females. Unemployment was also found among majority of rural females and more than half of urban females. Moreover, more than one third and one tenth of rural and urban females were divorced and have an average of three to four children. Study results also revealed that early marriage practice although silent but still present and higher among rural females than their counterparts in urban area. Age at marriage was lower in rural than in urban areas as well. Furthermore, consanguineous marriages were prevalent among one fourth of urban and more than one third of rural community.

This result is supported by OHCHR, 2014 report concluded that empirical evidence shows poverty and insecurity as one of the root causes of early and forced marriage. Although the proportion of child brides has generally decreased over the last 30 years, child marriage remains common in rural areas and among the poorest communities. This goes with the Egyptian Demographic Health Survey (EDHS, 2014) report which stated that women in rural areas in Egypt marry on average nearly four years earlier than women in the urban areas and that consanguineous unions are common practice where thirty percent of ever-married women report their current husband was a blood relative. The report also added that, in rural areas, the total fertility rate is around four births per woman and around thirty percent higher than the rate in urban areas which is around three. El-Zanaty, 2015 also added that childbearing begins early for many Egyptian women; more than one quarter of women age twenty five to forty nine had their first birth by age twenty and forty five percent gave birth by age twenty two. Seven percent of adolescents are already mothers, and four percent are pregnant with their first child. Amin, 2011 mentioned that, while the high cost of marriage has been documented for Egypt, an extremely poor family may calculate that the husband’s family will be better able to provide for their daughter, or the economic gains incurred through her marriage may be part of the family’s survival strategy.

In this respect, Okereke, 2013 reported that early marriage still thrives in spite of various conventions against the practice and added that the physical health and psychological consequences of early marriage can constitute a huge price; in order to stem the tide of early marriage and its consequences, education of the girl-child must take pre-eminent position. Farzaneh, 2014 also concluded that child marriage can be seen as both a cause and a consequence of poverty and the low status of girls and women. In Egypt, girls belonging to the poorest one-fifth of the population are at least four times more likely to wed before their eighteen birthday than those belonging to the richest one-fifth. In the same line, education is a powerful way to prevent child marriage,

especially keeping girls in school through secondary grades. In a study done in Egypt in 2012, educated parents were more likely to keep their daughters in school and less likely to marry them off at a young age than parents who had little or no schooling.

The results of current study revealed that, in relation to medical and obstetrical history, more than half of females in the current study mentioned that they suffered from several health problems such as diabetes mellitus, hypertension, and repeated vaginal infections. It was also found that more than half of both rural and urban female had many pregnancy- related complication such as chronic fatigue, eclampsia, anemia, and hyperemesis gravid rum, water around fetus, pelvic inflammatory diseases, bleeding, spouse violence, abortion, still births and preterm infants. This goes with Smith, 2009 who mentioned that pregnant adolescents, particularly from the poorest segments of society, may not have completed their physical growth, and may be malnourished, thus increasing their risk of complications requiring medical care, including obstetric fistula.

In the same line, OHCHR, 2014 reported that early marriage is associated with a range of poor health and social outcomes and other negative consequences. Specifically, early and frequent pregnancies and forced continuation of pregnancy are all common in child marriages. They are closely linked to high maternal and infant morbidity and mortality rates and can have an adverse effect on girls' sexual and reproductive health. In fact, "pregnancy-related complications are the main cause of death for young women, with girls being twice as likely to die from childbirth as women in their twenties". According to WHO, 2013 girls who marry young are usually not empowered to make important health decisions, such as practicing family planning to avoid unwanted pregnancy, or lack accurate information about, their sexual and reproductive health, which compromises their ability to, inter alia, decide on the number and spacing of their children and negotiate contraceptive use. Moreover, having babies during early and mid-adolescence has a serious consequence for the health of mothers and their newborns. Children born to adolescent girls are more likely to be premature and have low birth weight, conditions that have a long-term impact on the newborns' health and development and put them at a higher risk of dying before their first birthday. Stillbirths and deaths during the first week of life are fifty percent higher among babies born to mothers under age 20 than among babies born to mothers in their twenties

In the current study around one third of females have reported that they have experienced physical violence during pregnancy. In this respect, El-Zanaty, 2015 added that three in ten ever-married women age fifteen to forty nine years in Egypt have ever experienced some form of spousal violence, with twenty five percent saying they were subjected to physical violence, nineteen percent emotional violence, and 4 percent sexual violence. Moreover, Ibrahim, 2010 found that girls who marry at a younger age are generally more vulnerable to spousal violence than girls who wait longer to marry. Farzaneh, 2014 also added that child brides have little opportunity to develop awareness of their rights, and are in no position to demand them. Too often, child brides are much younger than their husband, which adds to the uneven power dynamic between the brides and their husbands—and their husbands' families. Bayisenge (2010) noted that young married girls are more likely to be beaten or threatened and more likely to believe that a husband might sometimes be justified in beating his wife. The International Center for Research on Women (ICRW, 2008) reported that in Egypt twenty nine percent of married adolescents were beaten by their husbands. Of these, 41 percent were beaten when they were pregnant.

In the same line, UNFPA, 2015 concluded that early marriage directly threatens the health and well-being of girls. Complications from pregnancy and childbirth are the main cause of death among adolescent girls in developing countries due largely to girls' physical immaturity where the pelvis and birth canal are not fully developed. Complications in labor are exacerbated where emergency obstetric services are scarce, as is the case in many societies where child marriage is prevalent. A child born to a girl under eighteen has a sixty percent greater chance of dying in the first year of life than one born to a woman nineteen and older. Married girls and young women between the ages of fifteen and nineteen with low levels of education are at a much greater risk of domestic and sexual violence from their spouses than older and more educated women. Research cites spousal age difference, typical of child marriage, as a significant risk factor associated with violence and sexual abuse against girls.

As regards knowledge of legal marital age among participants in the current study, around two third of study participants didn't know the right response. Furthermore, regarding causes of early marriage as perceived by females, enforcement by parents, Lack of knowledge about related- health consequences, protecting chastity of the girl, perpetuating family name/ honor, reduce financial and social familial burden, poverty, respecting religious instruction, appearance of puberty signs and fear of spinsterhood were all reported by rural and urban females . The current study findings are also supported by (Getiye, 2014) study who found that the main reasons

behind the high prevalence of early marriage practices in his study area are perceived as social and economic benefits and little knowledge of the consequences of early marriage and lack of knowledge regarding the minimum legal marriage which was also low in that study.

In the same line, Okereke, 2013 paper which explored reasons behind early marriage in Nigeria included economic, socio-cultural and religious as well as notions of morality and honor and examined early marriage devastating effects on physical, health, psycho-social as well as the denial of education is also emphasized in the Nigerian study. Bayisenge, 2011 also found that, various factors are responsible for early marriages including male dominancy, parents ignorance, lack of awareness, pressures from relatives and community, girls are regarded as burden so parents get rid of them by marrying them, parents believes that it offers protection to their daughters and to enhance family socio-economic status. In relation to physical health consequences as perceived by females in the current study, there was an agreement on vulnerability to health problems due to increased frequency of delivery and physical immaturity of girl at the age of marriage, chronic fatigue, and back pain were the adverse health consequences of early marriage. Meanwhile, females agreed that adverse social health consequences include continuous familial conflict, school termination and social isolation. Furthermore, psychological health consequences included tension, anxiety, psychological pressure and sleep problems.

In this respect, Sadaf, 2013 also concluded in his study which aimed to evaluate the aspects of psychological disturbances occurring in married young girls along with depression rate and educational withdrawal, with comparison of unmarried young girls of the same age that, early marriage, multiple responsibilities and early pregnancies are risk factors of higher depression rate among half of his studied early married females. He also added that with marriage there will be increased stresses and pressures and early married girls are more prone to marriage problems as their individuality has been interrupted. There should be health awareness programs conducted for the girls as well as their parent to overcome the problems caused due to early marriages and to improve their quality of lives.

This goes with, Muazzam, 2014, who reported in his qualitative study that most early married females were uneducated, poor and were working as housemaids. The majority participants were unaware of the negative health outcomes of child marriages. Strong influence of culture and community perceptions, varying interpretation of religion, and protecting family honor are some of the reasons that were narrated by the participants. From my point of view as a current study researcher, early marriages violate many human rights; including education, freedom from violence, reproductive rights, and access to reproductive and sexual health care, employment, freedom of movement, and the right to consensual marriage. Many girls under the age of eighteen are not emotionally ready for the challenges of marriage so they too face many difficulties of knowing how to manage a home, a husband and a family effectively. Again, this adds pressure on the girl and can cause long term emotional damage.

Despite people knowing these facts and awareness being made across Egypt, girls are still being married at a young age. Many families resist change because it is altering age old traditions and beliefs. In addition, many families see little point on changing rules on child marriage because once they have found a suitor willing to pay a dowry, it seems apt that the marriage takes place, however, young the girl. Child marriage is a human rights violation that prevents girls from obtaining an education, enjoying optimal health, bonding with others their own age, maturing, and ultimately choosing their own life partners. So, from the current study researcher's point of view, education and support services regarding family planning for adolescent wives and their families are also clearly indicated in order to reduce the reproductive health consequences of this socially normative practice. Raising awareness among communities regarding legal marital age and the possible devastating health consequences of early marriage for the girl, family and the community as a whole, engaging media local and religious leaders, involvement of parents, and empower girls through education and employment must be applied. Enforcing strict laws against early marriage practice were recommended to overcome this practice in Egypt.

VIII. Conclusion and recommendations

The prevalence of early marriage practice was higher among the rural community than in the urban community. All marriages were before eighteen. Causes of early marriage as perceived by females in rural and urban areas were enforcement by parents, lack of knowledge about adverse health-related consequences, protecting chastity of the girl, perpetuating family name, following traditions and customs reducing financial familial burden, poverty, respecting religious instruction, appearance of puberty signs and fear of spinsterhood. The knowledge regarding the minimum legal marriage was lower in rural area than in urban area. Adverse health consequences of early marriage as perceived by females were obstetrical health problems chronic fatigue,

back pain, continuous familial conflict, social isolation, tension, anxiety, psychological pressure and sleep problems. Thus, enforcement of existing policies is critical to prevent early marriage.

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